

Bundle Public Board of Directors 3 June 2026

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**MEETING IN PUBLIC OF THE BOARD OF DIRECTORS
OF THE ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
WEDNESDAY 3 JUNE 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:	Paul von der Heyde, Chair	Verbal	-
2.	Written questions from the public		Verbal	I/D
3.	Minutes of the Board of Directors meeting held in public on 1 April 2026		Enc.	A
4.	Action Log		Enc.	A/D
5.	Patient Story	Toni Lynch, Chief Nursing Officer	Pres.	I/D
6.	CEO and Managing Director's Report Letter from Region and Trust Response	Cara Charles-Barks, Chief Executive / John Palmer, Managing Director	Enc.	I
7.	Chair's Report	Paul von der Heyde, Chair	Verbal	I
8.	Board Assurance Framework Summary and Closure	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	I/D
9.	Management Executive Committee Upward Report	John Palmer, Managing Director	Enc.	I/D
10.	Finance and Performance Committee Upward Report	Antony Durbacz, Non-Executive Director	Enc.	I/D
11.	Quality Assurance Committee Upward Report	Simon Harrod, Non-Executive Director	Enc.	I/D
12.	Integrated Performance Report	Executive Leads	Enc.	I/D
13.	UEC CQC Report	Toni Lynch, Chief Nursing Officer	Enc.	I/D
14.	MIS combined Maternity and Neonates Quarterly Report Q3	Zita Martinez, Director of Midwifery / Jane Farey, Obstetric Lead	Enc.	I/D
15.	Midwifery and Neonatal Bi-Annual Staffing Report	Zita Martinez, Director of Midwifery / Jane Farey, Obstetric Lead	Enc.	I/D
16.	Freedom to Speak Up - Q4 Report - Annual Report	Para Perera, Freedom to Speak Up Guardian	Enc.	I/D
17.	2026/27 Business and Financial Plan	Rhiannon Hills, Director of Transformation / Jon Lund, Site Director of Finance	Enc.	I

18.	Statutory Governance Framework to support the implementation of BSW Hospitals Group	Roxy Milbourne, Interim Head of Corporate Governance / Simon Wade, Chief Finance Officer	Enc.	A
19.	Annual Review of Directors' Fit and Proper Persons Test	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	A
20.	Annual Review of Declarations of Interest	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	A
CLOSING BUSINESS				
21.	Any Other Business	Paul von der Heyde, Chair	Verbal	-
22.	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	Paul von der Heyde, Chair	Verbal	

Key:

A – Approval
D – Discussion
I – Information

Enc – Paper enclosed with the meeting pack
Pres– Presentation to be delivered at the meeting
Verbal – Verbal update to be given by the presenter at the meeting

ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE PUBLIC BOARD OF DIRECTORS

WEDNESDAY 1 APRIL 2026, 09:30 – 12:00

VENUE: ROOM T0.24, BATH SPA UNIVERSITY SION HILL CAMPUS, SION HILL,
BATH, BA1 5SF

Present:

Members

Liam Coleman, Chair (*Chair*)
Paul von der Heyde, Group Chair
Sumita Hutchison, Interim Vice-Chair
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
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
Jamie Caulfield, Deputy Director of Estates and Facilities (*item 17*)
Abby Strange, Corporate Governance Manager (*minute taker*)
Members of the public

Apologies

Judy Dyos, Group Chief Strategic Officer
Simon Harrod, Non-Executive Director
Joy Luxford, Non-Executive Director
Jonathan Hinchliffe, Group Chief Digital and Information Officer (Interim)
Andrew Hollowood, Clinical Strategic Transformation Director

BD/26/04/01 Chair's Welcome, Introductions, Apologies and Declarations of Interest:

The Chair welcomed everyone to the meeting and advised that it was his last Board meeting. He extended his thanks to the Board for their support during his time in post and introduced Paul von der Heyde who had been appointed as Interim Group Chair for BSW Hospitals Group from 1 April 2026..

Apologies had been received from those listed above and the Board confirmed that they had no additional interests to declare.

BD/26/04/02 Written questions from the public

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

BD/26/04/03 Minutes of the Board of Directors meeting held in public on 4th March 2026

The minutes of the meeting held on 4th March 2026 were approved as a true and accurate record.

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

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

PB640 – The Managing Director confirmed that capital projection work was ongoing around the Green Heart project and that there were several available options for the site going forward. The Trust remained committed to the project with a £500k budget for landscaping and work and the Associate Director of Capital Projects and Infrastructure was developing an options appraisal for review. The report would be presented to the Board in June 2026 and the action would remain open in the interim.

BD/26/04/05 CEO and Managing Director's Report

The Chief Executive reported that the Group continued to focus on performance recovery and financial sustainability, alongside safe mobilisation of the Group operating model. She explained that the mobilisation continued to progress and the inaugural meeting of the pilot Risk and Assurance Committee (RAC) had taken place in March 2026 to shape how Group-level risk and assurance would operate ahead of go-live. She also highlighted the hard work of the Trust in bringing in the financial position while delivering a significant improvement in performance and thanked those involved for their diligence.

The Managing Director celebrated the improvements in performance and reported that the Trust was now rated 102 of 134 based on Q3 data. Unvalidated data indicated that the Trust had delivered a positive year-end position, particularly in terms of diagnostics and elective recovery. Further work was required around the 62-day standard but the organisation was close to delivering the trajectory. Urgent and Emergency Care (UEC) remained challenging but there had been recognition of the structural challenges in terms of capital allocation and work was ongoing to develop a full business case for an Urgent Treatment Centre (UTC) modular build under funding assumptions outlined by the regional team. In terms of forward planning, the Trust had developed a broadly compliant business plan but the financial plan would be challenging to deliver.

The Board reflected on potential challenges to sustaining the Trust's improved performance and where further interventions could be required. They discussed the impact of the modular UTC, noting that this would generate a performance improvement from October 2026. They also recognised that forward planning remained contingent on final discussions with the system and that work continued to secure the final elements of funding. Enhanced levels of elective activity were likely to continue into Q1 but UEC performance would remain challenging, with further work required around community virtual ward capacity, particularly following the HCRG Care Group decision to move a model that could be escalated up and down as required. It was acknowledged that the organisation needed to continue to scrutinise this while considering the level of hospital at home service it could continue to deliver.

The Managing Director reported that the organisation continued to maintain a clear focus on patient safety. There had been a general increase in the number of reported pressure ulcers during the last year and work was ongoing to understand any correlation with nursing safe staffing fill rates. Support and enhanced monitoring had also been put in place in clinical areas where clusters had been identified. The Trust awaited a draft report from the Care Quality Commission following the unannounced inspection of UEC in October 2025 and while a significant amount of work had taken place since the inspection, the report was likely to be challenging.

The Board of Directors noted the report and acknowledged the phenomenal work that had taken place to deliver the performance improvements.

BD/26/04/06 Chair's Report

The Chair summarised the report and confirmed that preparations continued to transition to the Group operating model from July 2026. He advised that he had met with the Lead and Deputy Lead Governors since the last report and thanked the Interim Head of Corporate Governance, the Council of Governors, and the Board of Directors for their support during his time in post.

The Non-Executive Directors sought clarity on the holding of Public Board meetings under the Group model. The Chair and the Interim Group Chair acknowledged the importance of transparency and public access and confirmed that public meetings would continue to be held. The Chief Executive added that the structure was likely to be similar with both public and private meetings held on the same day.

The Board of Directors noted the report.

BD/26/04/07 Board Assurance Framework (BAF) Summary Report

The Interim Head of Corporate Governance provided an overview of the report and explained that the risk profile remained stable. She highlighted that risk 1.2 had been replaced with separate UEC and planned care risks to better reflect operational drivers and both risks were currently rated 16. The Quality Assurance and Subsidiary Oversight Committees were due to review their risks in April and a further update would be provided at the next meeting.

The Board discussed ongoing work to restructure the way that risk was reported under the Group model. They recognised that a clear audit trail would exist between Trust-level risks and the Group BAF with much of the information flowing into RAC. They acknowledged that organisation-level BAFs would remain live until the Group BAF had been signed off and noted that work was ongoing to identify any potential gaps.

The Board discussed the wording of risk 3.4, debating whether it needed to be broadened to reference the critical infrastructure risk and investment in revenue maintenance. They acknowledged the need to ensure that there was consistency with the critical infrastructure risk paper that had been submitted for their meeting in private.

The Board of Directors noted the report.

BD/26/04/08 Management Executive Committee Upward Report

The Managing Director summarised the report, highlighting key discussions including the Trust's response to a recent Fire Safety Audit, short-term cash flow modelling, and the need to maintain safety standards amid operational and financial pressures. The Committee had also emphasised the importance of generating a visible response to the Staff Survey and had noted ongoing work around the clinical value review and strategic commissioning. The growing frailty cohort had been discussed and a business case had been approved in principle to implement a Frailty Same Day Emergency Care (SDEC) service. A proposal around the wider future of the frailty service design would be discussed at a future meeting.

The Board considered cash flow forecasting and acknowledged that the Chief Finance Officer was working to understand how the three Care Organisations could support each other. They also discussed the work around frailty, recognising the system-wide strategic risk and the opportunities that Group and work around prevention and neighbourhood health provided in terms of service redesign.

The Board of Directors noted the report.

BD/26/04/09 People Committee Upward Report

Paul Fairhurst reported that the Committee had discussed the 26/27 breakthrough objective around sickness absence, noting the importance of continuing to monitor metrics around staff feeling that their work was valued alongside this. The Trust remained an outlier in terms of sickness absence and a root cause analysis had indicated that issues related to leadership behaviours, communication, and organisational narrative rather than more traditional drivers. The Committee had agreed that the divisions need to own this rather than treating it solely as a HR issue. Workforce planning had also been discussed including the decision to reduce pay costs by increasing substantive staff.

Headline vacancy figures were masking shortages in key services and targeted interventions were underway, particularly in Estates and Facilities where the Committee had requested a deep-dive around cleaning. Appraisal compliance continued to be an issue, particularly in corporate services, and findings from a recent KPMG audit highlighted the need to enhance processes while shifting emphasis to the quality of appraisal conversations. Assurance had been received regarding progress on medical rostering and violence and aggression. In respect of risk management, it had been agreed that a specific risk relating to violence and aggression would be added to the corporate risk register.

The Board of Directors noted the report.

BD/26/04/10 Finance and Performance Committee Upward Report

Antony Durbacz summarised the report, highlighting discussions around the more progressive forward view of cashflow and the timeline and implications should the Trust need to seek support outside of the Group. Sustained focus and pace was required in terms of delivering the required savings for the year and it was essential to focus on converting identified ideas into fully developed and deliverable plans. The Committee had noted the improved alignment between the BAF and the operational risk register and reflected on the importance of continuing this under the Group governance framework. They had also discussed the improvement in diagnostics, particularly in terms of the impact of the Community Diagnostic Centre on the DM01 position.

The Board of Directors noted the report.

BD/26/04/11 Audit and Risk Committee Upward Report

Sumita Hutchison summarised the report, highlighting that an external review of risk management had identified the need to improve structural alignment, capability, and processes at the Trust. This was a recurring theme and there was an immediate need for investment. Additionally, KPMG had flagged that 23 internal audit actions were overdue and this, combined with key internal reports with limited assurance meant that the Board should prepare itself for a limited assurance opinion at the end of the financial year. The Audit and Risk and Management Executive Committees (MEC) were maintaining close oversight but the pace of change that was required had not been delivered to date.

The Chief Risk Officer advised that risk management arrangements had been discussed at the most recent Joint Committee and an improved risk management framework and policy had been agreed. He acknowledged that significant work was still required around training arrangements, workstream management, and risk management quality across all three organisations.

The Board discussed their concern around the number of outstanding internal audit actions, recognising that responsiveness was a key determinant of the overall internal audit opinion. They considered feedback that the position had been driven by the number of overly detailed action plans and acknowledged that discussions had taken place with KPMG regarding future approaches, with an emphasis on greater precision rather than a reduction in scrutiny. Members agreed that the focus should be on delivering required improvements and then addressing residual actions, rather than attempting to limit recommendations. They recognised that work continued to reduce the number of outstanding actions, but identified this as a recurring issue. They reflected on the potential to improve the position under the Group governance structure and understood that a further debate would take place via the Joint Committee.

The Board of Directors noted the report.

BD/26/04/12 Non-Clinical Governance Committee Upward Report

Sumita Hutchison provided an overview of the report, highlighting that the Committee had discussed risks around critical infrastructure and fire safety and the green and climate adaptation plans. She advised that both risks were due to be discussed by the Board in greater detail during their meeting in private. While further work was required around divisional engagement and training, good assurance had been received around Emergency Preparedness, Resilience and Response and the Trust continued to meet national core standards. The overall information governance and data security trajectory remained positive and the Committee had also recognised progress made by catering colleagues towards achieving Soil Association Gold accreditation.

The Board of Directors noted the report.

BD/26/04/13 Integrated Performance Report (IPR)

The Chief Operating Officer summarised the report, highlighting that the Trust had been identified as a successful organisation in terms of the elective improvement and had been asked to share its approach. She added that the national focus on corridor care continued and data would be included in the IPR going forward. The Trust had seen a reduction over the last few weeks and would continue to focus on a daily zero tolerance with the aim of removing it entirely by the October 2026 deadline. In terms of quality, pressure ulcers had improved in February but it had been a challenging month in terms of staffing and operational pressures. The number of falls and influenza cases had decreased but Norovirus had increased, impacting the number of bed closures. There was continued fragility in neonatal nursing and Midwife-to-birth ratios were also above target. Work was in progress to fully understand the position including a benchmarking and evidence gathering exercise around Neonatal Unit activity levels and analysis of workforce drivers on Mary Ward.

The Board discussed the clear clinical and moral imperative to eliminate corridor care and recognised that this had been driven by the Wait 45 initiative. They emphasised that this was a symptom UEC demand and flow challenges and acknowledged that system

discussions continued to agree targets for each component of the pathway and determine where partner organisations were accountable. Emerging data indicating increased readmission rates was also considered as was the need to ensure that planned re-attendance through SDEC models was not being conflated with readmission. The Interim Chief Medical Officer advised that feedback indicated that this related to changes in the SDEC model but that data would continue to be monitored and benchmarked to determine whether there was cause for concern.

The Board acknowledged the national scrutiny around maternity and neonatal services and noted that an external review of Birthrate Plus methodology had found that it remained contemporaneous but required refinement to better reflect increasing acuity and complexity. The Chief Nursing Officer advised that current establishment levels did not fully meet acuity demands, particularly with a continuation of cot closures in Bristol. She indicated that findings from the ongoing benchmarking work would be reported to the Board through the quarterly Maternity and Neonates Report.

The Board considered data on deteriorating patients, noting reduced compliance with sepsis screening, delays in escalation, and acute kidney injury (AKI) indicators. Members discussed whether these metrics reflected true deterioration in care or data quality issues. The Chief Nursing Officer confirmed that work was underway through a newly established improvement group to cleanse data, align escalation processes with National Early Warning Score standards, and identify barriers to timely escalation. The Interim Chief Medical Officer added that in terms of AKI indicators, the Trust had engaged with the South West Regional Network to review the data and this would be progressed through the Clinical Effectiveness Committee.

The Board reflected on recurring themes in complaints and discussed the impact of ongoing challenges in clinical administration on patient communication and waiting times. Improvements in performance and time to first appointment were noted, with the expectation that this would correspondingly reduce complaints. Progress in clearing appointment backlogs in the most challenged areas was also acknowledged, but it was recognised that there was continued pressure due to demand and recruitment difficulties. Members noted that the Trust continued to appoint to clinical administration roles where possible; however, the underlying operating model was outdated and heavily manual. The need to transition to a more digitally enabled model was discussed as a priority, albeit with recognition of the disruption that this could cause. Group-level opportunities were highlighted, including work on ambient voice technology and digital transformation within corporate services, with an update to be brought back via the Joint Committee.

Action: Chief Digital and Information Officer (Interim)

The Board of Directors noted the report.

BD/26/04/14 Staff Survey Results

The Chief People Officer provided a high-level overview of the Staff Survey results, noting that detailed discussions had already taken place via MEC and People Committee. She outlined the emerging themes and indicated that Trust staff had strong sense of belonging and purpose, with many feeling valued by their managers. Areas for improvement included career development, workload, wellbeing, and disparities for global majority staff and colleagues with disabilities. Overall staff survey scores were broadly stable with some deterioration compared to the previous year. The key priority for 26/27 would be to increase response rates, with an ambition to reach at least 60%.

Divisions were developing action plans in response to their results and these would be reviewed via People Committee and Board.

The Board discussed staff experience feedback indicating generally positive reporting, alongside opportunities to improve learning from incident reporting. It was noted that the Patient Safety Incident Response Framework (PSIRF) was implemented during the survey period, and it was anticipated that further embedding of PSIRF would support improvement in staff confidence around responses to incidents.

Communication was discussed as a critical enabler. Members noted that while communication infrastructure and regularity had improved, there was a need to be clearer and more consistent in articulating organisational vision, direction of travel and how difficult decisions contributed to a better future. Challenges in reach were highlighted, given the size and dispersion of the workforce, with feedback from Staff Governors indicating that positive messages were not consistently reaching all staff groups. The balance between digital communication and increased face-to-face engagement was discussed, including the importance of senior visibility and opportunities for in-person dialogue.

The Board discussed inclusion, discrimination and the experience of global majority staff as ongoing priorities, noting that these themes appeared consistently across multiple data sources and were reflected as a risk in the BAF. Members noted that this was a national issue affecting the wider NHS system and reflected on the link between staff and patient experience. They agreed that divisions would need to translate Trust-level themes into local action, with aggregated reporting to the People Committee in May and the Board in June. It was also proposed that work was undertaken to better understand the experience of global majority patients across the Group, with this to be progressed by the Chief Nursing Officers.

Action: Chief People Officer
Action: Chief Nursing Officer

The Board of Directors noted the report.

BD/26/04/15 Delegation of Sign Off – Annual Report and Accounts and Quality Account

The Interim Head of Corporate Governance summarised the report and advised that due to changes to the Board calendar the approval timelines fell later than the statutory national submission deadlines for the 25/26 Annual Report and Accounts and Quality Account. In order to ensure compliance with statutory obligations, the Board was asked to delegate authority for the approval of the Annual Report and Accounts and Quality Account to the Audit and Risk Committee and Quality Assurance Committee respectively.

The Board of Directors noted the report and delegated authority for the approval, finalisation and sign off of the Annual Report and Accounts and Quality Account to the Audit and Risk Committee and Quality Assurance Committee respectively.

BD/26/04/16 NHSE Licence Self-Certification CoS7

The Interim Head of Corporate Governance reported that the Trust was required to self-certify that it was compliant with CoS7 on an annual basis as part of the conditions of the NHS Provider License. The Board was asked to review and confirm the statement in appendix 1 in line with its provider license CoS7.

The Board of Directors approved the self-certification CoS7 for publication on the Trust website.

BD/26/04/17 Annual Health and Safety Compliance Report

The Chair welcomed the Deputy Director of Estates and Facilities to the meeting who provided an overview of the report, highlighting areas of good progress alongside ongoing risks and constraints. There were notable estates related risks including backlog maintenance and fire safety and this was reflected in recent audit findings and variable engagement with some health and safety initiatives. There was a year-on-year increase in reported incidents and while this could reflect an improvement in the overall reporting culture, the increase in RIDDOR incidents was a concern. Incident themes remained consistent, with manual handling, slips, trips, and falls, and violence and aggression continuing to be the most common.

The Board discussed the nature of the report, noting that it was largely retrospective and compliance focused, providing limited real-time assurance. They were assured that the Trust was compliant with statutory health and safety reporting and publication requirements and that a more contemporaneous view of health and safety performance was provided through clear executive accountability, upward reporting, and active management of risks. They acknowledged the resource constraints within the health and safety function, noting that these challenges were not unique to the Trust and were being considered as part of the wider corporate services review.

The Board reflected on violence and aggression and the known disproportionate impact on global majority staff. They considered the need to discuss workforce safety from all perspectives and discussed current initiatives and opportunities to strengthen support by working with system partners and the police on the Never Ok campaign.

The Board of Directors noted the report.

BD/26/04/18 Any Other Business

The Board of Directors acknowledged the Chair's significant contribution to the organisation during the last year and thanked him for his leadership.

BD/26/04/19 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 12:15

**ACTION LIST - BOARD OF DIRECTORS MEETING IN PUBLIC
WEDNESDAY, 1 APRIL 2026**

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB640	Charities Committee Upward Report Executive Team to provide an update on the plan for progressing the Green Heart project. April 2026 An options appraisal will be presented to the Board in June 2026.	BD/26/03/13	March 2026	June 2026	The Green Heart Project options appraisal is due to be reviewed by the Care Organisation Leadership Team on 02/06/26 and an update will be provided to the Board in due course via the Management Executive Committee Upward Report. To close	Executive Team
PB641	Integrated Performance Report Chief Digital and Information Officer to provide an update on Group-level opportunities to digitally enable clinical administration via the Joint Committee.	BD/26/04/13	April 2026	June 2026	In discussion with the RUH Managing Director, a limited number of Microsoft Copilot Premium licenses will be made available to RUH clinical administration to operate alongside clinicians using Microsoft Dragon Copilot Ambient Voice Technology. Care Organisation will identify return on investment on the deployed licenses which will have usage monitored by NHS England. To close	Chief Digital and Information Officer

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB642	Staff Survey Results Chief People Officer to provide an aggregated update on Trust-level themes and local action to the People Committee in May and the Board in June.	BD/25/04/14	April 2026	June 2026	The next People Committee meeting has been postponed until 15 June 2026. An update will be provided to the Board following this meeting. To close	Chief People Officer
PB643	Staff Survey Results Chief Nursing Officer to work with her counterparts at GWH and SFT to better understand the experience of global majority patients across the Group.	BD/25/04/14	April 2026	August 2026		Chief Nursing Officer

Report to:	Public Board of Directors	Agenda item:	5
Date of Meeting:	3 June 2026		

Title of Report:	Patient story
Status:	For discussion
Board Sponsor:	Toni Lynch, Chief Nursing Officer
Author:	Sharon Manhi, Head of Patient Experience Charlotte Nicol, Trustwide Lead Nurse for Children & Young People
Appendices	None

1.	Executive Summary of the Report
‘See it My Way – through a young person’s eyes.’ The ‘See it my Way’ programme started in 2010 and the purpose of the programme is to: • Hear the story of patients, family/carers and staff about living with a situation or condition and their experience of the RUH. • Raise awareness and understanding for staff regarding a specific area or sometimes condition. • Role model involvement and engagement with our community. • Implement changes to improve patient, carer and staff experience. Films are used in staff training and education and raising awareness, subject to consent from the speakers. All previous films are on the Trust intranet pages. Background and context This film covers the experiences of children and their families at the hospital. The children are aged 5-17 years old and each of them has a specific health condition that has brought them to the RUH. The majority of the children have been coming to the hospital regularly for many years and provide a valuable insight into what is working well and where we can improve. The film highlights the complex care pathways, the needs of children/young people with long-term conditions and having a cancer diagnosis. It emphasises the importance joined up care in an age-appropriate setting and of the role of continuity, trust, and good relationships with staff. Overall, the children and young people and their families describe compassionate, joined up person-centred care, saying that they feel safe and confident in the staff looking after them. Next Steps The two key priorities of the Children and Young People (CYP) Committee for 26/27, are transition (to from Children’s and Young People services to adult services) and the environment. The film will be presented widely across the organisation to raise awareness and improve services. <u>Transition</u> Our focus is on emotional readiness to move from children/young people services to adult services and how to instil trust and confidence in new teams, in order to maintain a	

Author: Sharon Manhi, Head of Patient Experience Document Approved by: Toni Lynch, Chief Nursing Officer Agenda Item: 5	Date: 26 May 2026 Version: Final
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sense of safety during the period of transition and in future care.

Environment

As well as considering our physical environment, such as facilities, play spaces and age-appropriate waiting areas, we are also focussing on the emotional environment we provide across the Trust, such as staff behaviours, communication style and creating emotional safety.

The Trust is developing a youth forum to ensure a that a wide variety of patient/family feedback is collected and then used to inform a co-designed CYP strategy and future improvement work. We are currently in the initial stages of exploring what this would involve and how to achieve it.

2. Recommendations (Note, Approve, Discuss)

The patient story is for discussion.

3. Legal / Regulatory Implications

Under the Health and Social Care Act 2008 and the Health and Social Care Act 2012, NHS Trusts have a legal duty to secure continuous improvement in safety, clinical effectiveness and patient experience.

The Care Quality Commission (CQC) regulates NHS Trusts against the fundamental standards including person centred care.

The NHS Constitution for England sets out patient rights, including to be involved in decisions and to be treated with dignity and respect.

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

A failure to demonstrate sustained quality improvement could risk the Trust's registration with the Care Quality Commission (CQC) and the reputation of the Trust.

5. Resources Implications (Financial / staffing)

None.

6. Equality and Diversity

Ensures compliance with the Equality Delivery System (EDS).

7. References to previous reports

Monthly Quality Reports and Quarterly Patient Experience reports to the Trust's Patient Experience Committee, Quality Committee and the Care Organisation Management Committee.

8. Freedom of Information

Public.

Report to:	Public Board of Directors	Agenda item:	6
Date of Meeting:	3 June 2026		
Title of Report:	Chief Executive & Managing Directors Report		
Status:	For Information		
Board Sponsor:	Cara Charles-Barks, Chief Executive Officer & John Palmer, Managing Director		
Author:	Helen Perkins, Senior Executive Assistant to Chief Executive and Katie McClean, Executive Assistant		
Appendices	Appendix 1: NHSE acceptance of final medium term plan for 2026/27 to 2028/29 Appendix 2: Trust update on MTFP contract conditions		

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 2026/27 Plan ➤ Urgent and Emergency Care (UEC) National update • Secretary of State for Health and Social Care • Resident Doctors Industrial Action Group • Joint Committee • Leadership Team • Group Governance and Assurance Arrangements and Transition Roadmap • Group Priorities and Prioritisation Approach • EPR Deployment Options Appraisal • Model of Care Transformation Programme • Corporate Services Transformation Programme • Group Board Meetings • Councils of Governors Workshop Managing Director's Report • Local (RUH) ➤ Operational ➤ Finance ➤ Quality ➤ Business planning update ➤ Year end position ➤ Executive appointments ➤ Use of Trust Seal ➤ Membership	

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- 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 and 2026/27 Plan

The Group entered 2026/27 with an improving but still high-risk financial profile. RUH closed 2025/26 with a year-end deficit of £20.5m against a forecast £34m, and is recognised nationally as one of the most improved providers for diagnostics, elective recovery and UEC. SFT have an efficiency programme of £32.5m that is fully identified but high-risk in delivery, internal turnaround support has been implemented to support delivery. GWH has commenced with external financial turnaround support arrangements to assist with the delivery of a challenging £47.2m efficiency requirement. Group-wide CIP delivery for 2026/27 will remain a Joint Committee focus throughout the year.

Urgent and Emergency Care (UEC)

UEC pressure remains the dominant operational and quality risk across the Group. RUH is now the most improved provider in England for average days to discharge (ranked 51st), is in the most-improved cohort nationally for 4-hour performance (2024/25 v 2025/26) to further support pathway improvement; a 100-day UEC challenge will launch on 27 May. SFT continues to operate under sustained pressure, with ED 4-hour performance at 69.3% against a plan of 78% and bed occupancy above 96%. No-criteria-to-reside numbers remain elevated across all three sites.

Across the Group there is robust clinical oversight of Corridor Care in each Care Organisation and reporting is now underway in line with national requirements. As part of the BSW UEC Reset at system-level, elimination of Corridor care is expected to be an output of reduced demand, improved flow within and out of Care Organisations. Internal actions to improve flow are overseen at UEC Improvement Boards with a focus on internal changes to support more timely discharges and reduced internal delays whilst in hospital and on leaving. GIRFT support in GWH and RUH has focused on Clinical Operational standards, and this is being replicated in SFT. Frailty at the front door and long length of stay reviews are areas of focus.

National Update

Secretary of State for Health and Social Care

The Rt Hon James Murray MP was appointed as the Secretary of State for Health and Social Care on 14th May 2026. The Secretary of State is responsible for the work of the Department of Health and Social Care, including overall financial control and oversight of NHS delivery and performance and oversight of social care policy.

The Rt Hon James Murray has served as the Member of Parliament for Ealing North since 2019 and was previously Chief Secretary to the Treasury from 1st September 2025 to 14th May 2026.

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Resident Doctors Industrial Action

Resident Doctors in England will take industrial action from 7.00 am on Monday, 15th June to 6.59 am on Friday, 19th June.

As in previous cases, in depth planning for the industrial action is being undertaken at each Care Organisation to ensure that disruption to services for our patients is kept at a minimum.

Group Development

Joint Committee

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

Leadership Team

The Group executive leadership team is almost fully established albeit with two interim positions still in place. Recruitment for the substantive Group Chief Digital and Information Officer is complete – following interviews held on 28 April, Jonathan Hinchliffe has been appointed.

In Care Organisations, interviews for the substantive RUH CMO post were held in early March, an offer has been made and we anticipate our new CMO starting in-post in August. Following the announcement of the planned retirement of Toni Lynch in June 2026, recruitment has been completed, with Jason Lugg being appointed as the next RUH Chief Nursing Officer.

Non-Executive Model. The Joint Committee reviewed and approved our planned NED model on 18th February; subsequently, the three Care Organisation Councils of Governors (CoGs) met, and each endorsed the recommended model. In readiness for our Group Board launch, we now are nearing completion of the Group-wide NED appointment process.

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, meeting fortnightly. Supporting this work, the Non-Executive Governance Reference Group meets monthly. On 5th May, the NED team considered the Governance Roadmap, our Safe to Start Gateway tool, and detailed transition timeline. The team also discussed draft Standing Financial Instructions and the planned Scheme of Reservation and Delegation.

On 7th May, we achieved a significant milestone by signing a formal partnership agreement between our three Care Organisations. This was the final formal step in establishing our Group Board. Working as one Board will provide clear oversight, faster and better co-ordinated decisions and a consistent approach to risk, quality and

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safety, allowing us to work at scale, making joint investment and estates decisions for the benefit of our community.

In April and May, the pilot Risk and Assurance Committee met and continued its work shaping how group-level risk and assurance will operate ahead of go-live planned in July. A Shadow Risk & Assurance meeting is planned for 1st June, to test new ways of working.

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. Transforming Models of Care through the acute services review and clinical services framework design
4. Completion of the Corporate Services Review
5. Developing our Group

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

EPR Deployment Options Appraisal

The EPR programme team, led by Jonathan Hinchliffe, Chief Digital & Information Officer, has been working with suppliers and our Executive team on delivery planning. The Board met on Thursday 7th May and following discussions, approved a recommendation for Go Live phasing for the shared EPR Programme. The first Go Live will be in mid-July 2027 for GWH, with the second Go Live in late-October 2027 for both SFT and RUH concurrently.

Model of Care Transformation Programme.

The Model of Care Transformation programme, led by Andrew Hollowood, Chief Clinical Transformation Officer, is in development: a clinical stocktake has been completed to inform the selection of first wave specialties to establish Clinical Transformation Groups to explore potential service models, using a set of design principles, founded on serving our population, supporting our teams and reduction of unwarranted variation.

A Steering Group and Working Group are in place, and the governance structure has recently been reviewed to include Elective Care and UEC as part of the Steering Group to enable sharing of best practice, reduce silo working and duplication of work.

Corporate Services Transformation Programme

Our Corporate Services Transformation Programme, led by Jude Gray, Group Chief People Officer, is making progress with the design stage for services completed and consultation exercises now underway. The Steering Group and Design Authority meet regularly, and designs have been approved for eight services. 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.

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Group Board Meetings

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.

Councils of Governors Workshop

A Councils of Governors development session was held on 30th April 2026 with the agenda for the day being co-designed by lead Governors to address priorities. The session was well attended and following introductions by Group Chair Paul Von Der Heyde and the Non-Executive Director team, there were updates and discussion on our Model of Care Transformation, Financial Sustainability and the EPR Programme. Lead Governors also facilitated discussion groups on member engagement.

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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 April 2026, and an improved ranking on the 4-hour standard (for all types performance) with the RUH improving from 113/123 in October to 95/123 at year end. We also achieved the national target to reduce the number of patients waiting to less than 1% of our total waiting list ahead of trajectory. The month 1 position for 2026/27 remains stable but several metrics are rated amber and red and continue to require focused management attention.

We continue to report progress via our 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. Further details on all operational performance and financial recovery are provided below.

1. Operational

Urgent and Emergency Care

4-hour performance in April slightly decreased by 1.62% to 61.02%. The average ambulance handover delay from April 2026 was 33.1 minutes, an improvement from 44.92 minutes on average in March. The average Non-Criteria to Reside (NCTR) number was 89.4. Our performance for Medical Same Day Emergency Care (SDEC) was 42.1% of all medical admissions for April 2026, exceeding the national standard of 40%.

We continue to embed our internal professional standards which involve improving board/ward rounds, reducing long length of stays (> 14 days), a redesign of our escalation processes, streaming within Emergency Department (ED) Majors and Urgent Treatment Centre (UTC) and preparing to move the UTC in October 2026. The UEC care standard remains our biggest challenge and one that poses significant clinical risk, along with poor patient experience. At the end of May, we will launch a 100-day challenge focused on driving improvement in our non-admitted patient cohort. This is a cohort of patients where performance is the responsibility of the Trust, and we will be using detailed breach analysis to identify trends and opportunities to make the necessary improvements.

- **Emergency Department:** Monitor non-admitted performance across UTC and ambulatory ED, including Extended Emergency Medicine Ambulatory Care (EEMAC) activity, time to triage, and delays to being seen.
- **Specialties:** Provide details of all 4-hour breaches where delays are specialty-related to drive solutions, improving ED response times and decision-making.

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- **Wards:** Work with system partners to track and escalate the 7-48-48 positions daily, monitor discharges by 12:00, and review post-15:00 discharges to identify delays and agree improvements.

Referral to Treatment

We have a high level of confidence in our RTT recovery plans. The improvements and lessons learned from the elective 12-week challenge are continuing to support our recovery and the programme approach has been shared with the NHS England team. We are continuing to keep our focus on good Patient Tracking List (PTL) management with a strengthened governance and executive oversight of our processes. Evidence that we are focusing on the right things is visible in our performance numbers again this month.

In April, RTT performance saw an increase in overall performance of 1.2% to 70.3% vs trajectory of 68.3%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 73.8% (+ 0.8% from March) The target for over 52-week waiters was achieved with 0.47% 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

In April, performance (unvalidated) declined against all three national standards. Having achieved the national 80% standard in February and March, April is currently 79.0% with Colorectal followed by Urology, Gynae and Breast seeing the largest reduction. 31 Day performance is showing a reduction but remains above the national target at 94.3%. 62 Day performance has improved marginally to 69.1% but remains considerably below trajectory (75.6%). The most notable improvements were in Colorectal, Lung and Skin. However, this was counteracted by deterioration in Urology who reduced by 15.3%.

Diagnostics

In April 2026, 85.32% of patients received their diagnostic within the 6-weeks against the 85.40% target. Performance decreased 0.76% from March 26. However, this decrease was due to a reduction in denominator, as the Trust received less referrals. Total breaches, overall, reduced by 44 from the previous month.

2. Finance

The overall financial position at month 1 is a deficit of £2.9m which is £1.3m adverse to plan. This is driven by:

- Industrial action: £303k
- Expenditure budgets: £439k
- Funding gaps: £194k
- Sulis: £134k

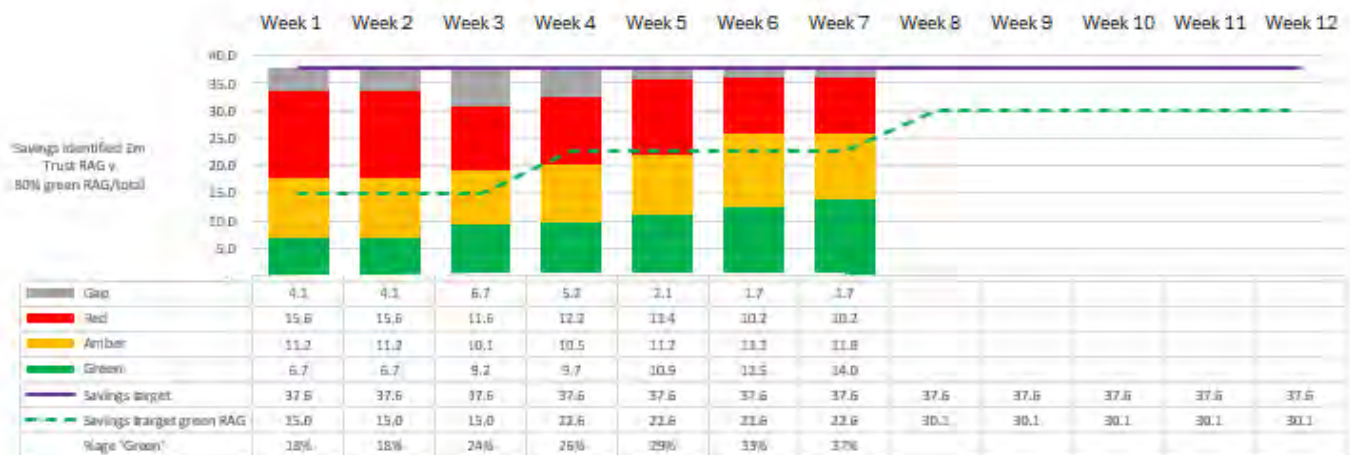
The Trust is required to deliver 15% or £5.64m of its Cost Improvement Programme (CIP) and to have 80% of schemes rated green by the end of Q1.

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The total identified savings opportunities are £35.5m against a target of £37.6m. Work is underway to move to opportunities and plans in progress to 'green' or 'in delivery', with targets of 40% in April, 60% in May, and 80% in June.

At week 5 the Trust had £10.9m worth of schemes rated green, representing 29% of the total savings target. At week 7 the Trust now has £14.0m of schemes rated green, representing 37% of the total savings target.

Figure 1: CIP Savings Profile



3. Quality

Care Quality Commission (CQC)

In May 2026, the CQC published the report following their unannounced inspection of Urgent and Emergency Care in October 2025. The outcome of this was a rating of 'Requires Improvement' for Urgent and Emergency Services. The CQC downgraded the rating for 'Caring' from 'Good' to 'Requires Improvement.' The safe, responsive, and well-led domains were also rated as 'Requires Improvement' with effective rated as 'Good.'

Item 13 provides a full briefing on the CQC report, an associated action will be presented in due course.

Nursing and Midwifery Council

The Chief Nursing Officer for England, accompanied by the Chief Executive of the Nursing and Midwifery Council, led a briefing to all Chief Nursing Officers on 21 May 2026 regarding an investigation in the Nursing and Midwifery Council (NMC).

The NMC have identified that systems and processes relating to the screening of applicants requesting to join the NMC register had not been followed for 12 years. The processes relate to the screening of applicants' suitability and safety to practice from a health and conduct perspective. The NMC have reviewed 18,086 applications, of which, 98% require no further action. As of 27 May, the NMC is contacting 421 nursing and midwifery professionals who will be asked to provide further information for a more a detailed assessment by an Assistant Registrar.

All employers have been advised that they do not need to take any action unless contacted directly by the NMC and the Trust has a plan to support any staff member who may receive a letter from the NMC.

The Chief Nursing Officers across BSW Hospitals Group will report to the Care Organisation Management Committee should any staff be contacted by the NMC.

Excel at Every Level Accreditation

The accreditation framework continues to be the largest quality improvement initiative undertaken across the organisation. Since the last public Board of Directors, the Breast Unit and the Older Persons Unit Short Stay have been awarded Gold Accreditation.

Patient Experience award winners

In April, we announced the winners of our annual Patient Experience Awards. These awards shine a light on the exceptional work taking place across the hospital to improve the experience of patients, families and carers. They celebrate the compassion, creativity and commitment of colleagues who go above and beyond to make a real difference. Award winners included Diabetes environmental improvements, improvements to our Uro-gynaecology pessary clinic and improving digital inclusion for patients.

4. Business planning update

Executive Summary

The Care Organisation continues to operate in a highly pressurised environment with both GP referrals and emergency demand exceeding plan at month 1. Whilst we continue to demonstrate good progress in our elective recovery plans for referral to treatment, diagnostics, cancer wait times, there remains significant system demand pressures for emergency care and we have seen a dip in our 4 hour performance in April compared to May, although remaining above the planned trajectory.

The focus for quarter 1 remains the sustained improvement in elective operational standards (RTT, Cancer, Diagnostics) and improved partnership working to reduce urgent demand and NCTR discharge delays with a focus on patients being discharged home (P0) delayed over 24hrs and length of stay of patient discharged to a community setting (P2). The UEC team are developing a UEC 100 day challenge to support improvements across all non-elective pathways as well as planning for the relocation of the Urgent Treatment Centre by quarter 3.

Year-to-date financial performance is £1.3m adverse to plan, driven by savings shortfall, industrial action, and contract funding gaps. Cash balances remain a risk, and system finance performance is adverse overall. Key priorities for Quarter 1 include closing the financial gap and strengthening savings delivery confidence, through the maturity of CIP schemes to achieve 80% Green by the end of June 2026, coupled with the delivery of the quarter 1 CIP target (15%). This is supported by continued productivity improvement which is reporting a 3.7% year on year improvement, putting us in the 2nd quartile nationally.

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Focused improvement work continues to address the deteriorating pressure injury performance across the Trust and remains a key priority. This includes targeted support in wards that have experienced clusters of pressure injuries, alongside a Trust wide task and finish group reviewing relevant systems and processes.

Data shows that during April 98.7% of inpatients did not fall in our care. Trust wide in April 90.0% of adult inpatients had a falls risk assessment completed within 6hours of admission and falls per 1,000 bed days in April were below the National Audit for inpatient falls (NAIF) benchmark of 6.6.

Workforce continues to present a degree of risk, with elevated sickness absence (5.62%) and appraisal compliance impacting productivity, staff wellbeing and overall organisational resilience. Notwithstanding these pressures, vacancy levels remain low. This reflects the success of targeted recruitment campaigns, particularly within the Emergency Department and across Trust-wide Healthcare Support Worker roles. The Care Organisation continues to demonstrate strong attraction, supported by sustained low levels of turnover.

Work is in progress to develop a more focused Healthier Workforce Programme, identified as a breakthrough objective for this year in response to high sickness levels. It's purpose is to provide a clear and structured approach to improving the physical, mental, and emotional wellbeing of staff, thereby enabling a healthier, more resilient workforce and supporting the delivery of high-quality patient care.

Figure 2: Business Plan 2026/27 Scorecard

Domain	Metric	Performance against trajectory (in year)			3 Year Plan Profile		
		26/27 NHSE Instruction	Current Month Trajectory	Apr-26	Year End 26/27 RUH Plan	Year End 27/28 RUH Plan	Year End 28/29 RUH Plan
UEC	ED Attendance Growth	Versus 25/26 actual	-0.5%	3.6%	-0.5%		
	NEL Admission Growth	Versus 25/26 actual	-4.6%	12.4%	-4.6%		
	Eliminating Corridor Care	0> 45mins by Nov '26	Trajectory	556 (15%)	0	0	0
	4-hour ED performance (type 1)	66.9% by Mar '27	58.7%	61.2%	66.9%	72.9%	79.1%
	4-hour ED performance (all types)	82% by Mar '27	69.1%	71.1%	75.3%	80.2%	85.0%*
	12-hour ED performance	96.1%	Trajectory	92.0%	93.7%	94.7%	95.0%
Elective & Diagnostic	Ambulance handover	Reduce toward 15 mins	33 mins	33.1 mins	30 mins	29 mins	28 mins
	GP Referral Growth	Per planning assumption	0.0%	10.9%	0.0%		
	18w RTT Performance	74.7% for RUH	68.3%	70.3%	74.7%	83.4%	92.0%
	52 Week Waiters	Reduction towards zero	331	183	198	62	0
	52 Week Waiters %	Improvement on 1%	0.9%	0.5%	0.8%	0.4%	0%
Cancer	Diagnostics 6 week wait	13.1% for RUH	14.6%	14.7%	12.50%	9.0%	1.0%
	28 day FDS	80% annual ave	80.2%	79.1%*	80.0%	80.5%	80.7%
	31 day	94%	92.8%	92.5%*	94.2%	96.0%	96.1%
Workforce	62 day RTT	80%	75.3%	68.9%*	80.5%	82.7%	85.1%
	30% Reduction in agency use	30% improvement from M06	Trajectory	13.3 WTE	5 WTE	3 WTE	0
	10% reduction in bank spend	10% reduction from M06	Trajectory	283.7 WTE	237 WTE	-10%	-10%
Finance	Sickness rate (rolling 12 month average)	Improvement	Trajectory	5.5%	4.8%	4.6%	4.4%
	2% productivity improvement	(min 2% improvement)	6.7%	6.5%	5.0%	2.7%	1.5%
	Savings Plan	37.6m (£56.6m over 3 yrs)	1,883	1,400	37.6m	10.3m	8.7m
Discharge	Balanced or surplus financial position	Balance or surplus	-1,610	-2,886	0.0m	0.0m	0.0m
	Non Criteria to Reside (NC2R)	Number of NC2R	86	89			
	Pathway 0 - Home	% within 24 hours	tba	94.0%			
	Pathway 1 - Home with support	% within 48 hours	tba	50%			
	Pathway 2 - Community setting	% within 48 hours	tba	15%			
	Pathway 3 - Residential care	% within 7 days	tba	60%			

* draft - unvalidated position

Summary of performance across the breakthrough objectives and key standards

RUH 4-hour performance - in April 2026 was 61.02% on the RUH footprint (unmapped), a decrease of 1.62% from March's performance (62.64%). Non-admitted

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performance was 71.62%, which is a slight decrease against March's 73.03%. Admitted performance was 39.45%, which is a decrease from 42.46% in March.

Corridor Care - The RUH implemented the use of a corridor in the Emergency Department in October 2025 with launch of Wait 45 (W45), to support timely ambulance handover. In April 2026, the number of patients who spent > 45 minutes of their ED visit in the corridor was 566, representing 15% of all ED attendances during that time. Eliminating corridor care will form part of the 100-day UEC Challenge in June 2026 and we will define countermeasures to address performance improvement.

Elective waits - in April, RTT performance saw an increase in overall performance of 1.2% to 70.3% vs trajectory of 68.3%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 73.8% (+ 0.8% from March) The target for over 52-week waiters was achieved with 0.47% of patients on the waiting list being over 52 weeks vs the Trust target of 1%. The Trust continues to sustain the position of having zero patients waiting over 65 weeks.

Diagnostic waits - in April 2026, 85.32% of patients received their diagnostic within the 6-weeks against the 85.40% target. Performance decreased 0.76% from March 26. However, this decrease was due to a reduction in denominator, as the Trust received less referrals. Total breaches, overall, reduced by 44 from the previous month.

Cancer waits - Cancer performance will now be reported as last month's position, previously reported one month in arrears. In April, performance (unvalidated) declined against all three national standards. Having achieved the national 28 day 80% standard in February and March, April is currently 79.1% with Colorectal followed by Gynae and Breast seeing the largest reduction. 31 Day is currently showing a reduction to 92.5% although further validation/recording of treatment is expected to bring an improvement to near the national 94% standard. Waiting times for Minor Operations (MOPS) in Skin remains the area of most challenge. 62 Day performance has been maintained at 68.5% with a minor improvement expected on completion of validation.

5. Year end position

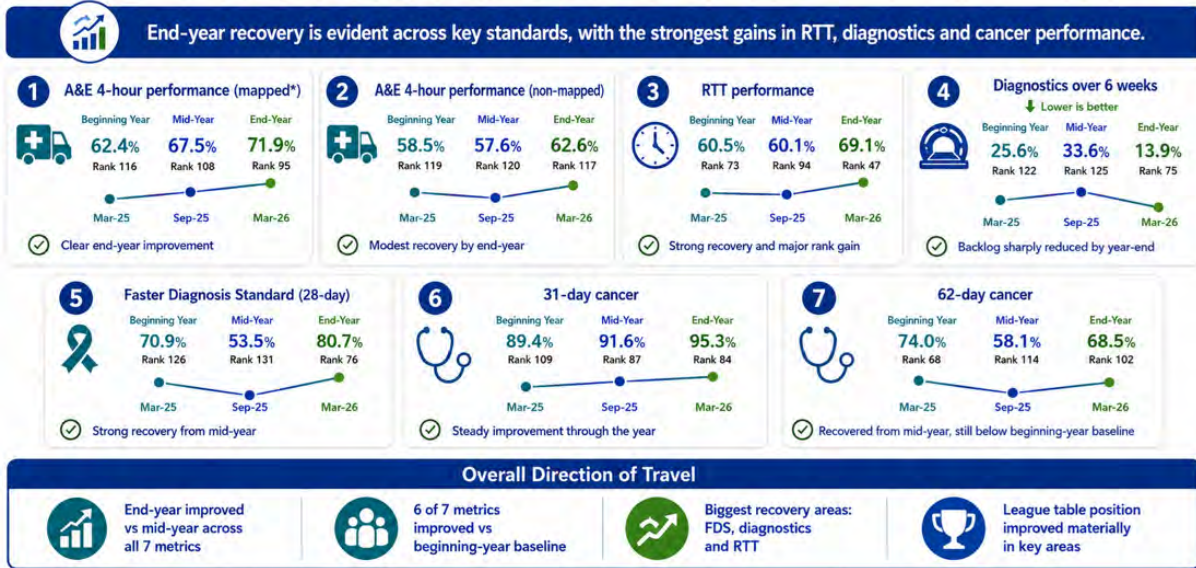
An enormous amount of effort has been made across the organisation to improve performance and provide better services for patients through the Call to Action over the last 6 months of 2025/26. The National super stats were published in the third week of May and demonstrated the step change improvements we have made across all of our key indicators.

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Figure 3: Improvement Progress during 2025/26

RUH Bath – Beginning-, Mid- and End-Year Results

Visualising improvement and recovery across key operational measures (Mar-25, Sep-25, Mar-26)

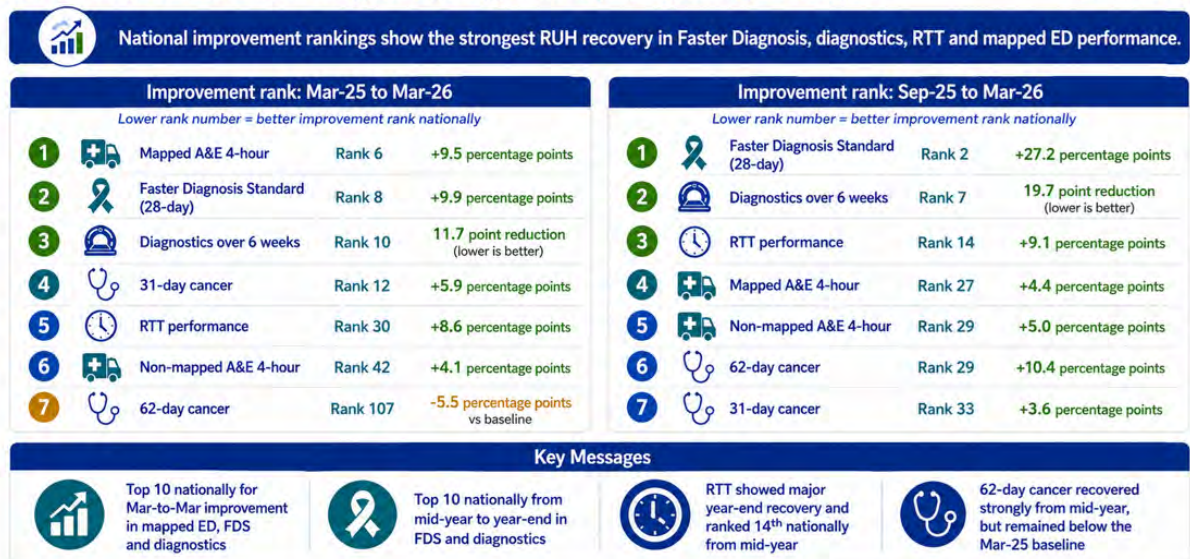


*Mapped ED methodology gives the clearest comparable urgent care measure; non-mapped result shown for completeness.

Figure 4: Percentage Improvement Rankings 2025/26

RUH Bath – Percentage Improvement Rankings

How RUH's improvement ranked nationally from beginning-year to end-year, and from mid-year to end-year



*Diagnostics improvement is shown as a reduction in long waits. *Mapped ED methodology gives the clearest comparable urgent care measure; non-mapped result is shown for completeness.

Some of the key areas to celebrate include:

- Top 10 nationally for Mar-to-mar improvement in mapped 4 hour performance, 28 day Faster Diagnostics standard and Diagnostics 6 week wait standard
- Referral to Treatment showed significant year end recovery in our position, ranking 14th nationally from the mid year point.
- 62 days cancer standards recovered strongly from the mid-year but remains a challenge in terms of meeting national standards.

These improvements provide a strong base on which to build during 2026/27.

6. Executive Appointments

Over the coming months, there will be changes to the Trust's Executive leadership team, following substantive appointments to the Chief Nursing Officer (CNO) and Chief Medical Officer (CMO) roles.

Toni Lynch, Chief Nursing Officer, will retire in June 2026 after 5 years at the Trust. I would like to thank Toni for her leadership not only of nursing, midwifery, AHPs and Estates and Facilities but the Trust as a whole. Toni has made a significant and lasting contribution to the Trust, strengthening and developing the professional agenda and improving patient outcomes and experience. Jason Lugg, currently Deputy Chief Nursing Officer, has been appointed as her successor.

Dr Kheelna Bavalia's secondment as Interim Chief Medical Officer, concludes in June 2026; I would like to record my thanks for her leadership and contribution to the Trust over this time. Dr Rebecca Maxwell has been appointed as substantive CMO and will join later in August 2026 with interim cover arrangements being finalised.

These changes support continuity of leadership and strengthen our focus on quality, finance, performance and group readiness.

7. Use of Trust Seal

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

8. Membership

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

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

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

9. Consultant Appointments

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

Author: Helen Perkins, Senior Executive Assistant to Chair and Chief Executive, Katie McClean, Executive Assistant	Date: 27 May 2026
Document Approved by: Cara Charles-Barks, Chief Executive Officer & John Palmer, Managing Director	
Agenda Item: 6	Page 14 of 16

Dr Catherine Morgan was appointed as Consultant Neurologist and will join the Trust in June and is currently working at the Trust in Speciality Training.

Dr Alexandra Rogers was appointed as Consultant in Dermatology and will join the Trust in September from Southampton University Hospital.

Dr Samuel Copson was appointed as Consultant in Emergency Medicine and will join the Trust in July from North Bristol NHS Trust.

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

More than a century of nursing work celebrated at the RUH

In April we celebrated the ‘Class of 96’ – four nurses at the RUH who trained together at the RUH and still work here today. Reflecting on their time at the RUH, they highlighted significant changes including advances in technology and the growth of the hospital, alongside the challenges of the Covid-19 pandemic. They also emphasised the strong sense of teamwork, supportive culture and career development opportunities that have contributed to their continued commitment to the RUH.

Deaf awareness boxes launched

In May we marked Deaf Awareness week and the launch of Deaf Awareness boxes across all our medical and surgical wards. The boxes have been introduced to help staff communicate with patients who are deaf or having hearing loss. They contain a range of products and resources including whiteboards, spare hearing aid batteries and information cards.

Thank you Bernard and Jane Rymer

We said farewell and thank you to Bernard and Jane Rymer, who stepped down as Friends of the RUH Chair (Bernard) and Treasurer (Jane) in April after an incredible twenty years of volunteering. Bernard and Jane have transformed the charity, which oversees volunteers, runs the RUH’s onsite shop and popular B18 cafe as well as providing thousands of pounds of charitable grants to the RUH. We are incredibly grateful for their dedication, professionalism and resilience, and the countless hours they have given to ensure the charity can support so many projects and people.

Celebrating Midwives, Nurses and Operating Department Practitioners

In May we marked International Day of the Midwife, International Nurses’ Day and National Operating Practitioner Day. Staff were invited to celebrate with afternoon tea, a service in our spiritual care centre and other activities. The day provided an opportunity to shine a spotlight on these teams for all the work they do every day to provide high quality, compassionate care.

RUH brings cancer care closer to home for Frome and neighbouring community

In May we highlighted that people in Frome and the surrounding area can now access cancer care closer to home, thanks to our new satellite clinic. The new Systemic Anti-Cancer Treatment (SACT) Centre, based at Frome Medical Centre, opened earlier this year and has already provided care for over 200 patients. Patients still receive their initial treatment at the Medlock Unit at the RUH’s Dyson Cancer Centre. Suitable patients continue their therapy in Frome and still receive treatment from the Medlock

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Unit's team of nurses. Feedback from patients has been very positive, and we are grateful to the Bath Cancer Unit Support Group for their support in purchasing and installing equipment.

25 years of supporting babies and their families

In May we celebrated 25 years of a vital community outreach service which has supported thousands of babies cared for in the neonatal unit at the RUH. The service provides care and support to babies that have been looked after in the Dyson Centre for Neonatal Care and who still need additional support in the first few weeks or months at home. The team visits families once they are home from hospital to provide help with things like feeding and nursing care. They also provide practical and emotional support for parents and can signpost families to professional support services.

Eye Unit makeover

Our Eye Unit makeover was completed in May, creating a brighter, more welcoming and accessible space for patients and staff. New flooring provides a seamless route for visibly impaired patients and improved lighting reduces glare and makes the clinic more comfortable for people with visual sensitivity. The Unit also includes a dedicated play area for younger patients and comfortable seating to make visits less stressful for families. We are grateful to Friends of the RUH and Time is Precious for their support to make this refurbishment possible, along with the Pollock Family and Friends of the Eye Unit.

Author: Helen Perkins, Senior Executive Assistant to Chair and Chief Executive, Katie McClean, Executive Assistant Document Approved by: Cara Charles-Barks, Chief Executive Officer & John Palmer, Managing Director Agenda Item: 6	Date: 27 May 2026
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To: Cara Charles-Barks, CEO Royal
United Hospitals Bath NHS Trust

NHS England
South West Region
South West House
Taunton
TA1 2PX

22 April 2026

Sent via email

Dear Cara,

Royal United Hospitals NHS Foundation Trust

Acceptance Status: Accepted with conditions

I am writing in response to the submission **of your final medium-term plan for 2026/27–2028/29** and your **five-year- Integrated Delivery Plan**, and to set out next steps. Thank you for the extensive work across the organisation that has contributed to the development of these plans. Annex One of this letter summarises the key commitments your organisation has set out for delivery and any supporting actions to address key issues that have been agreed.

As we move into implementing the plans our shared focus moves firmly toward delivering the strategic shifts and long-term transformation required to reset NHS performance and build a sustainable, modern health and care service. The Medium-Term Planning Framework set a clear expectation that organisations will work over multiple years to restore constitutional standards, strengthen community-based care, and accelerate prevention and digital transformation. Planning over multiple years does not end with acceptance of the plan; as the focus moves to delivery, foundational work will continue as you work on understanding any changes in the demand and capacity of your services and population health needs.

Transforming our services remains essential to achieving the required outcomes for patients as well as productivity and efficiency improvements to ensure sustainability. We will continue to work with you to ensure your organisation has access to the development and improvement support needed to strengthen capability and capacity.

Your submitted plan has been reviewed against the expectations set out in the national guidance and has been assessed as:

- **Compliant with Conditions**

Although the BSW Hospitals Group has submitted a breakeven plan across all three years, we have significant concerns regarding the current deliverability of the financial plan. The financial plan has significant delivery risks as the efficiency programme lacks the level of maturity and credibility required. Progress in developing a robust, evidence based efficiency plan has been limited. The plan includes a £117.34m efficiency requirement (7.1%), of which 18.2% remains unidentified and 54.7% is assessed as high risk, significantly undermining confidence in deliverability.

Effective oversight of the delivery of these plans will be important to ensure that the ambitious trajectories are met. We will review progress against these plans with you through our Regional governance arrangements which include System Delivery Stocktake meetings, System Mid Year Review meetings, Provider Oversight meetings, Tiering and other performance and delivery meetings, to ensure that there is continuous oversight, alignment across organisations, and transparent governance.

We are aware that the data collection template for “Percentage of clinically urgent appointments seen on the same day” for the 2026/27 period is not expected until after the main planning round has concluded. With that in mind please note specific discussions may be needed around this area following issue of this letter.

We will work with you over the course of 2026/27 to support you in delivering this plan which your Board has approved. It is important to note if you are unable to deliver against your commitments, this will lead NHS England to consider the full range of regulatory options available to us as part of any subsequent escalation.

Please let me know if you wish to discuss any of the above. I would be grateful if you could share this letter with your full Board.

Yours sincerely,



Sue Doheny
Regional Director

Copy to:

Simon Wade, Group Chief Finance Officer
Jude Gray, Group Director of People
John Palmer, Managing Director

Annex One

Below is the outcome of your full submission and the compliance against the key ambitions within the three years until 2028/29:

Programme	ICB	Provider		View			
Multiple selections	All	Royal United Hospitals Bath		Provider			
Programme	Measure Name	26/27 Plan	Target/Baseline	27/28 Plan	Target/Baseline	28/29 Plan	Target/Baseline
Ambulance	Ambulance handovers > 45 minutes %	7.6	0.0	0.0	0.0	0.0	0.0
Ambulance	Average handover time	30.0	73.3	29.0	30.0	28.0	29.0
A&E	A&E <4 hour performance % - all types	75.3	82.0	79.9	83.0	82.0	85.0
A&E	A&E <4 hour performance % - children	88.1	95.0	95.1	95.0	95.1	95.0
A&E	A&E 12+ hour attendances - types 1&2	7,915.0	8,141.0	5,588.0	7,915.0	5,675.0	5,588.0
Cancer	Cancer % treated within 31 days of DTT	94.2	94.0	94.6	96.0	96.1	96.0
Cancer	Cancer % treated within 62 days of referral	80.5	80.0	79.0	82.5	81.9	85.0
Cancer	Cancer FDS % within 28 days	80.0	80.0	80.5	80.0	80.7	80.0
Elective RTT	RTT % within 18 weeks	74.7	74.7	83.4	83.4	92.0	92.0
Elective RTT	RTT waiting list size	32,987.0	38,352.0	29,547.0	29,567.0	26,785.0	20,762.0

Specific issues that require ongoing review and/or further system action are:

CONDITIONS PLACED ON 18 MARCH PLAN ACCEPTANCE			
Plan area / Metric	Outstanding Issues	Conditions	Success Criteria & Timescales
UEC	Not meeting 4 hours in years 1-3, not meeting 12 hours in year 3, increases in handovers high across all 3 years – need a plan to achieve national standards	Reliance on Capital schemes. Factor in the expected improvements within capital builds and GIRFT improvement across all UEC metrics for their return on their investment in years 2 and 3	Plans shared and agreed with NHS E by end April 2026
Workforce	No change in plans submitted. Do not currently have granular workforce plans.	Expect development of detailed workforce plans which underpins the submitted plan, triangulated with finance and activity and for these to be shared with the regional team.	Plans shared and agreed with NHS E by end April 2026
Cancer	Compliant plan, however, delivery is dependent on the funding from Cancer Alliance, which is not full, so a risk to delivery	Trust need to consider further additional actions to close the gap and mitigate the risk	Plans shared and agreed with NHS E by end April 2026
Productivity	Not delivering target in Years 2 and 3	Need to focus on delivery of CIP as a means to improving implied productivity. To be included in desktop deep dive in Q1 to provide assurance on efficiency delivery, with the expectation that efficiency plans are identified during Q1 and progress monitored monthly, not just at quarter-end.	
Finance	Although the BSW Hospitals Group Trust has submitted a breakeven plan across all three years, there remains a material concern regarding the maturity and credibility of the efficiency programme. Progress in	Clear plans to derisk savings plan, with agreed milestones and progress updates to be provided fortnightly. Clear plan to derisk the financial plan, with agreed milestones and progress updates to be provided monthly. The expectation is risks should be fully mitigated.	CIP plans should be fully identified by the end of June 2026 and the percentage of CIP deemed

	developing a robust, evidence-based efficiency plan has been limited. The plan includes a £117.34m efficiency requirement (7.1%), of which 18.2% remains unidentified and 54.7% is assessed as high risk, significantly undermining confidence in deliverability.	Retriangulation of financial and workforce plans once savings proposals are confirmed, to ensure workforce assumptions remain robust and deliverable. Acceleration of contract finalisation, including resolution of any outstanding contractual issues and securing all necessary approvals to enable contracts to be signed without delay. Full implementation of all controls set out in the 2025/26 Financial Management Arrangements and continue with any recovery actions implemented during 2025/26. Establishment of a formal Cash Management Committee, with agreed terms of reference and agenda, aligned to best practice examples available on the ONF site. Organisations should appreciate that securing revenue cash support is likely to be challenging and therefore they should endeavour to manage cash constraints internally or with the use of system support. It is unlikely that any provider is able to access cash support greater than the value of its planned deficit. All investments and discretionary cost pressures over £50k should be subject to organisational, system and NHSE review in line with existing 'Triple Lock' arrangements. Development of sufficient mitigations to offset any financial impact should planned subsidiary savings be delayed or not approved during 2026/27.	high risk should be no more than 20% by the end of June 2026. Retriangulation of finance and workforce completed by the end of June 26

30th April 2026

Sent via Email

Sue Doheny, Regional Director, NHSE South West
Jeff Buggle, Director of Finance, NHSE South West

Directors' Office

Royal United Hospitals Bath
NHS Foundation Trust
Combe Park
Bath
BA1 3NG

Email: cara.charlesbarks@nhs.net
www.ruh.nhs.uk

Dear Sue and Jeff,

**Royal United Hospitals Bath Medium Term Financial Plan (MTFP)
Contract Conditions, 18th March 2026**

We are writing in response to the contract close down letter received on 22nd April 2026 which set out the formal response to our MTFP submitted on 18th March 2026. The letter confirmed that our plan was assessed as **Compliant with Conditions**.

There were five conditions placed on the RUH plan acceptance:

UEC	Reliance on Capital schemes. Factor in the expected improvements within capital builds and GIRFT improvement across all UEC metrics for their return on their investment in years 2 and 3
Cancer	Trust needs to consider further additional actions to close the gap and mitigate the risk
Workforce	Expect development of detailed workforce plans which underpins the submitted plan, triangulated with finance and activity and for these to be shared with the regional team
Productivity	Need to focus on delivery of CIP as a means to improving implied productivity. To be included in desktop deep dive in Q1 to provide assurance on efficiency delivery, with the expectation that efficiency plans are identified during Q1 and progress monitored monthly, not just at quarter-end
Finance	Clear plans to derisk savings plan, with agreed milestones and progress updates to be provided fortnightly. Retriangulation of financial and workforce plans once savings proposals are confirmed. Acceleration of contract finalisation. Full implementation of all controls set out in the 2025/26 Financial Management Arrangements. Establishment of a formal Cash Management Committee

Please find an update on these conditions as requested including progress since our last correspondence.

UEC

We have seen an effective winter response despite seeing 5.6% growth in ED Attendances and 12.8% increase in non-elective admissions during 2025/26.

We have seen a strong March performance for UEC, which has resulted in RUH Bath being in the top 10 most improvement hospitals for 4 hours in the country. This has resulted in us gaining an additional £2m capital funding to support our transformation of UEC.

The plan delivers an improvement in 4-hour performance of 9.6% (from December 2025 baseline) to 75.3% by March 2027. This improvement is reliant on the capital plan for a modular build which will see the move of the UTC in October 2026, separating patient flows and increasing capacity for patient assessment in both UTC and Majors pathways. We are adopting a 100-day plan under Bernie Bluhm's leadership to ensure our improvement pathways are in place in ED and UTC so that the modular is immediately optimised when it is installed.

Performance improves to 80.2% in year 2 of our plan and 82.0% in year 3 through a number of transformation schemes including a move to a single surgical SDEC footprint, a frailty hub, 7-day therapy provision, increased GP productivity and expansion of MIU provision.

This is also predicated on significant levels of demand management support from our partners, 2.1% of ED Attendances and 4.8% non-elective admissions.

Cancer Standards

As part of the business plan for delivery of Cancer Standards, the Trust identified the need for circa £1.6m SWAG funding in addition to the RUH investments / business cases agreed as part of 2026/27 business plan to respond to capacity constraints and growth in demand. Following price improvements and accelerated delivery of internal schemes, the Trust has managed to reduce the external funding requirement to £1.3m.

£840k of the external funding has already been secured from SWAG for quarter 1 and 2, with the remainder being held in a ring-fenced pot which will be allocated to the RUH quarter by quarter based on delivery of our performance trajectory.

As at the end of quarter 4, we have seen achievement of the year end position for 28 days and 31 days (pending final validation) with 62-day cancer standard improving but below plan. Robust plans are in place to continue our improvement across all three cancer standards therefore confidence in successfully securing the additional SWAG funding is high. The key risk in delivering year end performance is delayed or unsuccessful delivery of business plan investments which are reliant on recruitment to difficult to fill roles (i.e. dermatology, pathology and radiology consultants).

Figure 1: Year End Position 2025-26

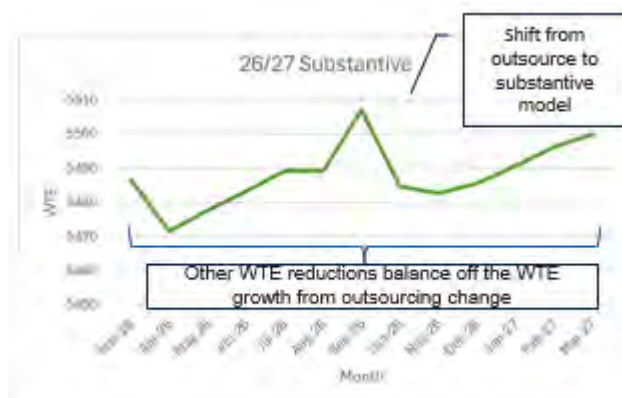
Domain	Metric	25/26 Year End plan	Mid year (September 2025)	Current Performance (March 2026)
UEC	4-hour ED performance (type 1 / all types)	72% / 78%	57.6% / 67.6%	62.6% / 71.6%
	12-hour ED performance	4.9%	9.0%	8.2%
	Ambulance handover	33 mins	74.9 mins	44.9 mins
Elective	18w RTT Performance	68.7%	58.2%	69.1%
	52 Week Waiters	<1%	1.93%	0.55%
Diagnostics	DM01	16.1%	34.8%	13.9%
Cancer	28d FDS	80%	53.7%	82.2%*
	31d	94%	91%	94.0%*
	62d RTT	75%	58.3%	64.4%*
Finance	2% productivity improvement	£20.5m	£32.0m	£20.5m

Workforce

Our MTFP has full triangulation between workforce, finance and activity. The workforce plan is built up from schemes to improve our elective standards through a shift from outsourcing and premium rate models to substantive, more cost effective models. This will increase WTE but reduce the overall cost base. This is coupled with productivity and efficiency plans including bank and agency reductions linked to reduced sickness and use of escalation areas which reduce WTE. The net effect of this is a broadly static WTE position whilst reducing the overall costs of provision.

There remains a gap in our current CIP programme of circa £5.2m which remains unidentified. As further schemes develop in maturity, any impact on workforce will be incorporated into our plans accordingly.

Figure 2: Overall impact of workforce plans 2026/27



WTE	FOT 31/03/2026	FOT 31/03/2027	Change
Substantive	5486.5	5499.95	13.45
Bank	250.82	237.38	-13.44
Agency	10	5	-5
Total	5747.32	5742.33	-4.99

Staff sickness levels have been increasing across the organisation; coupled with a sustained periods of winter pressures and industrial action, we recognise an increasing risk to staff morale, health and well-being. One of our Breakthrough Objectives for 2026/27 is to improve our sickness rate to 4.8%. This will be achieved through our Healthier Workforce Programme which will adopt a range of interventions to support and empower staff to retain health and at work.

Productivity

It is recognised that the productivity expectations in the plan of 6% are over and above the level of productivity opportunity identified in the national benchmarking. This will require the trust to be operating in the top decile of productivity (currently in top quartile for most indicators) and delivery of transformation change to release the level of financial benefit required.

Benchmarking identified £43.3 million in opportunities over a three-year period compared to a need to delivery £27.6m of savings in year 1 of the plan. Mitigations to this mismatch include a clear focus in the plan to maximise on the productivity gains delivered during quarter 4 through the successes of the Elective Sprint Funding as well as seeking to maximise commercial income, alongside BSW Hospitals Group partners, and leverage value from our wholly owned subsidiary, Sulis Hospital.

Other productivity areas include proactively manage bio-similar high-cost drug switching, work with partners to reduce the overall length of stay of our non-criteria to reside patients (currently bottom quartile) and reduction in sickness absence rates.

Finance

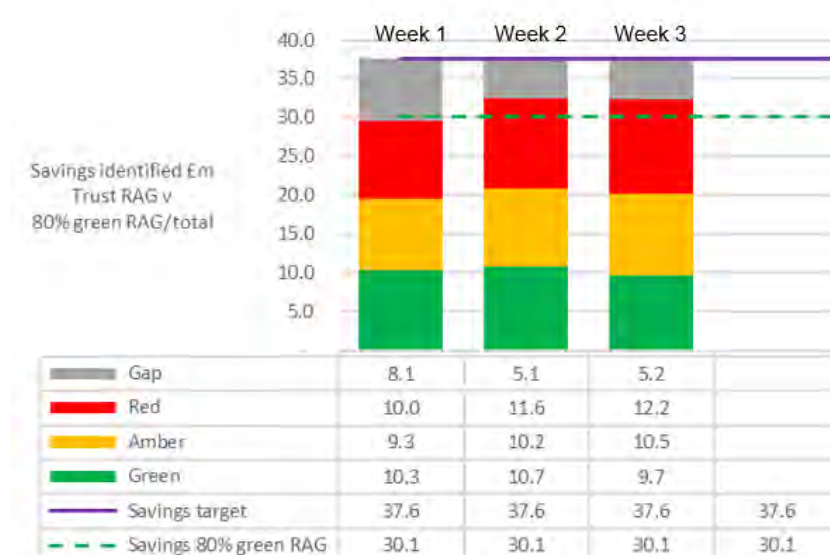
We have reset our governance and resourcing to mirror the Group Task & Finish; Care Organisation new financial framework & governance; and reduction in Turnaround support.

Savings targets have been set for divisions, corporate teams and against our commercial strategy and we are tracking the development of our savings plan maturity weekly using a visual savings totaliser (see example below).

The programme reports into the Financial Improvement Programme Board (FIPB), supported by Divisional Financial Improvement Review Meetings (FIRMS) with a clear focus on;

- (i) Delivery of 15% of our CIP plan in quarter 1 (£5.64m) and
- (ii) Maturing to 80% of CIP schemes as Green by the end of quarter 1

Figure 3: Savings Totaliser



We will continue to provide fortnightly updates on progress against the maturity of the CIP programme.

We appreciate your ongoing support and look forward to working with you and system partners to delivery this ambitions plan.

Your sincerely



Cara Charles-Barks
Chief Executive

**Great Western Hospitals NHS Foundation Trust,
Royal United Hospitals Bath NHS Foundation Trust,
Salisbury NHS Foundation Trust**

cc: John Palmer, Managing Director, Royal United Hospitals Bath
Simon Wade, Chief Financial Officer, BSW Hospitals Group
Jude Gray, Group Chief People Officer, BSW Hospital Group,

Enc: RUH Bath Trust Priorities 2026/27

RUH Priorities 2026/27

**The RUH,
where you matter**

Our Strategic Initiatives

Our 2026/27 Breakthrough Objectives

Our Corporate Projects

The **people** we care for

Partnerships

As a community, we face significant challenges. We will create strong partnerships to deliver the best possible services for our patients



Achieve safety standards



Eliminate Corridor Care
Reduce NC2R Length of Stay
Zero 52 weeks
Cancer 28-day diagnosis 80%
Diagnostic Waits 12.5%

The **people** we work with

Service Redesign

We have £140m capital funding to transform our hospital and we will use it to design services and spaces that are truly fit for the future



Support and empower our staff



Improve sickness rate absence to 4.8%

The **people** in our community

Commercial Opportunities

We can harness commercial opportunities to fuel innovation, grow new services and reinvest in the NHS for the future



Making the most of our resources



Deliver £37.6m of Savings
Exceed 2% Productivity

UTC Modular Build

Advice & Refer

Demand Management & Discharge

Healthier Workforce Programme

Clinical Admin Transformation

Medical E-Rostering Staff Accommodation

Digitalisation of Outpatients

Shared EPR

Trowbridge Neighbourhood & Community Diagnostic Centre Project Clean Heat

Report to:	Public Board of Directors	Agenda item:	8
Date of Meeting:	3 June 2026		
Title of Report:	Board Assurance Framework Summary Report		
Status:	Assurance		
Board Sponsor:	Paul von der Heyde, BSW Hospitals Group Chair John Palmer, Managing Director Mark Ellis, Chief Risk Officer		
Author:	Roxy Milbourne, Interim Head of Corporate Governance All Executive Directors		
Appendices	None		

1.	Executive Summary of the Report
This report provides a summary update on the Trust's Board Assurance Framework (BAF). The Board is receiving a high-level summary in line with established practice for public reporting. The BAF position remains materially stable since the previous reporting cycle, with no substantive amendments to risk descriptions, controls or assurances. One risk rating increased during the period, as outlined below. Strategic risks remain stable in nature, with changes typically occurring incrementally over time. Oversight of the BAF continues through established committee and Executive governance arrangements, with Board subcommittees routinely reviewing risks within their remit. In light of the forthcoming transition to a Group Board Assurance Framework from July 2026, a further detailed refresh has not been undertaken for this reporting cycle. A proportionate approach has therefore been adopted, maintaining the current framework as the Trust's formal statement of strategic risk. The current BAF will remain in place until it is formally superseded by the Group BAF as part of the transition to the BSW Hospitals Group governance arrangements.	

2.	Recommendations (Note, Approve, Discuss)
The Board of Directors is asked to: • Note that the Board Assurance Framework position remains materially stable since the previous reporting cycle. • Note the increase in Risk 3.4 (Estate) from 16 to 20 in April 2026. • Note that the current BAF will remain in place until it is formally superseded by the Group BAF as part of the transition to the BSW Hospitals Group governance arrangements.	

3. Legal / Regulatory Implications

Maintaining a Board Assurance Framework is a core component of effective NHS governance. The BAF supports compliance with the Well-Led Framework and provides assurance to the Board on the management of principal strategic risks.

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

The Board Assurance Framework articulates the principal risks to achievement of the Trust's strategic objectives and forms a key component of the organisation's wider risk management framework.

5. Resources Implications (Financial / staffing)

The BAF sets out strategic risks relating to resources and requires ongoing input across the organisation to ensure it remains an accurate reflection of the Trust's risk position.

6. Equality and Diversity

The BAF includes risks that may impact equality, diversity and inclusion, including workforce, access and outcomes.

7. References to previous reports/Next steps

Board subcommittees will continue to review risks within their remit ahead of the transition to the Group Board Assurance Framework.

8. Freedom of Information

This summary report is available in the public domain.

9. Sustainability

The BAF includes strategic risks relating to climate change and the Trust's ability to meet statutory and national expectations regarding environmental sustainability.

10. Digital

The BAF includes strategic risks relating to digital capability, cybersecurity and the delivery of digital-enabled clinical transformation.

1. Introduction and Current Risk Position

This report provides a summary of the current position of the Trust's Board Assurance Framework.

The Board Assurance Framework (BAF) continues to comprise 13 principal strategic risks aligned to the Trust's strategic objectives.

All risks remain unchanged in terms of description, controls and assurances since the previous report to the Board. One risk has changed in rating, as set out below.

Risk movement:

One risk has changed since the previous reporting cycle. Risk 3.4 (Estate) increased from 16 to 20 in April 2026 to better reflect our current estate risk exposure; however the underlying controls and assurance arrangements remain unchanged.

No other risks have changed in score or direction of travel.

The Board can take assurance that the BAF continues to provide an appropriate and accurate articulation of the Trust's principal strategic risks, supported by established governance processes and committee oversight arrangements.

2. Transition to Group Board Assurance Framework

The Board previously noted the intention to transition to a Group Board Assurance Framework aligned to the BSW Hospitals Group governance model.

Work is ongoing to develop the Group BAF, with implementation expected from July 2026. Until that point, each organisation retains its own Board Assurance Framework, with Executive Leads remaining accountable for maintaining oversight of risks within their remit.

Given the proximity of this transition, it is not considered proportionate to undertake a further detailed refresh of the current BAF for this reporting cycle. The existing framework will therefore be maintained as the Trust's formal position and will be formally closed at the point of transition to the Group Board arrangements.

This approach ensures continuity, clarity and a stable audit trail of the Trust's strategic risk position during the transition period.

3. Recommendations

The Board of Directors is asked to:

- **Note** that the Board Assurance Framework position remains materially stable since the previous reporting cycle.
- **Note** the increase in Risk 3.4 (Estate) from 16 to 20 in April 2026.
- **Note** that the current BAF will remain in place it is formally superseded by the Group BAF as part of the transition to the BSW Hospitals Group governance arrangements.

Royal United Hospitals Bath NHS Foundation Trust
Board Assurance Framework
June 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 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	16	STATIC	Chief Operating Officer	Finance and Performance
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	16	STATIC	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	The Trust's ageing estate carries a backlog maintenance and critical infrastructure risk that exceeds the capital available to address it, while the revenue-funded maintenance activity that has historically compensated for this is itself under sustained pressure. This reduces the Trust's ability to manage the rate of deterioration effectively, resulting in an increased risk of service disruption, compromised patient and staff safety, statutory non-compliance and regulatory action, and a degraded environment for patients and staff.	The people in our community	16	20	INCREASE	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

Report to:	Public Board of Directors	Agenda item:	9
Date of Meeting:	3 June 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 meetings on 29 April and 27 May 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

April 2026

- **Local Response to Temporary Staffing Changes:** The Committee discussed the local response to the ongoing work around temporary staffing and the associated risks.

May 2026

- **Fire Safety:** A risk-based prioritisation exercise has been undertaken to align the highest-rated fire safety risks identified in the Authorising Engineer (Fire) Annual Audit Action Plan to the appropriate funding and operational responses within the Trust's existing five-year financial envelope. This prioritisation is subject to ongoing review. While available capital and revenue funding limits the pace at which all identified works can be completed, robust interim risk management and fire safety assurance regimes are being implemented where required to maintain a safe environment. In parallel, further work is being progressed through a Group-wide Task and Finish Group, focusing on fire safety priorities and the associated Capital Departmental Expenditure Limit (CDEL) and revenue implications.
- **Finance:** The Trust is reporting a deficit of £2.9m, which is £1.3m adverse to plan. Actions are in place to strengthen financial performance, including exploration of commercial opportunities and acceleration of delivery and assurance around CIP schemes. External scrutiny remains high and the Trust continues to focus on maintaining a disciplined approach.

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

April 2026

- **Change in Turnaround Support Arrangements:** The Trust is transitioning from turnaround-supported recovery to self-sustained, internally led financial and operational management. Despite improvements in the financial position, external scrutiny remains high. Performance Review Meetings (PRMs) and the Financial Intervention Programme Board (FIPB) will continue to provide robust

oversight, structure, and discipline as part of the Trust's ongoing governance arrangements.

- **GMC National Training Survey:** The latest survey results indicate a downward trend across a number of areas. The Committee recognises this as a priority and has agreed that improvement actions and potential interventions will be developed and progressed through a dedicated Task and Finish Group.

May 2026

- **Clinical Value Review:** The Committee has reviewed work undertaken through the Clinical Value Review to date and has agreed to share this to ensure that it is included in the scope of the Acute Services Review across the Group.
- **Frailty Strategy:** A Frailty Strategy has been drafted setting out a comprehensive, system-wide approach to transforming care for older people living with frailty. The strategy aims to improve outcomes, experience, and flow for this growing and clinically vulnerable cohort, while supporting more effective and sustainable use of Urgent and Emergency Care services (UEC). The strategy will continue to be developed in partnership with stakeholders, with delivery priorities to be progressed as corporate programme aligned to UEC recovery, elective delivery, and wider system working.
- **Integrated Performance Report:** The report demonstrates a mixed position. While overall performance at month 1 is stable, several metrics are rated amber and red and require focused management attention, with actions in place to support improvement.

ASSURE: Inform the Board where positive assurance has been achieved

April 2026

- **Transition from 2025/26 to 2026/27:** The Trust delivered a strong year-end position for 2025/26, with notable improvement across diagnostics, elective recovery, and in March 2026, for UEC. The focus is now on ensuring a controlled and confident transition into Q1 of 2026/27, while continuing to build on progress and maximising short and long term opportunities to sustain and further improve performance.

May 2026

- **Freedom to Speak Up (FTSU):** The Committee received the Q4 Report and Annual Reports for 2025/26 and was assured that FTSU continues to provide a credible, accessible, and independent route for staff voice. Work is ongoing to strengthen the triangulation of FTSU data with other intelligence sources, to enhance insight into organisational culture, with a particular focus on workforce and quality indicators.

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

April 2026

- The increase in the number of major risks continues to be monitored. A limited term Risk Management Improvement Group has been established and is in its early stages, focusing on reviewing and strengthening the effectiveness of controls across the Trust's key risks and is providing focused oversight on the adequacy and effectiveness of existing risk controls.

May 2026

- The number of major risks has remained stable since April, with the overall risk profile largely unchanged. Progress has been made in reducing the number of unapproved risks, and work continues to strengthen organisational oversight and risk management arrangements through the Risk Management Improvement Group, supporting improved governance, oversight, and consistency in risk management across the organisation.

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

April 2026

- **End of Year Performance:** An outstanding contribution has been made across the organisation to improve performance and provide better services for patients. There are notable improvements in 65 and 52 week waits, diagnostic waits, cancer standards, ambulance handover delays, and the year-end deficit position.
- **Industrial Action:** Staff worked incredibly hard to keep the Trust safe during the most recent period of industrial action and the Committee acknowledged their significant efforts.
- **Complaint Response Times:** The Trust met its 90% formal complaint response time target in March 2026 with Medicine Division achieving 100%.

May 2026

- **Improvement Progress during 2025/26:** The Committee continues to recognise the significant effort made across the organisation to improve performance and enhance patient services through the Call to Action during the final 6 months of 2025/26. National performance data, published in May, demonstrates notable improvements across a range of key indicators.

APPROVALS: Decisions and Approvals made by the Committee

April 2026

- **Chair's Action:** Chair's Action around the Specialist Weight Management Service, Paediatric Chronic Fatigue Service, and the execution of patent

documentation was taken between meetings. The Committee noted the actions taken and is assured that due process has been followed in each instance.

- **Endoscopy Business Case:** A recurrent investment was approved to improve endoscopy capacity. This will support DM01 and Referral to Treatment (RTT) recovery and will improve patient safety.
- **Palliative Care:** A temporary reduction to the specialist palliative care nurse-led service was agreed to stabilise staffing while recruitment and training is undertaken. The risk to patients has been assessed and mitigations are in place.
- **Medlock Short Term Agency:** The Committee approved the use of short term agency to maintain safe Systemic Anti-Cancer Therapy (SACT) service delivery, reduce clinical risk, and provide resilience.
- **Respiratory Water System:** The temporary closure and relocation of respiratory ward has been approved in principle to enable essential maintenance works to be carried out.
- **Pharmacy Aseptics Business Case:** The Committee approved a phased investment over two years to support Quality Assurance (QA) requirements in aseptics and radiopharmacy.
- **Risk Register Management Report:** The Committee approved updates to the Risk Register, including new, upgraded, and downgraded risks.

May 2026

- **Policies and Guidelines:** The Committee approved the following documents:
 - o Taxi Policy
 - o Reverse Boarding Guideline
- **Risk Register Management Report:** The Committee approved updates to the Risk Register, including new, upgraded, and downgraded risks.
- **Risk Management Group Terms of Reference:** The Committee approved the Terms of Reference, recognising the importance of improving the Trust's risk management processes.

Report to:	Public Board of Directors	Agenda item:	10
Date of Meeting:	3 June 2026		
Title of Report:	Alert, Advise and Assure Report – Finance and Performance Committee		
Status:	For information		
Author:	Antony Durbacz, Non-Executive Director		

Key Discussion Points and Matters to be escalated from the meeting held on 26 May 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

- The actual cash balance has fallen below the previously proposed minimum working balance of circa £19m. Active cash management is in action with forecasts being further scoped if support is needed from the region/group.

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

- The surplus for the month was behind budget by £1.3m. The variance included shortfalls against saving plans and £0.2m of structural contract issues which will lead to a variance for the year.
- Recovery by the first quarter is anticipated and is dependent on the sale and lease back transaction. Sign off from the region will be required for this treatment.

ASSURE: Inform the board where positive assurance has been achieved

- Reflection on the improvement in year against prior year on operational metrics. The achievement is outstanding.
- Root cause metric dashboards have been developed for Accident and Emergency (A&E) which bring together ambulance service/community/hospital performance.
- A matrix of ownership has been drafted for the Cost Improvement Programme (CIP) showing where group/region ownership for delivery is required.

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

- The underlying improvement in Referral to Treatment (RTT) has been maintained but is undertaken at risk in the absence of sprint funding.

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

- Noted that the trajectory on 62 day cancer for the coming year would be a top percentile performance.

APPROVALS: Decisions and Approvals made by the Committee

- The Committee recommends to the board approval for the commissioning of Sulis to provide outpatient pharmacy dispensing services to RUH.

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

Report to:	Public Board of Directors	Agenda item:	11
Date of Meeting:	3 June 2026		
Title of Report:	Alert, Advise and Assure Report - Quality Assurance Committee		
Status	For Information		
Author	Simon Harrod, Non-Executive Director		

Key discussion points and matters to be escalated from the meeting on 13 April 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

- There remains a significant backlog of clinical letters to be typed. Although extra resource is in place with a large reduction in the backlog since January, there are 8000 letters untyped after 7 days. Work is needed on a digital solution which is now being trialled.

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

- A KPMG Audit recently took place, focusing on the Patient Safety and Incident Response Framework (PSIRF) process for investigating and learning from incidents. The audit described many areas of good practice and identified several areas requiring improvement, most notably the length of time to complete an investigation. This relates to the risk described within the risk section of this report around resource limitation
- There is an issue regarding sharing maternity ultrasound scans/results across digital platforms. Work is ongoing with the Business Intelligence Unit to capture data from the new maternity Badgernet (maternity digital platform) system.

ASSURE: Inform the Board where positive assurance has been achieved

- The coding resource needed to accurately code Summary Hospital-level Mortality Indicator (SHMI) data has been identified and appointed to. It is expected the backlog will clear by May 2026. Work also continues to prevent the reoccurrence of a backlog in Structured Judgement Reviews (SJRs).

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

The Committee discussed two new or upgraded risks relating to:

- Insufficient patient safety, risk, audit and quality improvement resource (score=16).
- Trust preparedness for high consequence infectious disease admissions (score=15).

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding
• There are no items to report this month.
APPROVALS: Decisions and Approvals made by the Committee
• There are no decisions or approvals to report.

Report to:	Public Board of Directors	Agenda item:	12
Date of Meeting:	3 June 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 April 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.

Performance

RUH 4-hour performance in April 2026 was 61.02% on the RUH footprint (unmapped), a decrease of 1.62% from March's performance (62.64%). Non-admitted performance was 71.62%, which is a slight decrease against March's 73.03%. Admitted performance was 39.45%, which is a like-decrease from 42.46% in March.

Corridor Care - the RUH implemented the use of a corridor in the Emergency Department in October 2025 with launch of W45, to support timely ambulance handover. In April 2026, the number of patients who spent > 45 minutes of their ED visit in the corridor was 566, representing 15% of all ED attendances during that time. Eliminating corridor care will form part of the 100-day UEC Challenge in June 2026 and we will define countermeasures to address performance improvement.

Elective waits in April, Referral to Treatment (RTT) performance saw an increase in overall performance of 1.2% to 70.3% vs trajectory of 68.3%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 73.8% (+ 0.8% from March) The target for over 52-week waiters was achieved with 0.47% of

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 Document Approved by: Bernie Bluhm, Chief Operating Officer / Toni Lynch, Chief Nursing Officer / Jude Gray, Chief People Officer / Simon Wade, Chief Finance Officer	Date: June 2026
Agenda Items: 12	Page 1 of 5

patients on the waiting list being over 52 weeks vs the Trust target of 1%. The Trust continues to sustain the position of having zero patients waiting over 65 weeks.

Diagnostic waits in April 2026, 85.32% of patients received their diagnostic within the 6-weeks against the 85.40% target. Performance decreased 0.76% from March 26. However, this decrease was due to a reduction in denominator, as the Trust received less referrals. Total breaches, overall, reduced by 44 from the previous month.

Cancer waits - Cancer performance will now be reported as last month's position, previously reported one month in arrears. In April, performance (unvalidated) declined against all three national standards. Having achieved the national 28-day 80% standard in February and March, April is currently 79.1% with Colorectal followed by Gynae and Breast seeing the largest reduction. 31-Day is currently showing a reduction to 92.5% although further validation/recording of treatment is expected to bring an improvement to near the national 94% standard. Waiting times for MOPS in Skin remains the area of most challenge. 62 Day performance has been maintained at 68.5% with a minor improvement expected on completion of validation.

Quality

Focused improvement work continues to address the deteriorating pressure injury performance across the Trust and remains a key priority. Analysis of harm includes patients who have had a prolonged length of stay in ED or another Front Door area, there are cases where harm has occurred. Actions include targeted support in wards that have experienced clusters of pressure injuries, alongside a Trust-wide task and finish group reviewing relevant systems and processes inclusive of training, development and leadership support.

Administration and prescribing incidents were the most common incident types reported. The Medicines Safety Group will review the initial datix reports as a cohort to look for themes and trends as well as receiving an update on the final reports when available. The outcome of the review and actions will feature in this report.

Data shows that during April 98.7% of inpatients did not fall in our care. Trust wide in April 90.0% of adult inpatients had a falls risk assessment completed within 6 hours of admission and falls per 1,000 bed days in April were below the National Audit for inpatient falls (NAIF) benchmark of 6.6.

Fill rates in nursing remain persistently low in some areas, impacted to high sickness levels and vacancies in some areas. Nursing staffing levels for registered nurses is known to impact directly on patient outcomes for indicators such as falls, pressure ulcers, administration of medicines and infection prevention and control, in addition to mortality where they are below the prescribed level. Significant work is being undertaken to recruit into specific areas such as ED (almost fully recruited) and the People Directorate are leading a workstream, supported by clinical leaders to understand and reduce sickness levels to improve fill rates.

As reported in the performance section of this report, there are prolonged waits in ED and other Front Door areas, patient outcome data relating to this will feature in future reports.

Workforce

The Trust's workforce position continues to present a degree of risk, with ongoing challenges in sickness absence and appraisal compliance constraining productivity, staff wellbeing, and overall organisational resilience.

Notwithstanding these pressures, vacancy levels remain low. This reflects the success of targeted recruitment campaigns, particularly within the Emergency Department and across Trust-wide Healthcare Support Worker roles. The Care Organisation continues to demonstrate strong attraction, supported by sustained low levels of turnover.

Work is in progress to develop a more focused, longer-term **People Strategy**, which will support delivery of the Trust's strategic priorities across quality, finance, operational performance, and group readiness.

Sickness Absence

Sickness absence remains structurally elevated; however, March 2026 saw a further reduction, with the rate decreasing to **5.62%**, representing a consecutive improvement.

This reduction was primarily driven by a decline in seasonal illness, with cold, cough, and flu-related absence resulting in **440 fewer WTE days lost** compared to February. A key priority for 2026/27 will be the delivery of the **Healthier Workforce**

Programme, identified as a breakthrough objective. Its purpose is to provide a clear and structured approach to improving the physical, mental, and emotional wellbeing of staff, thereby enabling a healthier, more resilient workforce and supporting the delivery of high-quality patient care.

Appraisal

Appraisal compliance has shown some improvement, with notable progress within Surgery. However, overall compliance has plateaued below the 90% target and lacks a sustained trajectory of improvement.

Without strengthened prioritisation, clearer accountability, and consistent leadership focus, current levels of appraisal compliance risk undermining broader workforce objectives, including efforts to reduce sickness absence, enhance staff engagement, and improve long-term workforce sustainability.

Finance

Productivity - Latest December data showed 3.7% improvement year on year, 2nd quartile nationally.

Savings Plan - 96% of plans identified, of which 37% are assessed as Green in delivery or fully developed.

Risks (Downsides) and Mitigations (Upsides) to Plan - Net unmitigated risk of £22.6m, with £6.2m consequences for lost transitional funding and revenue PDC charges.

Variance to Plan YTD [Risk 3165 – Score 20] - £1.3m adverse to plan, driven by £0.3m Industrial Action, £0.2m structural issues, £0.5m Savings shortfall and £0.1m Sulis.

Key Drivers and Assumptions - demand in excess of plan in all domains, notably Non-Elective 10.9% compared to 2.4% planed growth; NCTR 89 and Sickness 5.5%.

Commissioning Income - Elective income £0.1m ahead of plan; UEC £0.8m ahead of pan with 20% marginal payment = £0.2m.

Pay - WTE in line with run rate; Pay £1.1m adverse to budget caused by £0.3m Industrial Action and £0.7m Savings.

Non-Pay - £0.5m adverse to plan.

Sulis - £0.1m adverse to plan caused by self-pay income and overhead costs.

Underlying Financial Position - Planned Underlying position of £12.6m, after £37.6m Savings. Includes Underfunded Block of £28.1m and NCC Index of 98.

Capital [Risk 3288 – Score 16] - £0.4m EPR underspend YTD, re-forecast underway aligned to 1+2 Option; Board approval for £12m UTC scheme and proceeding at risk pending NHSE National approval.

Cash [Risk 3289 – Score 20] - £12.1m closing balance. Reduction of £11.1m in the month. Ahead of base case forecast but below £19m sustainable cash levels. Growing Inter-Group debtors with Sulis and BSW Hospitals Groups.

BSW Hospitals Group - £3.1m adverse to plan, with GWH £1.8m and RUH £1.3m and SFT on plan.

2. Recommendations (Note, Approve, Discuss)

The Public Board of Directors is asked to note the report and discuss current performance, risks and associated mitigations.

3. Legal / Regulatory Implications

Trust Single Oversight Framework.

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

The Integrated Performance Report is linked to the Board Assurance Framework and Risk Register.

5.	Resources Implications (Financial / staffing)
	Performance and Quality, Workforce, and Financial 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

May 2026
(April 2026 Data)

The RUH, where you matter



Our Strategic Initiatives

Our 2026/27
Breakthrough
Objectives

Our Corporate Projects

The people we care for

The people we work with

The people in our community

Partnerships

As a community, we face significant challenges. We will create strong partnerships to deliver the best possible services for our patients

Service Redesign

We have £140m capital funding to transform our hospital and we will use it to design services and spaces that are truly fit for the future

Commercial Opportunities

We can harness commercial opportunities to fuel innovation, grow new services and reinvest in the NHS for the future



Achieve safety standards



- Eliminate Corridor Care
- Reduce NC2R Length of Stay
- Zero 52 weeks
- Cancer 28-day diagnosis 80%
- Diagnostic Waits 12.5%



Support and empower our staff



Improve sickness rate absence to 4.8%



Making the most of our resources



Deliver £37.6m of Savings

Exceed 2% Productivity

UTC Modular Build

Advice & Refer

Demand Management & Discharge

Healthier Workforce Programme

Clinical Admin Transformation

Medical E-Rostering

Staff Accommodation

Digitalisation of Outpatients

Shared EPR

Trowbridge Neighbourhood & Community Diagnostic Centre

Project Clean Heat

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

May 2026
(April 2026 Data)

The RUH, where you matter



Executive Summary

The Care Organisation continues to operate in a highly pressurised environment with both GP referrals and emergency demand exceeding plan at month 1. Whilst we continue to demonstrate good progress in our elective recovery plans for referral to treatment, diagnostics, cancer wait times, there remains significant system demand pressures for emergency care and we have seen a dip in our 4-hour performance in April compared to May, although remaining above the planned trajectory.

The focus for quarter 1 remains the sustained improvement in elective operational standards (RTT, Cancer, Diagnostics) and improved partnership working to reduce urgent demand and non-criteria to reside (NC2R) discharge delays with a focus on patients being discharged home (P0) delayed over 24hrs and length of stay of patient discharged to a community setting (P2). The UEC team are developing a UEC 100-day challenge to support improvements across all non-elective pathways as well as planning for the relocation of the Urgent Treatment Centre by quarter 3.

Year-to-date financial performance is £1.3m adverse to plan, driven by savings shortfall, industrial action, and contract funding gaps. Cash balances remain a risk, and system finance performance is adverse overall. Key priorities for Quarter 1 include closing the financial gap and strengthening savings delivery confidence, through the maturity of CIP schemes to achieve 80% Green by the end of June 2026, coupled with the delivery of the quarter 1 CIP target (15%). This is supported by continued productivity improvement which is reporting a 3.7% year on year improvement, putting us in the 2nd quartile nationally.

Focused improvement work continues to address the deteriorating pressure injury performance across the Trust and remains a key priority. This includes targeted support in wards that have experienced clusters of pressure injuries, alongside a Trust-wide task and finish group reviewing relevant systems and processes. Data shows that during April 98.7% of inpatients did not fall in our care. Trust wide in April 90.0% of adult inpatients had a falls risk assessment completed within 6 hours of admission and falls per 1,000 bed days in April were below the National Audit for inpatient falls (NAIF) benchmark of 6.6.

Workforce continues to present a degree of risk, with elevated sickness absence (5.62%) and appraisal compliance impacting productivity, staff wellbeing and overall organisational resilience. Notwithstanding these pressures, vacancy levels remain low. This reflects the success of targeted recruitment campaigns, particularly within the Emergency Department and across Trust-wide Healthcare Support Worker roles. The Care Organisation continues to demonstrate strong attraction, supported by sustained low levels of turnover.

Work is in progress to develop a more focused Healthier Workforce Programme, identified as a breakthrough objective for this year in response to high sickness levels. Its purpose is to provide a clear and structured approach to improving the physical, mental, and emotional wellbeing of staff, thereby enabling a healthier, more resilient workforce and supporting the delivery of high-quality patient care.

The RUH, where you matter

Business Plan Scorecard

Performance against trajectory (in year)					3 Year Plan Profile		
Domain	Metric	26/27 NHSE Instruction	Current Month Trajectory	Apr-26	Year End 26/27 RUH Plan	Year End 27/28 RUH Plan	Year End 28/29 RUH Plan
UEC	ED Attendance Growth	Versus 25/26 actual	-0.5%	3.6%	-0.5%		
	NEL Admission Growth	Versus 25/26 actual	-4.6%	12.4%	-4.6%		
	Eliminating Corridor Care	0> 45mins by Nov '26	Trajectory	556 (15%)	0	0	0
	4-hour ED performance (type 1)	66.9% by Mar '27	58.7%	61.2%	66.9%	72.9%	79.1%
	4-hour ED performance (all types)	82% by Mar '27	69.1%	71.1%	75.3%	80.2%	85.0%*
	12-hour ED performance	96.1%	Trajectory	92.0%	93.7%	94.7%	95.0%
	Ambulance handover	Reduce toward 15 mins	33 mins	33.1 mins	30 mins	29 mins	28 mins
Elective & Diagnostic	GP Referral Growth	Per planning assumption	0.0%	10.9%	0.0%		
	18w RTT Performance	74.7% for RUH	68.3%	70.3%	74.7%	83.4%	92.0%
	52 Week Waiters	Reduction towards zero	331	183	198	62	0
	52 Week Waiters %	Improvement on 1%	0.9%	0.5%	0.8%	0.4%	0%
	Diagnostics 6 week wait	13.1% for RUH	14.6%	14.7%	12.50%	9.0%	1.0%
Cancer	28 day FDS	80% annual ave	80.2%	79.1%*	80.0%	80.5%	80.7%
	31 day	94%	92.8%	92.5%*	94.2%	96.0%	96.1%
	62 day RTT	80%	75.3%	68.9%*	80.5%	82.7%	85.1%
Workforce	30% Reduction in agency use	30% improvement from M06	Trajectory	13.3 WTE	5 WTE	3 WTE	0
	10% reduction in bank spend	10% reduction from M06	Trajectory	283.7 WTE	237 WTE	-10%	-10%
	Sickness rate (rolling 12 month average)	Improvement	Trajectory	5.5%	4.8%	4.6%	4.4%
Finance	2% productivity improvement	(min 2% improvement)	6.7%	6.5%	5.0%	2.7%	1.5%
	Savings Plan	37.6m (£56.6m over 3 yrs)	1,883	1,400	37.6m	10.3m	8.7m
	Balanced or surplus financial position	Balance or surplus	-1,610	-2,886	0.0m	0.0m	0.0m
Discharge	Non Criteria to Reside (NC2R)	Number of NC2R	86	89			
	Pathway 0 - Home	% within 24 hours	tba	94.0%			
	Pathway 1 - Home with support	% within 48 hours	tba	50%			
	Pathway 2 - Community setting	% within 48 hours	tba	15%			
	Pathway 3 - Residential care	% within 7 days	tba	60%			

* draft - unvalidated position

UEC System View (April 2026)				
RG rating based national trajectory or national target or being an improvement, on latest month, some figures are one month in arrears.				
111 Abandonment Jan - 2.1% Feb - 2.2% Mar - 4.2%	Ambulance Handover <i>average minutes</i> Feb - 71.2 Mar - 44.9 Apr - 33.1	Outliers Medical <i>average per day</i> Feb - 13 Mar - 14 Apr - 7	No EDD Recorded <i>average per day</i> Feb - 53.5 Mar - 54.8 Apr - 55.0	(P1) Reablement Capacity No data
111 Conversion Rate Jan - 9.5% Feb - 10.5% Mar - 10.1%	4 Hour Performance <i>RUH Type 1</i> Feb - 56.03% Mar - 62.64% Apr - 61.02%	Long LOS >=7 days <i>average per day</i> Feb - 244 Mar - 232 Apr - 226	Long LOS >=21 Days <i>average per day</i> Feb - 82.9 Mar - 65.7 Apr - 64.3	(P1) Average Wait between Request and Care Sourced via Brokerage No data
Primary Care Face to Face Jan - 57.9% Feb - 58.2% Mar - 57.8%	12 Hour Performance Feb - 87.3% Mar - 91.8% Apr - 92.0%	G&A Bed Occupancy Feb - 97.9% Mar - 96.4% Apr - 96.0%	Discharges <48hrs NC2R Pathway 1 Feb - 48.1% Mar - 52.4% Apr - 43.1%	(P2) Community Hospital LOS days
				Paulton (BANES) - 37.5
				St Martins (BANES) - 42.4
MIU Demand Feb - 2,427 Mar - 3,080 Apr - 2,847	SDEC Performance Feb - 41.3% Mar - 42.9% Apr - 40.9%	Ward Board Rounds No data	Discharges <48hrs NC2R Pathway 2 Feb - 38.8% Mar - 32.8% Apr - 30.8%	Cedar Ward (Wiltshire) - 32.1
				Longleat Ward (Wiltshire) - 37
				Mulberry Ward (Wiltshire) - 29.6
				Savemake Ward (Wiltshire) - 36.7
BANES UCR AA % Within 2hrs Feb - 79% Mar - 79% Apr - 78.7%	Hospital at Home <i>daily admissions</i> Feb - 7.0 Mar - 4.8 Apr - 5.9	Discharges by Midday Feb - 22.3% Mar - 20.9% Apr - 20.0%	Discharges <7d NC2R Pathway 3 Feb - 50.0% Mar - 43.2% Apr - 42.9%	(P3) Average Wait from carehome referral to discharge to care home No data
Pre Front Door	Front Door	In Hospital	Back Door	Post Back Door

Balanced Scorecard – SWOT Analysis

Successes

- Over 52-week waiters target <1% was sustained in April (0.5%)
- Sustained zero over 65-week waiters since end of December 2025
- Achieved RTT 18 week standard in April (70.3% vs 68.3%)
- 4 hour performance whilst remaining a challenging position, delivered above plan for April
- Cancer targets for the 28 day faster diagnosis and 31 day standard are just under plan at month 1 (unvalidated position)
- Falls per 1,000 bed days in April were below the National Audit for inpatient falls (NAIF) benchmark of 6.6.

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
- Capital investment to support our 3 year MTFP – UEC, Surgical SDEC and Ward Refurbishment
- Frailty hub development
- Implementation of Internal Professional Standards
- Commercial opportunities including sale and leaseback of Assets

Priorities for Quarter 1

- Maintenance of patient safety
- Sustain improvement in elective operational standards (RTT, Cancer, Diagnostics)
- Improve NC2R position with focus on P0 24hrs and reduced P2 LoS
- UEC 100 day challenge
- Maturity of CIP schemes (80% to Green) and delivery of Q1 CIP target (15%)
- Digital enablers; AVT and Microsoft 365 Premium
- Business case for relocating the Urgent Treatment Centre by Q3 2026/27
- Develop our Strategic Initiative programmes for Partnerships, Service Redesign and Commercial Opportunities
- Set up new Care Organisation Governance structure including Risk Management approach
- Corporate Services Redesign
- Review of clinical administration to ensure it delivers requirements
- Fully embed revised EQIA process into decision making
- Healthier Workforce Programme for 2026/27.
- Organisational readiness for Shared EPR implementation
- Implementation of Advice and Refer

Risk/Threats

- Consistently reduced nursing fill rates potentially impacting patient outcomes, mortality, falls, pressure ulcers
- Long waits in Front Door areas adversely impacting patient outcomes
- Maintenance of patient safety in light of financial & performance pressures
- Continuation of Resident Doctor Industrial Action
- Staff morale and burn out due to constant pressures of workload
- Significant increases in UEC demand far outstripping planned levels and lack of benefits seen from community demand management schemes
- Instability resulting from organisational changes across NHSE, ICB and Group
- Implementation of Advice and Refer coupled with closure of RSS service may adversely affect workload, income and RTT performance
- Navigation of the Tiering process and increased regulation
- Financial controls fatigue and loss of capacity following Turnaround
- 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

The RUH, where you matter

Performance & Quality Report

May 2026
(April 2026 Data)

The RUH, where you matter



Performance Summary

Summary of performance across the breakthrough objectives and key standards

RUH 4-hour performance - in April 2026 was 61.02% on the RUH footprint (unmapped), a decrease of 1.62% from March's performance (62.64%). Non-admitted performance was 71.62%, which is a slight decrease against March's 73.03%. Admitted performance was 39.45%, which is a like-decrease from 42.46% in March.

Corridor Care - the RUH implemented the use of a corridor in the Emergency Department in October 2025 with launch of W45, to support timely ambulance handover. In April 2026, the number of patients who spent > 45 minutes of their ED visit in the corridor was 566, representing 15% of all ED attendances during that time. Eliminating corridor care will form part of the 100-day UEC Challenge in June 2026 and we will define countermeasures to address performance improvement. Implementation of 'reverse board', also classified as 'corridor care', commenced in October 2025 to offset pressure at the Front Door.

Elective waits - in April, Referral to Treatment (RTT) performance saw an increase in overall performance of 1.2% to 70.3% vs trajectory of 68.3%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 73.8% (+ 0.8% from March) The target for over 52-week waiters was achieved with 0.47% of patients on the waiting list being over 52 weeks vs the Trust target of 1%. The Trust continues to sustain the position of having zero patients waiting over 65 weeks.

Diagnostic waits - in April 2026, 85.32% of patients received their diagnostic within the 6-weeks against the 85.40% target. Performance decreased 0.76% from March 26. However, this decrease was due to a reduction in denominator, as the Trust received less referrals. Total breaches, overall, reduced by 44 from the previous month.

Cancer waits - Cancer performance will now be reported as last month's position, previously reported one month in arrears. In April, performance (unvalidated) declined against all three national standards. Having achieved the national 28-day 80% standard in February and March, April is currently 79.1% with Colorectal followed by Gynae and Breast seeing the largest reduction. 31 Day is currently showing a reduction to 92.5% although further validation/recording of treatment is expected to bring an improvement to near the national 94% standard. Waiting times for MOPS in Skin remains the area of most challenge. 62 Day performance has been maintained at 68.5% with a minor improvement expected on completion of validation.

The RUH, where you matter

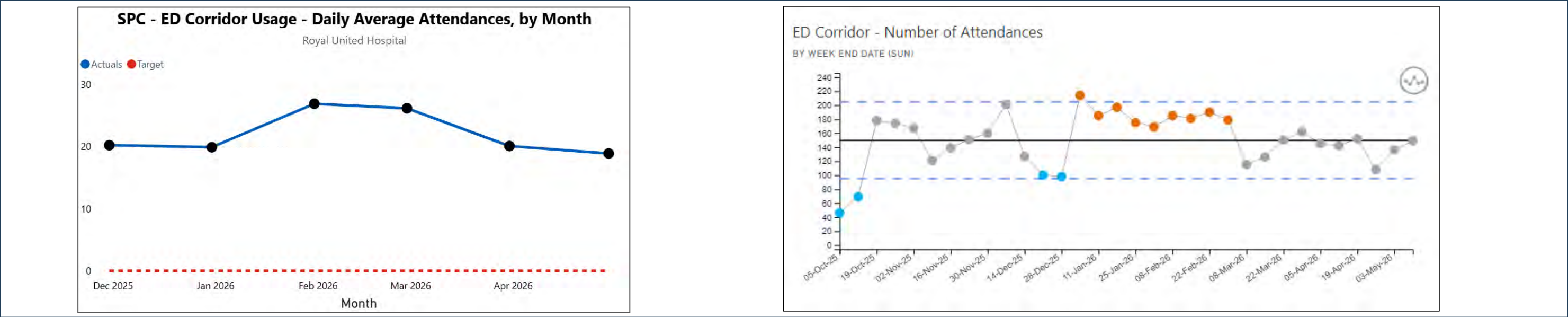
Business Plan – Performance Metrics

Performance against trajectory (in year)					3 Year Plan Profile		
Domain	Metric	26/27 NHSE Instruction	Current Month Trajectory	Apr-26	Year End 26/27 RUH Plan	Year End 27/28 RUH Plan	Year End 28/29 RUH Plan
UEC	ED Attendance Growth	Versus 25/26 actual	-0.5%	3.6%	-0.5%		
	NEL Admission Growth	Versus 25/26 actual	-4.6%	12.4%	-4.6%		
	Eliminating Corridor Care	0> 45mins by Nov '26	Trajectory	556 (15%)	0	0	0
	4-hour ED performance (type 1)	66.9% by Mar '27	58.7%	61.2%	66.9%	72.9%	79.1%
	4-hour ED performance (all types)	82% by Mar '27	69.1%	71.1%	75.3%	80.2%	85.0%*
	12-hour ED performance	96.1%	Trajectory	92.0%	93.7%	94.7%	95.0%
	Ambulance handover	Reduce toward 15 mins	33 mins	33.1 mins	30 mins	29 mins	28 mins
Elective & Diagnostic	GP Referral Growth	Per planning assumption	0.0%	10.9%	0.0%		
	18w RTT Performance	74.7% for RUH	68.3%	70.3%	74.7%	83.4%	92.0%
	52 Week Waiters	Reduction towards zero	331	183	198	62	0
	52 Week Waiters %	Improvement on 1%	0.9%	0.5%	0.8%	0.4%	0%
	Diagnostics 6 week wait	13.1% for RUH	14.6%	14.7%*	12.50%	9.0%	1.0%
Cancer	28 day FDS	80% annual ave	80.2%	79.1%*	80.0%	80.5%	80.7%
	31 day	94%	92.8%	92.5%*	94.2%	96.0%	96.1%
	62 day RTT	80%	75.3%	68.9%	80.5%	82.7%	85.1%
Discharge	Non Criteria to Reside (NC2R)	Number of NC2R	86	89			
	Pathway 0 - Home	% within 24 hours	tba	94.0%			
	Pathway 1 - Home with support	% within 48 hours	tba	50%			
	Pathway 2 - Community setting	% within 48 hours	tba	15%			
	Pathway 3 - Residential care	% within 7 days	tba	60%			

* draft - unvalidated position

Eliminating Corridor Care

We are driving this metric because..	NHS England considers the delivery of corridor care in departments or wards experiencing patient crowding to be unacceptable and should never be considered standard. Published evidence examining patient safety and crowding in emergency departments and wards, reports worse clinical outcomes and poorer experiences for patients, their loved ones and healthcare staff.
Performance Target:	<i>Elimination of corridor care so that no patient is in a corridor for > 45 minutes during an Emergency Department attendance.</i>



Understanding Performance	Countermeasures 2683	Owner	Due Date	Risks and Mitigation
The RUH implemented the use of a corridor in the Emergency Department in October 2025 with launch of W45, to support timely ambulance handover. Since this time, a corridor has been in operation, the occupancy of which peaked in January 2026 as the adult general and acute bed occupancy increased, which was also impacted also by high number of bed closures due to IPC restrictions. In April, the number of patients who spent > 45 minutes of their ED visit in the corridor was 566 representing 15% of all ED attendances during that time. Overall, in April, and in comparison, with the calendar year to date, the trend is that the average time in the Emergency Department corridor increases for patients who arrive in the Emergency Department from 19:00 to 05:00. In April, the average time of those patients who waited in the corridor was 146 minutes.	<i>In development as part of the 100-day UEC challenge</i>	SH	June 2026	Adult general and acute bed occupancy typically exceed 92% daily. Risk register ID 2683 score 20.

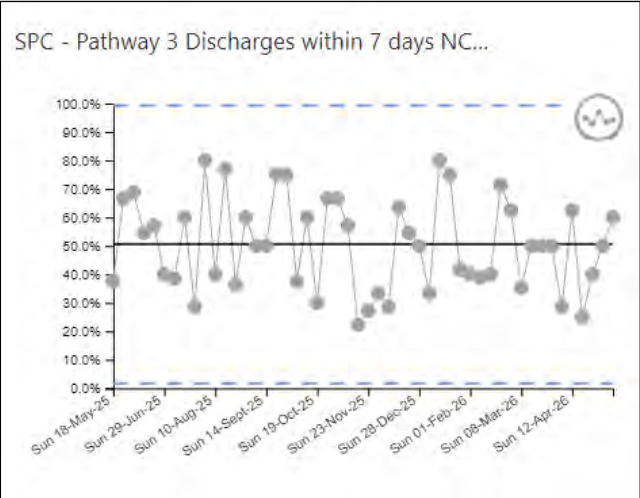
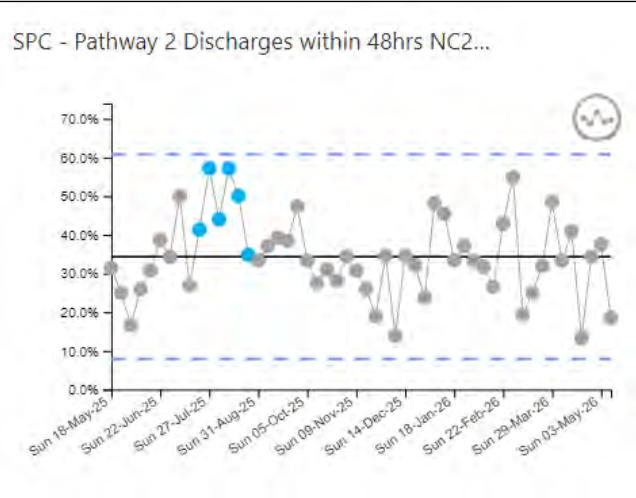
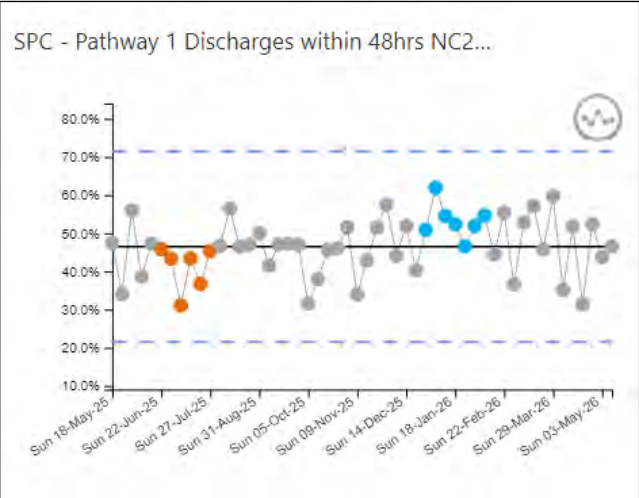
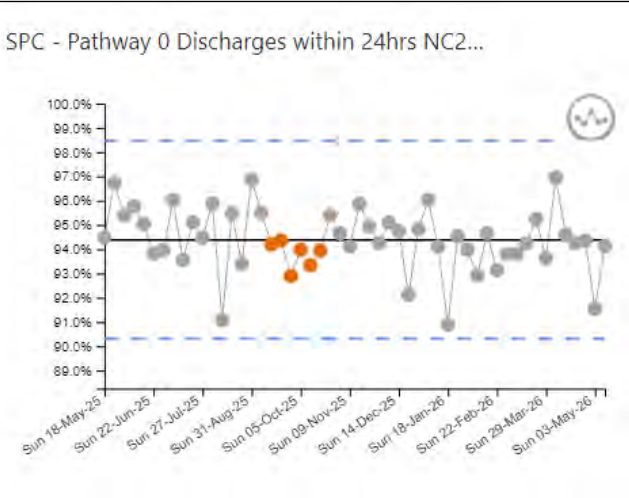
Breakthrough Objective

Non-Criteria to Reside – Length of Stay

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 April 2026, the average number of NCTR patients per day was 89.4, no change compared to previous month. The performance target is a maximum of 40 patients per day (community and hospital responsibility). Hospital responsibility NCTR discharges (P0) were sustained at 94.5% discharged within 24 hours. Community pathways 1-2, decreased in March to 39.2% of patients discharging within 48 hours, pathway 3 discharges also decreased to 42.9% within 7 days.



P	%
P0 24 hrs	94.5%
P1 48 hrs	50.0%
P2 48 hrs	15.0%
P3 7 days	60.0%

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. As of the 1st April 2026 HCRG have implemented new processes as part of a wider transformation programme; the trust is awaiting capacity and demand profiles from HCRG to understand if new capacity will meet demand and deliver within the BSW discharge timelines.

Improved performance:
Hospital responsibility NCTR In April reduced by 1 patient to a daily average of 23.9 patients. In April, 94.5% of the hospital responsibility patients were discharged within 24-hour hours of non-criteria, 97.4% within 48 hours and 99.5% within 7 days.

Countermeasures

Long length of stay review process (> 14 days) to ensure next steps re completed to impact on the reduction in NCTR hospital and Community daily from 26/03/26 then bi-weekly from w/c 13/04/26.

Providing a single source of the NCTR position for BSW and national reporting/monitoring. 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. The aim to provide a single source of the NCTR position. Project resource identified who started January 2026 to support implementation. Aimed to implement April 2026 when HCRG change care transfers hub processes now part of the 100-day challenge to drive daily improvement in NCTR discharge timelines.

Owner

SH

SH

Due Date

Launched 26/03/26 and now business as usual

30 June 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.

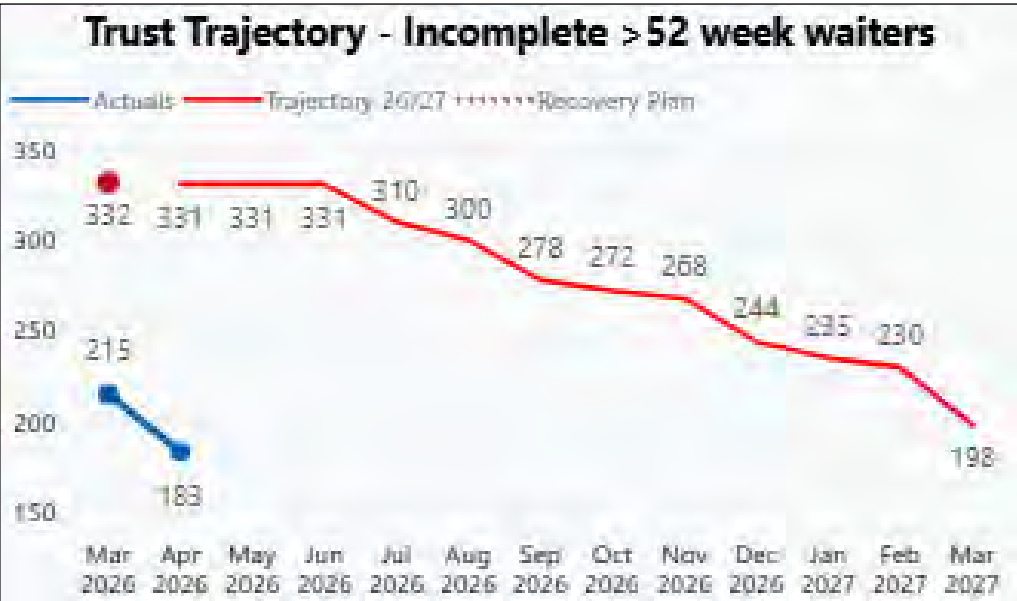
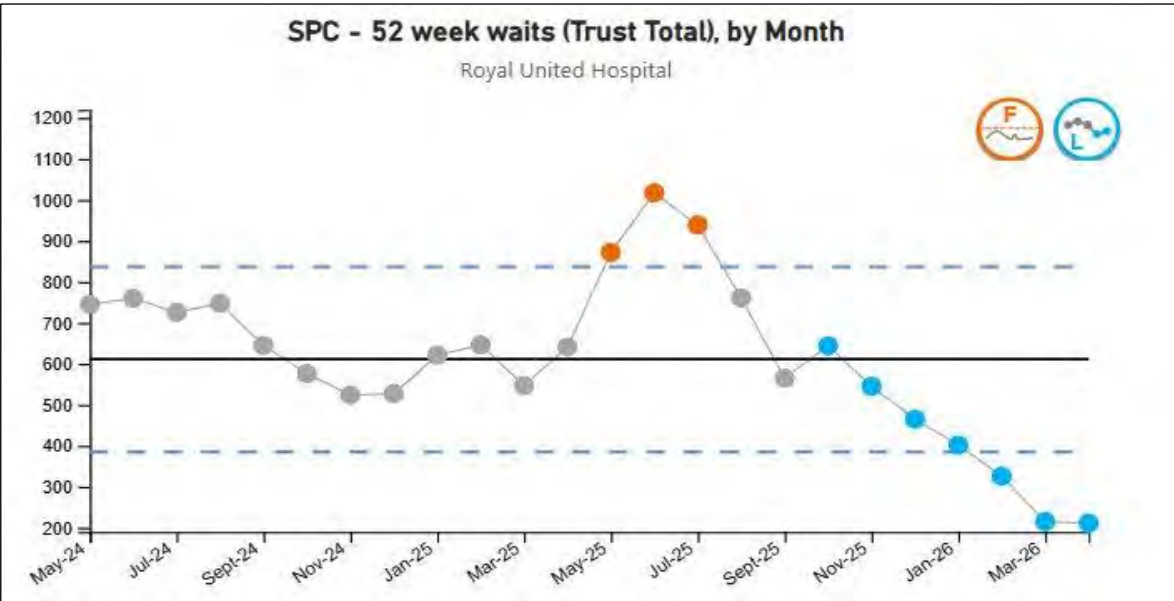
Referral To Treatment (RTT) over 52 weeks

We are driving this metric because..

Too many patients are waiting over 52 weeks for their definitive treatment.

Performance Target:

Target for 198 (0.8%) by March 2027. Internal stretch target to have Zero 52 week waiters by Sep-26



Understanding Performance
- The number of >52-week patients decreased from 215 to 183 (-15%). 0.5% of total RTT patients have waited >52 weeks - The top contributors to >52-week breaches: Pain and General Surgery - Pain remained static at 51 - General Surgery remained static at 36

Countermeasures	Owner	Due Date
General Surgery – replacement Locum due to start May 26 (UGI)	NL	June 2026
Long waiter (52 week cohort) PTL meeting held weekly to ensure close monitoring of patients	JD	Ongoing
Pain – Insourcing continuing to support wait to 1st OPA	KM/ES	June 2026
Additional WLI theatre lists for longest waiting patients in ENT	NG	June 2026

Risks and Mitigation
Risks: - Routine radiology capacity including reporting - General Surgery outpatient capacity - ENT outpatient capacity for Paediatrics (age limitations) Mitigations: - Additional consultant capacity from May 26 – ENT

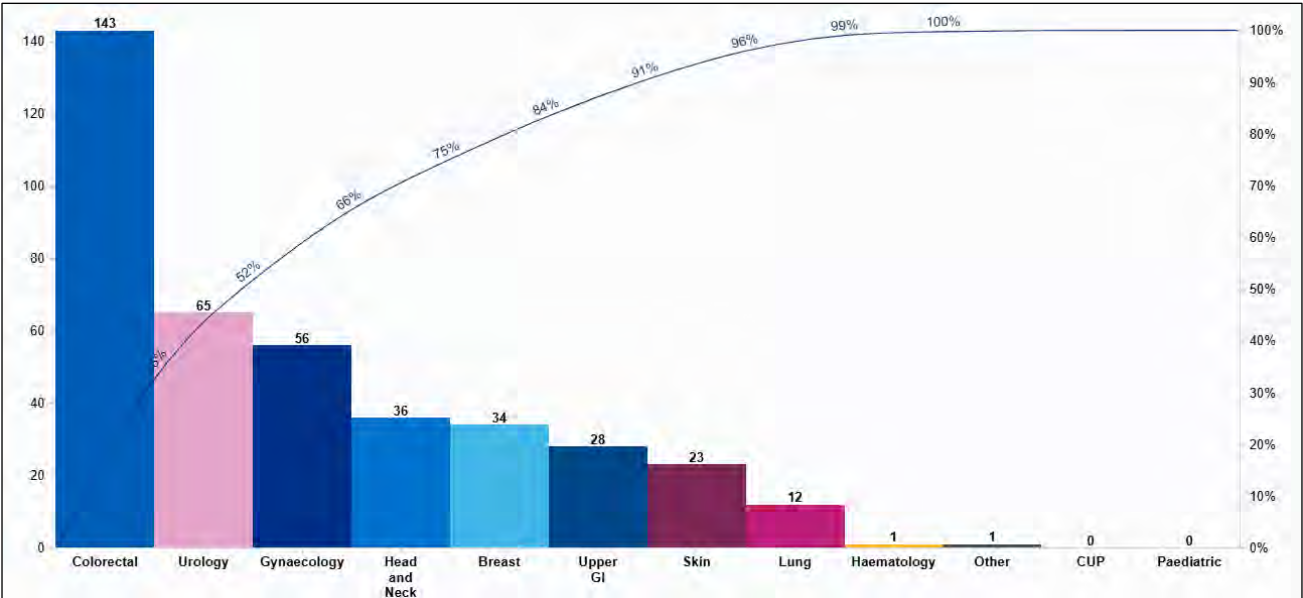
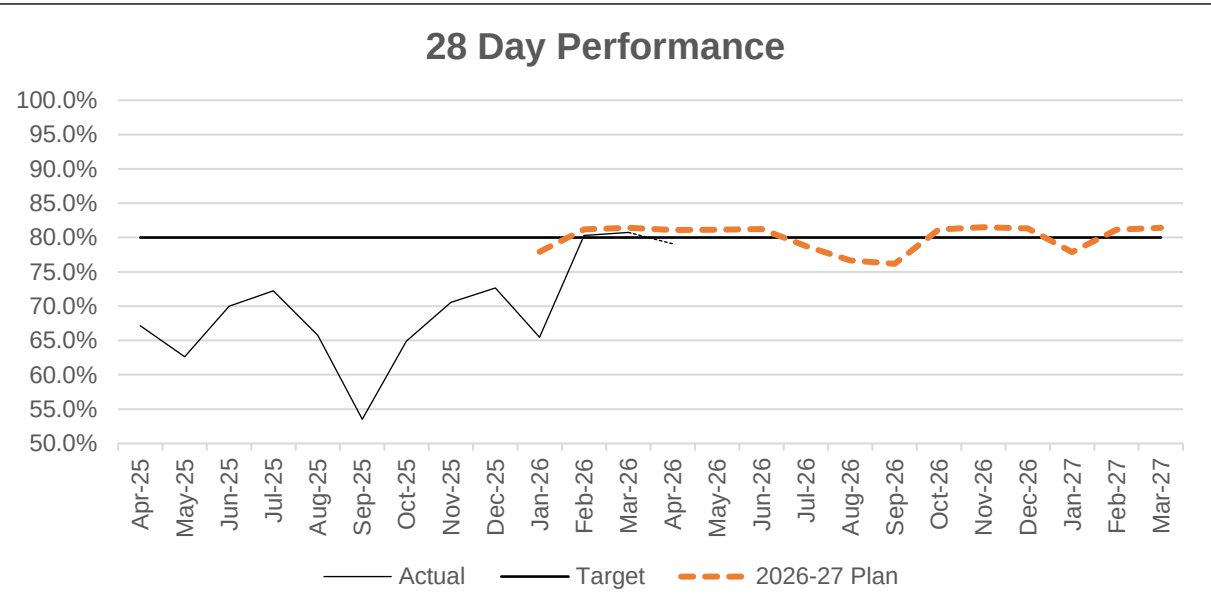
28 Day Cancer Performance

We are driving this metric because..

Performance Target:

The Trust is not meeting the national 28 Day Faster Diagnosis Standard target. There is a known link between delayed diagnosis of cancer and poorer outcomes for patients. The Trust is currently in NHSE Tiering for cancer performance.

80% by March 2027



Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
Trust: April Performance (unvalidated) below national target at 79.1%. May expected to achieve, risk to June due to Skin. Breast: Performance down due to admin issue causing increase in one-stop waits – now resolved. Colorectal: Increased Colorectal/Gastro IDA OPA now reduced through WLIs. Plain CT waits higher – challenges to identify pathway patients to be prioritised. Endoscopy waiting time static at two weeks. Gynae: PMB waits increased due to staff sickness. Skin: OPA waits increasing due to insourcing locum leaving. Urology: MRI scan and report waiting times.	Gastro nurse electronic triage Plain CT prioritisation – Radiology capacity summary A3 draft including referral pathway project phase 1 report PMB WLIs and Wid-Easy pilot Dermatology insourcing consultant replacement Skill-mixing / recruitment of non-medical staff Prostate MRI capacity/demand review Urology locum consultant recruitment – shortlisting Reviewing prostate diagnostics pathway outsourcing	TS NA/RB EN/NL/TS AJ GJ GJ NA KR KR/EJ	June 2026 June 2026 June 2026 June 2026 May 2026 October 2026 May 2026 August 2026 June 2026	Risks: • Demand increase • Recruitment, recruitment, depending on WLIs, locums, in / outsourcing • Pressures from RTT, DM01 Mitigation: • SWAG funding for WLIs, locums, in / outsourcing • Long-term investment/recruitment • Telederm • Pathway change (Gynaecology / Prostate / Colorectal)

Diagnostic waits

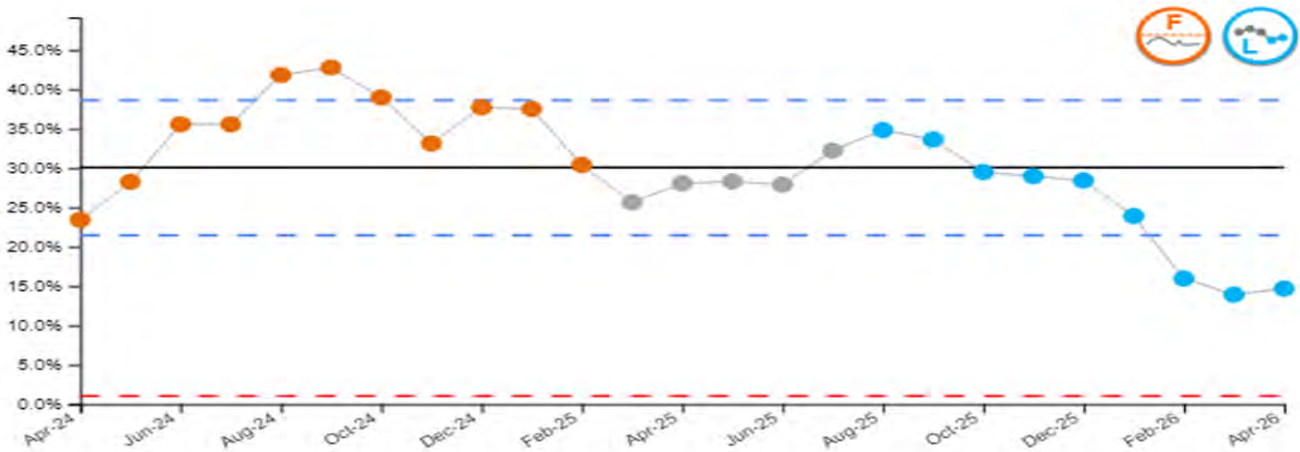
We are driving this metric because..

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 $\leq 15.9\%$ breaches for 2025/2026.

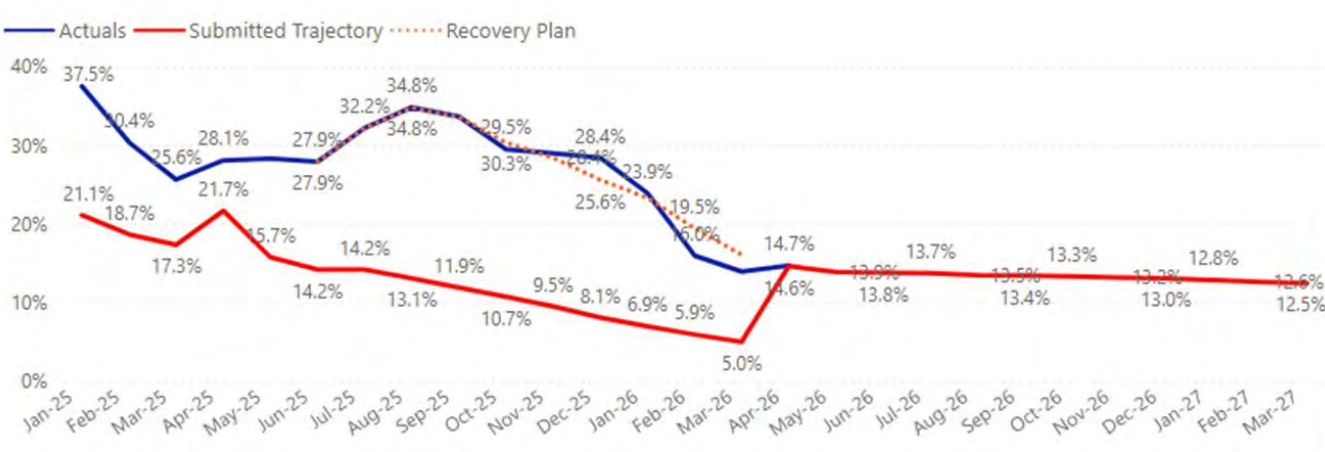
Performance Target:

84.1% compliance (<15.9% breaches)

SPC - Reported DM01 % >6Wk, by Month



DM01 >6Wk Breach % Performance



Understanding Performance

- In April 2026, **85.32%** of patients received their diagnostic within the 6-weeks against the **85.40%** target.
- Performance decreased 0.76% from March 26. However, this decrease was due to a reduction in denominator, as the Trust received less referrals. Total breaches, overall, reduced by 44 from previous month.
- Total activity delivered increased by 1053 tests when compared to previous month.
- USS, MRI, Echo, Audiology and Cystoscopy performing above plan.
- The **top contributors** to 6-week breaches were USS, Endoscopy and DEXA.

Countermeasures

Continuation of WLIs for USS, MRI and Echo.

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)

Transfer of Sleep Studies activity to Sulis CDC (still waiting to recruit physiologists)

Weekly review of each modality – performance, demand and activity against trajectory. (~3% performance gain)

Owner

NA/CF

PN/NA

SH/NA

Sulis CDC

NA/JS

Due Date

In place

In place

From August 2025

Q4 25/26

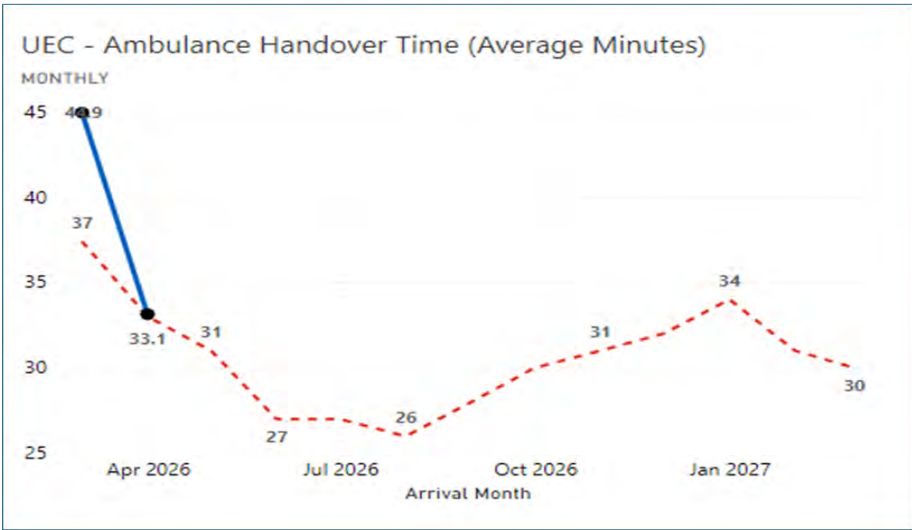
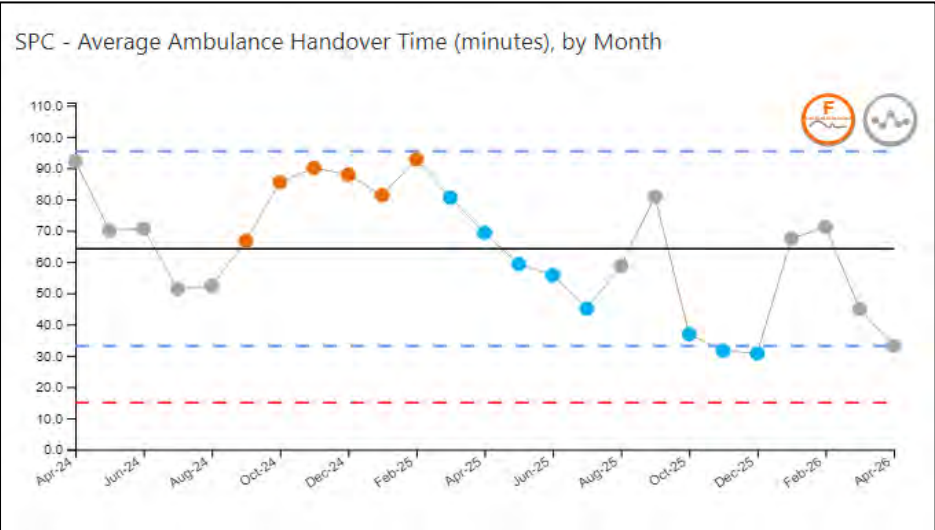
In place

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)

Ambulance Handover Times

We are driving this metric because..	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.
Performance Target:	Average ambulance handover = 33mins (30th June 2025)



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

The average ambulance handover delay for April 2026 was 33.1 minutes, an improvement from 44.92 minutes on average in March 2026. Through April 2026 the total hours lost was 862. This is a 580-hour improvement compared to last month's lost hours of 1,442. 60.2% of handovers were completed within 30 minutes (March 50.6%).

April 2026 performance is 0.1 minutes behind trajectory.

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 trolleys - Overcrowding in shared UTC waiting room - Stretchers being over-used by ambulance colleagues and RUH staff - Increased instances of corridor care due to W45.

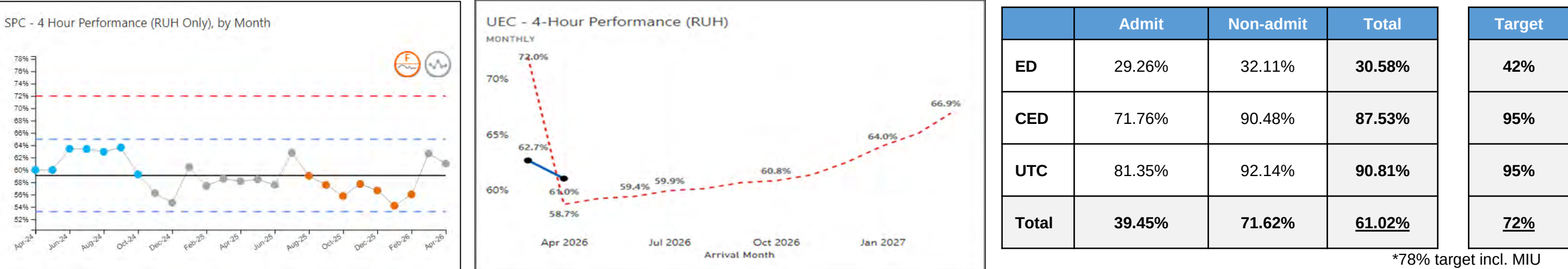
Countermeasures	Owner	Due Date
Implement the National Acuity Model to support triage and streaming. Blocked – SBAR with IT, pending support	JR	May 2026
Plan and agree case for change supporting an EEMAC model within current ED Obs footprint. Launched – ongoing optimisation, ave. 17.9pts/day.	MP	Ongoing
Support implementation and monitoring of IPS 2025 via UEC Improvement Programme. Delayed – focus on ED/UTC move and config.	Leadership team	May 2026
Recruit 10.24 WTE registrars following business case approval. In progress – 7 jobs accepted, planning to readvertise.	MP/BI	Ongoing

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

4 Hour Performance

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)

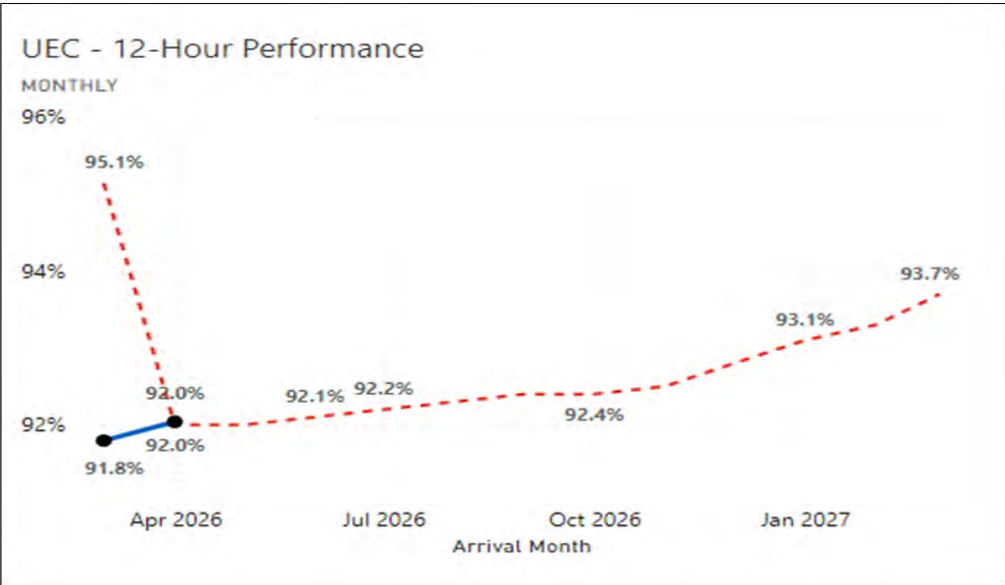
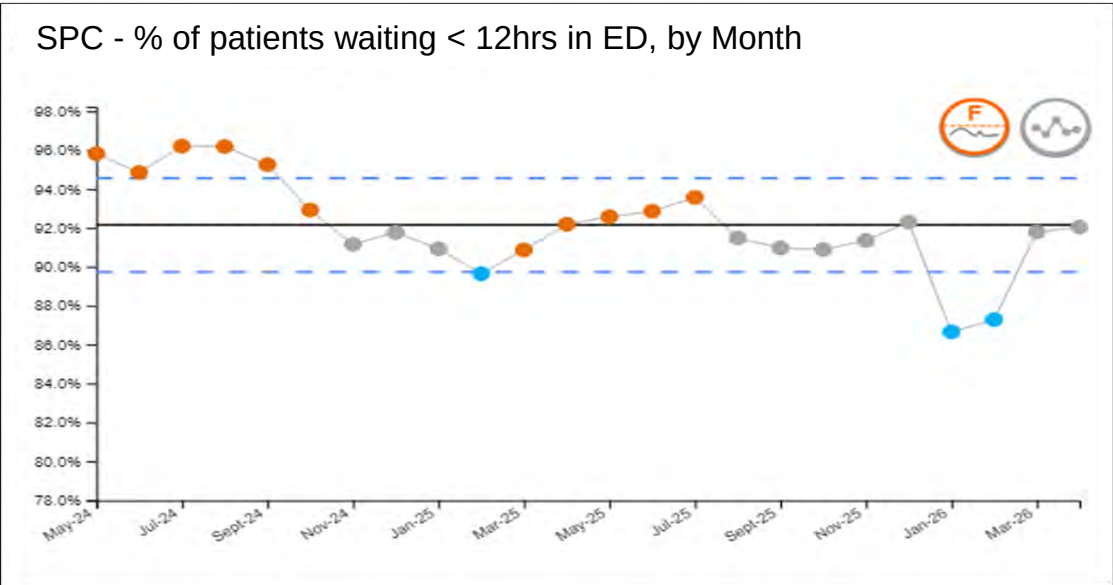
This measure demonstrates a common cause variation as it is has improved significantly since 7 nodes of negative special cause variation, though is currently failing the target of 72%



Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
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	Implement the National Acuity Model to support triage and streaming. Blocked – SBAR with IT, pending support Plan and agree case for change supporting an EEMAC model within current ED Obs footprint. Launched – ongoing optimisation, ave. 17.9pts/day. Support implementation and monitoring of IPS 2025 via UEC Improvement Programme. Delayed – focus on ED/UTC move and configuration. Recruit 10.24 WTE registrars following business case approval. In progress – 7 jobs accepted, planning to readvertise. Overnight streaming observation and re-education. JR undertaking night shifts supporting proper process.	JR MP Leadership team MP/BI JR	May 2026 Ongoing May 2026 Ongoing May 2026	- 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.

12 Hour Target

We are driving this metric because..	Prolonged stays in the Emergency Department over 12 hours from arrival are nationally associated with a higher risk of patient harm, delayed treatment and increased mortality.
Performance Target:	By March 2027 >93.7% of patients to have a total length of stay of under 12 hours in the Emergency Department from arrival to admission, discharge or transfer.



Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
In April, the proportion of patients attending the Emergency Department that spent less than 12 hours in the department (all types) was 92%. Performance is affected by. - Delays from decision to admit to admission due to downstream ward delays (low trust % discharges before midday). - Senior decision maker capacity and time to be seen. - Increase in patients requiring mental health input in ED. - Urgent Treatment Centre - inconsistent workforce capacity to meet the demand - streaming and redirection not consistently applied - not closing at midnight as model intended - clinicians assessing and treating non-UTC activity - assessment capacity being used by admitting specialties	Urgent Treatment Centre - in development as part of the 100-day UEC challenge Majors - in development as part of the 100-day UEC challenge	SH	May 2026	ED real time discharge processes to ensure accurate date and time recording. Patients requiring mental health input.

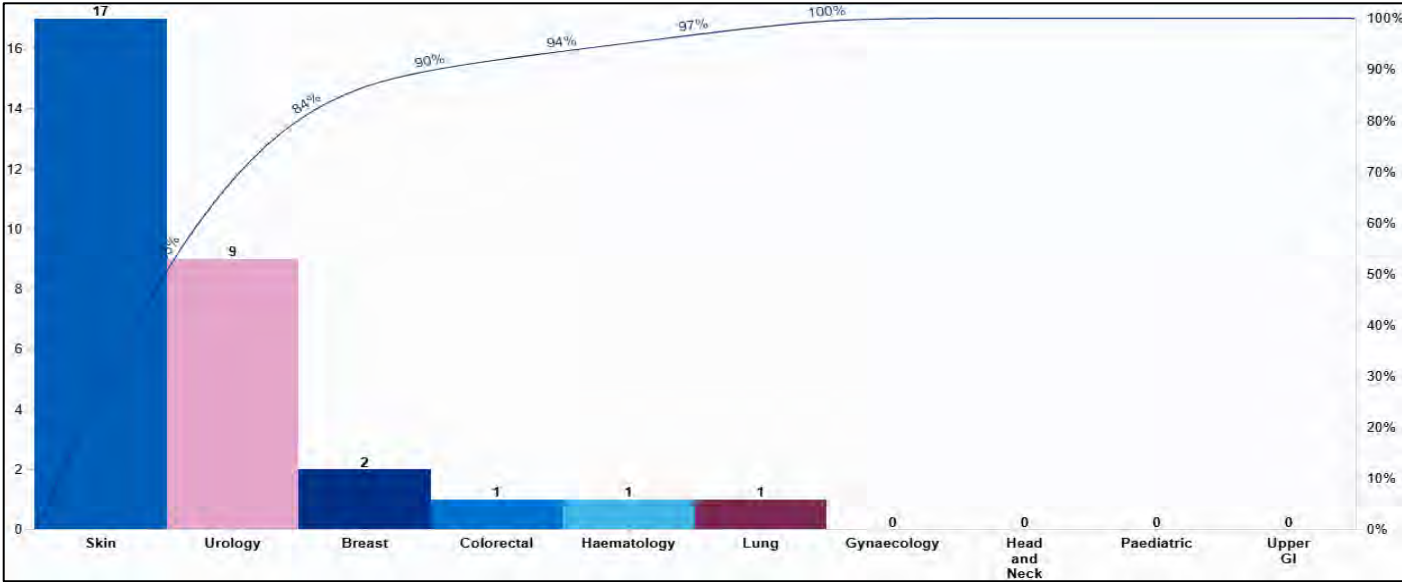
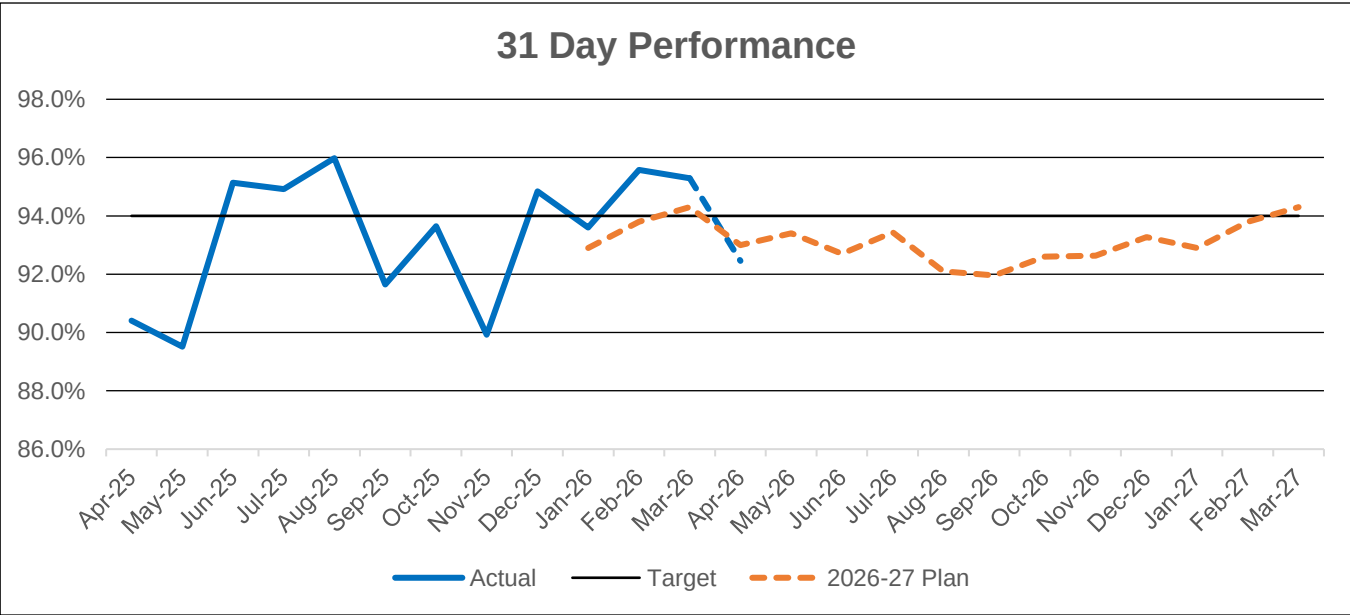
31 Day Cancer Performance

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:

94%



Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
Trust: April reduction to 92.5% but expected improvement through validation. Expectation to be on trajectory in Q1. Breast: Breaches reduced with clinical advice re subsequent surgery 'earliest clinically available dates'. Skin: MOPS prioritised by 62 day breach date – potential impact on 31 day performance. 62 day backlog at lowest point (8 patients down from 125 in January). MOPS waiting time reducing with continued use of external ICB commissioned excision services. Breaches in OMFS/ENT reducing following PTL change. Consultant Dermatologist appointed – start September 2026	Additional substantive Consultant Beast Surgeon recruitment with extra permanent theatre list Dermatology insourcing consultant replacement Dermatology workforce skill-mix New consultant appointed Locum Consultant Urologist recruitment	HW GJ GJ GJ KR	September 2026 May 2026 October 2026 September 2026 September 2026	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

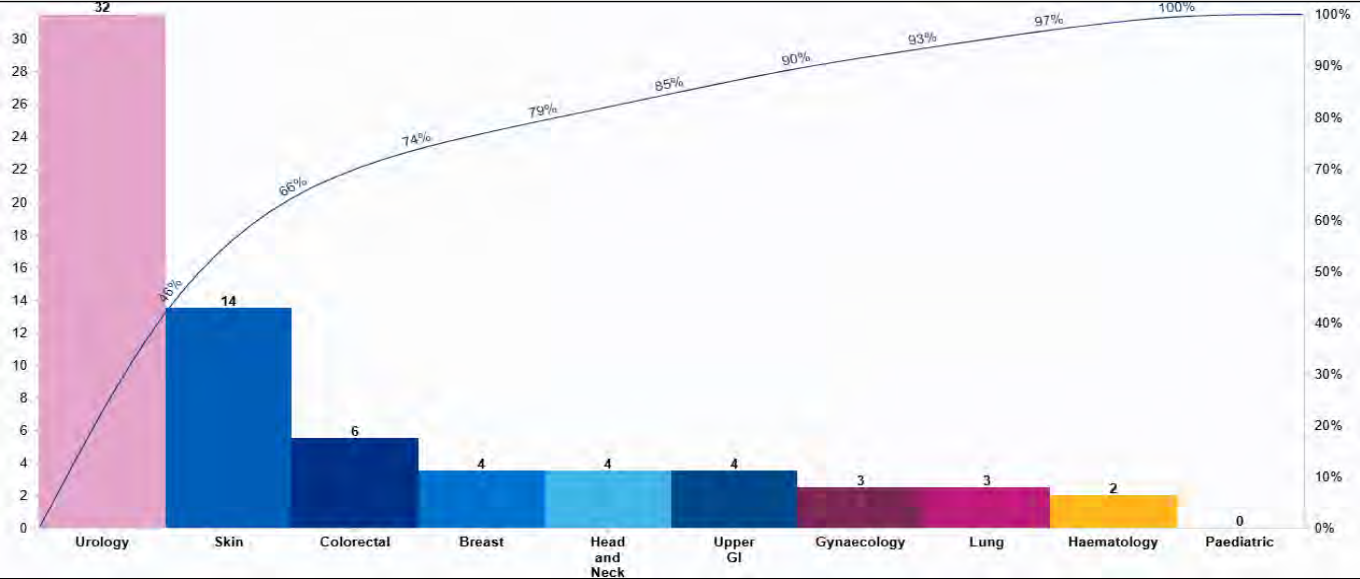
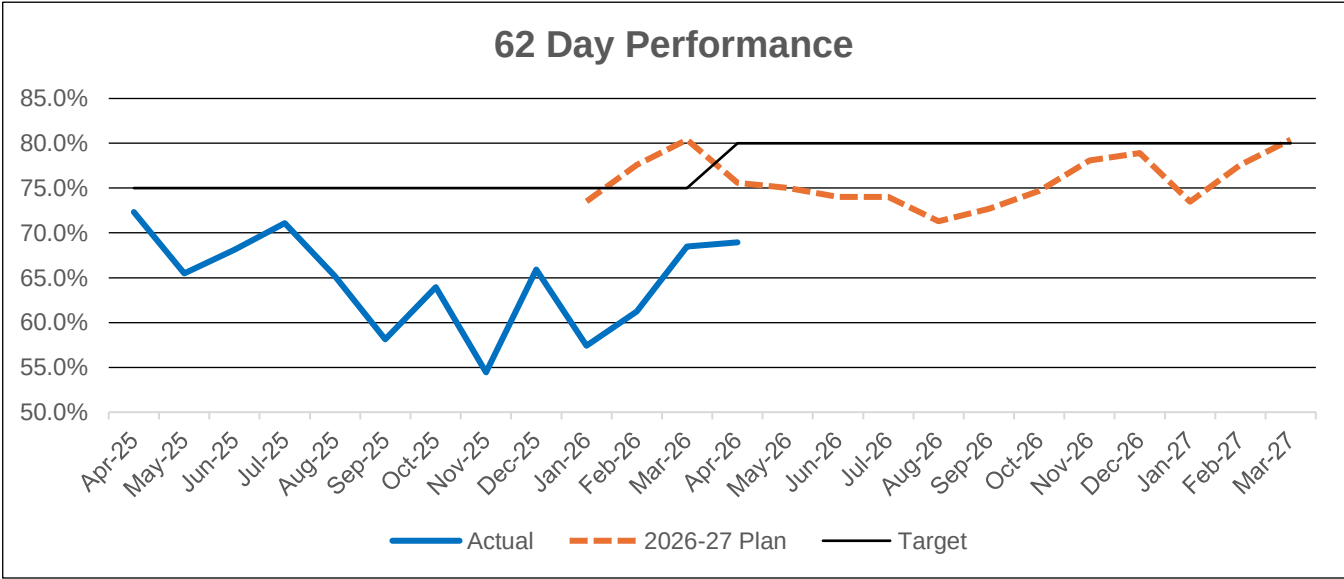
62 Day Cancer Performance

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:

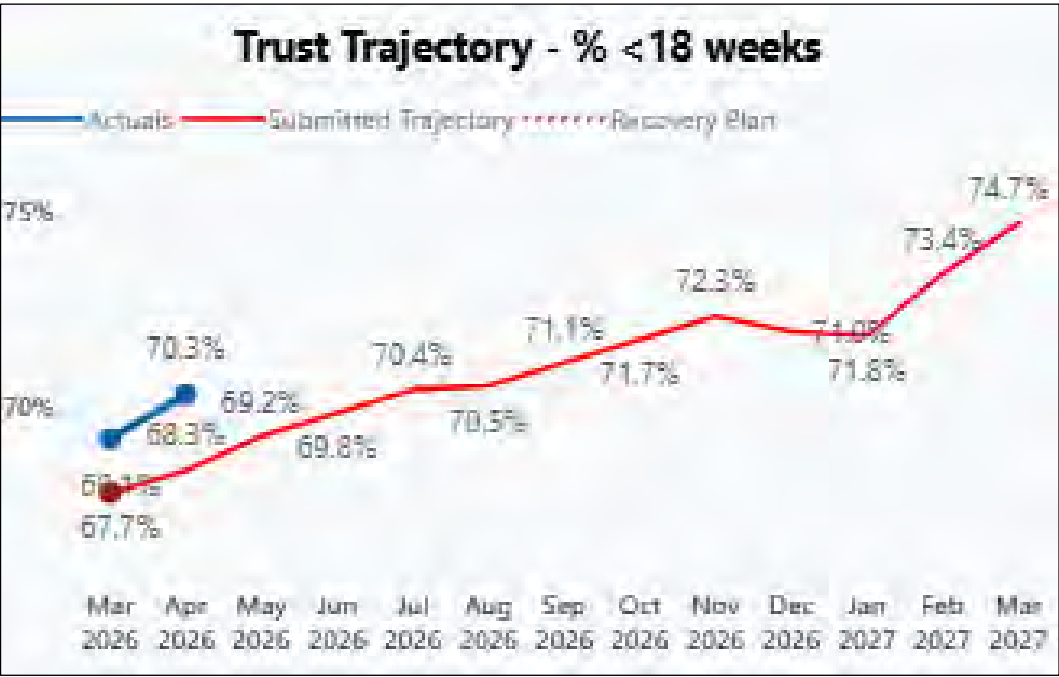
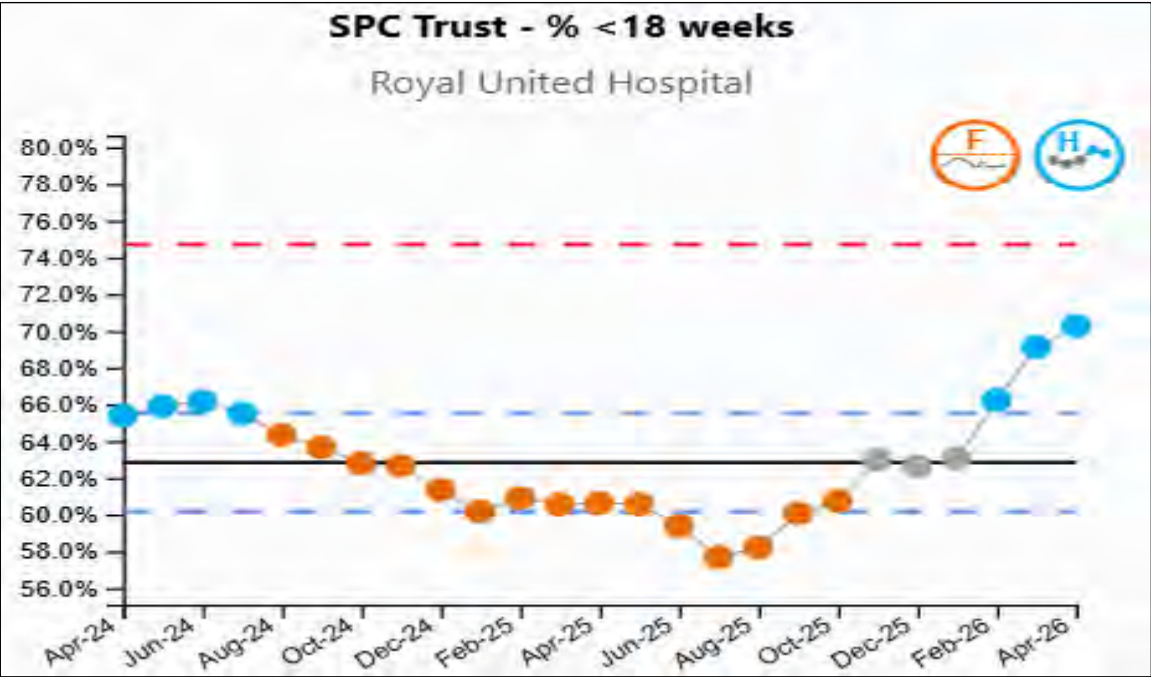
80% by March 2027 (increase from 75% in 2025/26)



Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
Trust: April performance improvement to 68.9% below trajectory. May performance risk due to Colorectal treatment of longer waiting patients and Urology imaging delays and risk to recovery of performance by June Colorectal: Improvement to 71% but increased breaches in May. Pathway review through A3. Skin: Increased OPA now 26 days. Risk to performance from insourcing consultant departure. Urology: Risk to Trust performance – Prostate MRI scan – long term increased demand, Radiology review to increase ringfenced capacity. Reporting delays requires increased staff. Non-pathway MRIs now outsourced for reporting. Downstream impact from MRI waits on LATP and histology.	Additional substantive consultant recruitment with extra permanent theatre list A3 draft including referral pathway project phase 1 report Lung chest CT ring-fenced capacity increase Radial EBUS pathway – SWAG-wide biopsy project Dermatology insourcing consultant replacement Dermatology workforce skill-mix Prostate MRI ringfenced capacity review/increase Extra weekly LATP list following nurse recruitment Urology locum consultant recruitment	HW EN/NL/TS MW-H/NA MW-H/JH GJ GJ KR/NA KR KR	September 2026 June 2026 June 2026 June 2026 May 2026 October 2026 June 2026 May 2026 September 2026	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)

Referral To Treatment (RTT) 18 weeks

We are driving this metric because..	The Trust is not meeting the national Referral to Treatment target and patients are experiencing long waits for their definitive treatment.
Performance Target:	74.7% by March 2027



Understanding Performance
- RTT performance in April was 70.3% vs trajectory of 68.3%. This is 1.1% increase on the previous month - The top Contributors to over 18 week breaches were in the following 5 specialties - General Surgery 1485 - Oral Surgery 1361 - ENT 1161 - Cardiology 1102 - Neurology 868

Countermeasures	Owner	Due Date
General Surgery – additional Locum x 3	NL	Aug 2026
Oral Surgery – outsourcing to Oral Surgery Ltd	NG	Ongoing
Cardiology – recruitment of 2 consultants due to start Aug & Sept	CF	Sept 2026
ENT – ongoing review of theatre sessions to pick up any extra	NG	July 2026

Risks and Mitigation
Risks: - Radiology capacity for routine patients v. cancer pts - Specialist radiology capacity for Head and Neck - Physical space for gastro, ENT and general surgery Mitigation: - ENT – patients triaged as suitable for Sulis transferred at under 18 weeks - Additional radiology Head and Neck capacity from Sept 26

Alerting

Watch Metrics

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%		Apr-26	20.0%	X			Common Cause Variation
People we care for	% of patients waiting <12hrs in ED		93.7%		Apr-26	92.0%	X			Common Cause Variation
People we care for	A&E Arrivals - Ambulance (av per day)				Apr-26	87				Special Cause Concerning - Above Upper Control Limit
People we care for	Adult % G&A bed occupancy		92.0%		Apr-26	96.0%	X			Common Cause Variation
People we care for	Mean time in ED - Mental health				Apr-26	623				Special Cause Concerning - Two Out of Three High
People we care for	Non Elective Length of Stay		8.4		Apr-26	8.6	X			Common Cause Variation
People we care for	RUH hospital at home team occupancy	Average occupancy	62.0		Apr-26	61.5	X			Special Cause Improving - Run Above Mean

Understanding Performance and Countermeasures

Provisional alerting watch metrics

- ED waits exceeding 24 hours from arrival
- 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

- In April <1% of all patients exceeded 24 hours in the Emergency Department, noting the change in process for patients requiring mental health team intervention, as no longer admitted and wait in the Emergency Department.
- In April 566 patients spent more than 45 minutes of their stay in the ED corridor (622 patients in March 2026).
- The median time in ED was 205 minutes for all pathways in April (200 in March), 175 minutes for non-admitted and 321.5 minutes for admitted.
- Adult general and acute bed occupancy in April was 96.0% (96.4% in March). Note, occupancy does not reflect the use of more 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 (20% April 2026) and sustained use of the discharge lounge (c30 patients transferring weekdays with a peak of 48 patients in April). 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 (April 94.5%).
- % Discharge summaries completed within 24 hours in April 2026 was 84.4% (88.5% in March 2026).
- Average monthly occupancy in April 2026 for RUH Hospital at Home was 99.1% (62 beds = 100% capacity). In April there were 178 admissions (143 in March). Hospital at Home have started some surgical pathways too, including pancreatitis and diverticulitis which are working well.
- The Trust reported zero 65-week breaches at the end of April 26.

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				Apr-26	81.8%				Common Cause Variation
People we care for	% with Discharge Summaries Completed within 24 Hours				Apr-26	84.4%				Common Cause Variation
People we care for	A&E Arrivals - Walk ins (av per day)				Apr-26	212				Common Cause Variation
People we care for	Mean time in ED - >75y				Apr-26	441				Common Cause Variation
People we care for	Mean time in ED - Admitted (mins)				Apr-26	407				Common Cause Variation
People we care for	Mean time in ED - Not Admitted (mins)				Apr-26	237				Common Cause Variation
People we care for	Weekend discharge %				Apr-26	17.6%				Common Cause Variation

Quality & Safety Summary

Focused improvement work continues to address the deteriorating pressure injury performance across the Trust and remains a key priority. Analysis of harm includes patients who have had a prolonged length of stay in ED or another Front Door area, there are cases where harm has occurred. Actions include includes targeted support in wards that have experienced clusters of pressure injuries, alongside a Trust-wide task and finish group reviewing relevant systems and processes inclusive of training, development and leadership support.

Administration and prescribing incidents were the most common incident types reported. The Medicines Safety Group will review the initial datix reports as a cohort to look for themes and trends as well as receiving an update on the final reports when available. The outcome of the review and actions will feature in this report.

Data shows that during April 98.7% of inpatients did not fall in our care. Trust wide in April 90.0% of adult inpatients had a falls risk assessment completed within 6 hours of admission and falls per 1,000 bed days in April were below the National Audit for inpatient falls (NAIF) benchmark of 6.6.

Fill rates in nursing remain persistently low in some areas, impacted to high sickness levels and vacancies in some areas. Nursing staffing levels for registered nurses is known to impact directly on patient outcomes for indicators such as falls, pressure ulcers, administration of medicines and infection prevention and control, in addition to mortality where they are below the prescribed level. Significant work is being undertaken to recruit into specific areas such as ED (almost fully recruited) and the People Directorate are leading a workstream, supported by clinical leaders to understand and reduce sickness levels to improve fill rates.

As reported in the performance section of this report, there are prolonged waits in ED and other Front Door areas, patient outcome data relating to this will feature in future reports.

Trust Scorecard - Quality Board Metrics

(April 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
Breakthrough	People we care for	28 day referral to informed of diagnosis of all cancers		80.0%		Mar-26	80.7%	✓			Special Cause Improving - Above Upper Control Limit
Breakthrough	People we care for	Diagnostic tests maximum wait of 6 weeks		12.5%		Apr-26	14.7%	X			Special Cause Improving - Below Lower Control Limit
Breakthrough	People we care for	RTT - Incomplete Pathways over 52 weeks	Number of patients waiting over 52 weeks	0.8%		Apr-26	0.5%	✓			Special Cause Improving - Decreasing Run
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)		75.3%	95.0%	Apr-26	61.0%	X			Common Cause Variation
National KPI	People we care for	Average Handover Time for All Arrivals (mins)	Average ambulance handover time (mins)	30		Apr-26	33	X			Special Cause Improving - Below Lower Control Limit
National KPI	People we care for	Combined 31 day cancer targets for first treatment, subsequent surgery, subsequent drug, subsequent radiotherapy and subsequent other treatments; excludes subsequent active monitoring and subsequent palliative care		94.2%	90.0%	Mar-26	95.0%	✓			Common Cause Variation
National KPI	People we care for	Combined 62 day cancer targets for GP referral, screening and consultant upgrade		80.5%	75.0%	Mar-26	68.6%	X			Common Cause Variation
National KPI	People we care for	RTT – wait to 1st OP appointment	% patients waiting <18 weeks for their first OP appt	72.0%	72.0%	Apr-26	73.8%	✓			Special Cause Improving - Above Upper Control Limit
Vision	People we care for	% of positive responses to friends and family test	Improve the experience of those who use our service			Apr-26	97.7%				Special Cause Improving - Above Upper Control Limit

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	% of ED admissions <60mins from CRtP		80.0%	80.0%	Apr-26	75.0%	X			Common Cause Variation
People we care for	Early Identification of Deteriorating Patient	NEWS 5+ Screening Completed in 30 - Trust (%)			Apr-26	23.8%				Special Cause Concerning - Two Out of Three Low
People we care for	Medication Incidents per 1000 bed days		7.0		Apr-26	12.0	X			Special Cause Concerning - Above Upper Control Limit
People we care for	Number of complaints received		30		Apr-26	32	X			Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 2		5		Apr-26	6	X			Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 3		4		Apr-26	9	X			Special Cause Concerning - Above Upper Control Limit
People we care for	Serious incidents with overdue actions		5		Apr-26	11	X			Common Cause Variation
People in our community	% Difference in 28 Day Diagnosis Performance between IMD 1-2 vs IMD 9-10		0.0%		Mar-26	-13.3%	X			Common Cause Variation

The RUH, where you matter

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	% complaints responded to within agreed timescales with the complainant		90.0%		Apr-26	92.3%	✓			Special Cause Improving - Run Above Mean
People we care for	% of ED patients assessed <15mins				Apr-26	72.8%				Special Cause Improving - Above Upper Control Limit
People we care for	Concerns are acknowledged within 2 working days		90.0%		Apr-26	97.0%	✓			Common Cause Variation
People we care for	Mixed Sex Accommodation Breaches				Apr-26	89				Special Cause Improving - Below Lower Control Limit
People we care for	Never events		0		Apr-26	0	✓			Common Cause Variation
People we care for	Number of reopened complaints each month		3		Apr-26	3	✓			Common Cause Variation
People we care for	Readmissions - Total		10.5%		Mar-26	8.6%	✓			Common Cause Variation
People we care for	Scanning Compliance for patients being given medication				Apr-26	67.3%				Special Cause Improving - Above Upper Control Limit
People we care for	SHMI				Apr-26	98.4%				Common Cause Variation

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			Mar-26	24				Common Cause Variation
People we care for	E.coli bacteraemia Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Mar-26	36				Common Cause Variation
People we care for	Flu - Healthcare Onset (+3 days)				Apr-26	0				Common Cause Variation
People we care for	Klebsiella spp Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Mar-26	12				Common Cause Variation
People we care for	MRSA Bacteraemias Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Mar-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			Mar-26	24				Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 4				Apr-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			Mar-26	0				Common Cause Variation

Alerting Watch Metric Commentary: Medication Incidents per 1000 bed day

Understanding Performance

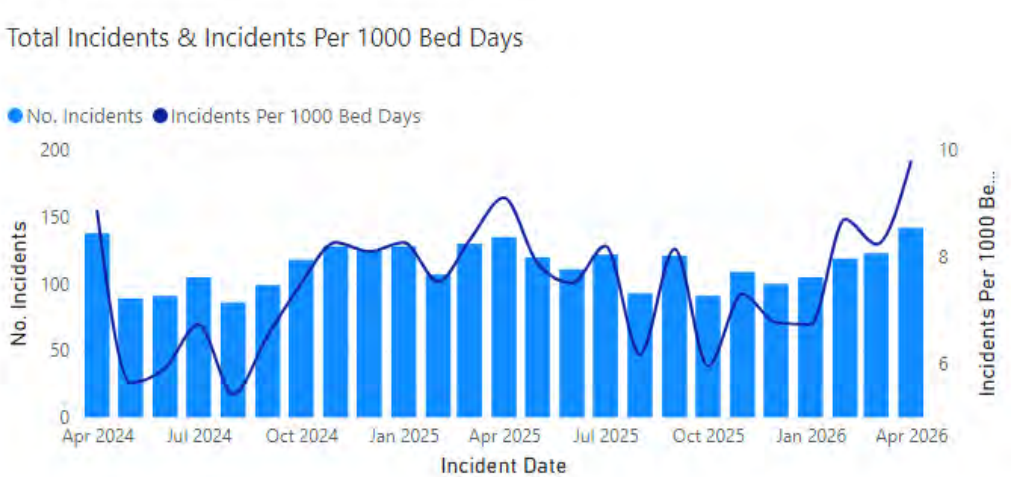
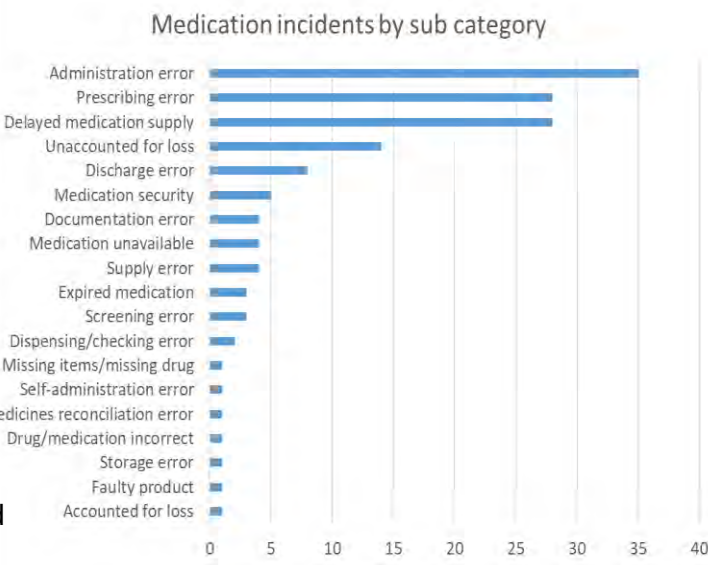
Total incidents per 1000 bed days increased to 9.79% and remains above upper control, local year-end target is 7%.

Incident reporting should be encouraged, with attention given to trends and themes as well as overall numbers of incidents. Increasing incident numbers alone should not be a cause for concern.

The majority of incidents were low or no harm, with one incident reported as moderate harm and one as severe harm. Over the last two quarters there has been an increase in incidents graded as moderate or above, compared to previous year. These have been individually managed through PSIRF responses by the patient safety team, and in most cases, investigation is still ongoing. The Medicines Safety Group will review the initial datix reports as a cohort to look for themes and trends as well as receiving an update on the final reports when available.

Similar to previous months, administration and prescribing incidents were the most common incident types reported. High throughput areas including ED, Medlock and pharmacy reported the highest number of incidents. Note that increased activity in these areas is not reflected in bed days. Due to issues with sterility in the RUH Aseptic Unit there were 27 incidents recorded as delayed medication supply. This issue has resolved and no further incidents reported.

The Medicines Safety Group will continue to review this metric as well as themes and trends to monitor and identify areas of improvement.

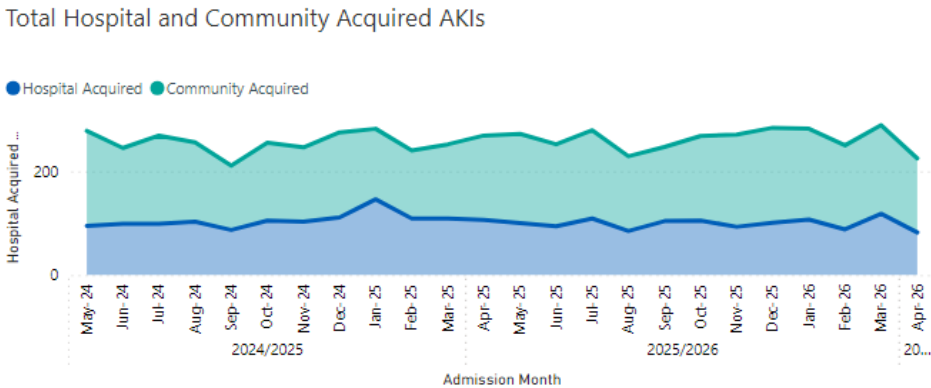
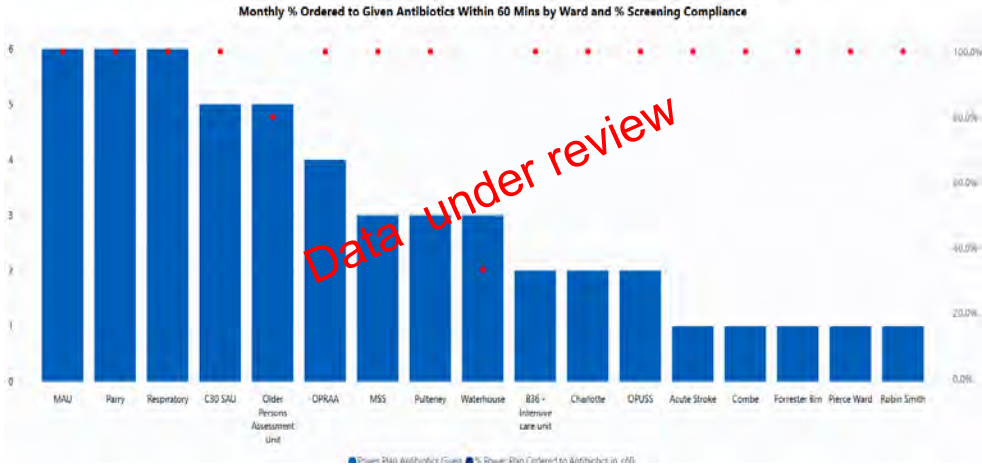
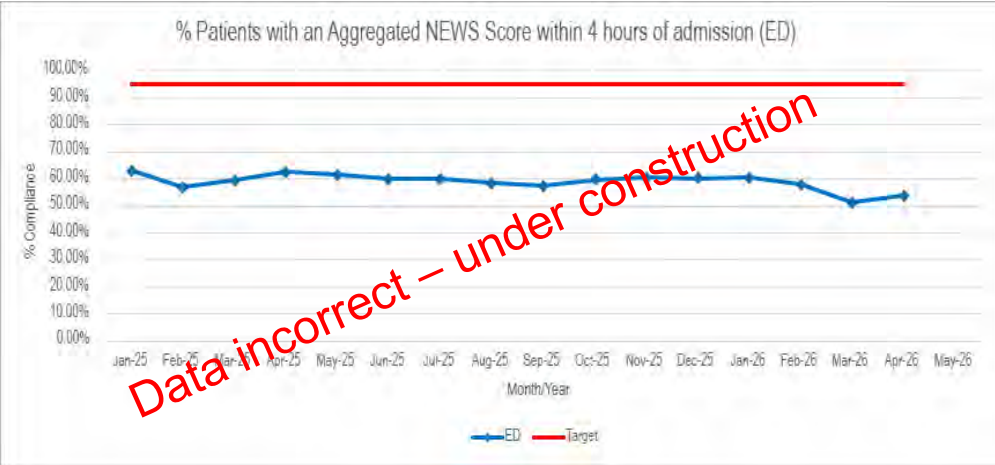


Countermeasures	Owner	Due Date
Incident themes and trends monitored via Medicines Safety Group. Medication safety workplan in place to monitor high risk themes and drive improvement work.	Claire McKenzie	NA
Review of moderate or above incidents over last 6 months to look for themes and trends to target with improvement work	Matthew Lambert	June 2026

Recognition of Deterioration

We are driving this metric because..

Recognition of the Deteriorating Patient is one of the Trust’s 5 safety priorities. Patients who are, or become, acutely unwell whilst in hospital should feel confident that should their condition deteriorate, they are being cared for in a safe environment that responds promptly, appropriately and provides effective treatment. AKI is a major, yet largely preventable, cause of avoidable harm and system pressure across the NHS. AKI drives significant mortality, prolonged length of stay, and high rates of readmission. With up to 30% of cases considered preventable (South West Renal Network)

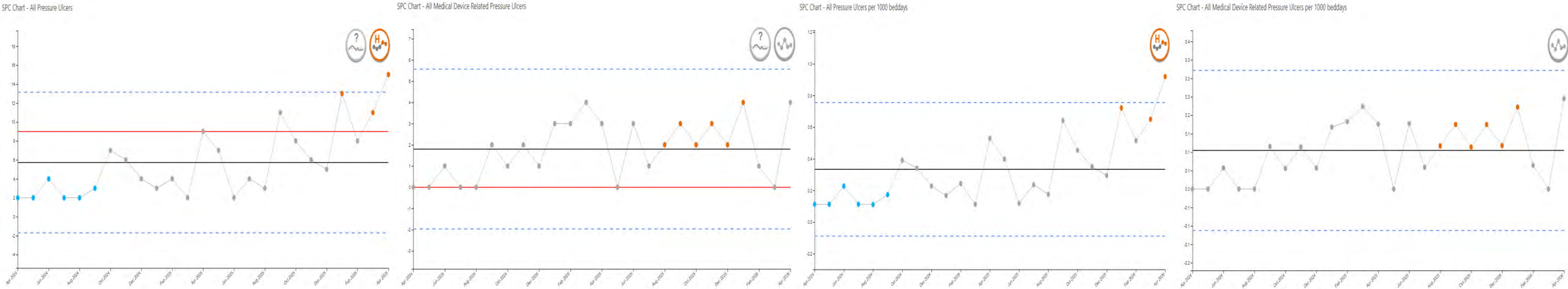


Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
NEWS: The percentage of patients who have a NEWS2 score recorded on admission to the Trust is currently not collected. Work is underway in conjunction with the Business Intelligent Unit to collect this data for all patients admitted via the Emergency Department. Once there is confidence in this data other places of ingress will be added. Antibiotics within 60 minutes: The percentage of patients who receive antibiotics within 60 minutes of diagnosis if Sepsis is under review. The current data pulled via BIU and as displayed above does not provide the level of detail required and is not in accordance with NICE guidance. AKI: The data describes the number of hospital acquired versus Community acquired AKIs. April 2026 shows a downwards trend with there being a total of 82 HA AKIs this month compared to the previous month having 118. Compared to April of 2025, the current picture also is improved with a reduction of 24 HA AKIs.	NEWS escalation audit to be created, tested and rolled out. The focus of this audit is to ensure that the correct escalations are undertaken for patients in relation to their increasing NEWS scores (RCP guidelines) Creating and testing a case note audit to provide data relating to performance providing antibiotics for patients scoring a NEWS of 7 or more who have a red flag for sepsis within 60 minutes (in accordance with NICE Guidance) A recent report for the Southwest Renal Network proposes to coordinate renal care across the Southwest to standardised pathways, reduce variation and improve outcomes for patients with kidney disease. Discussions with representatives from the network has resulted in the creation of an RUH action plan. A designated lead (Doctor) needs to be identified.	Senior Sister CCOT SKIP Team To be confirmed	August 2026 June 2026 TBC	We are an outlier regionally and nationally with our “NEWS up by 2” for escalating changes in NEWS score. To enable a change to this process the EPR requires modification. This is delayed due to developer capacity and the forthcoming upgrades. Following discussion with the CNO, plan to take an options appraisal and data to reflect the current risk of screening compliance to COLT.

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.



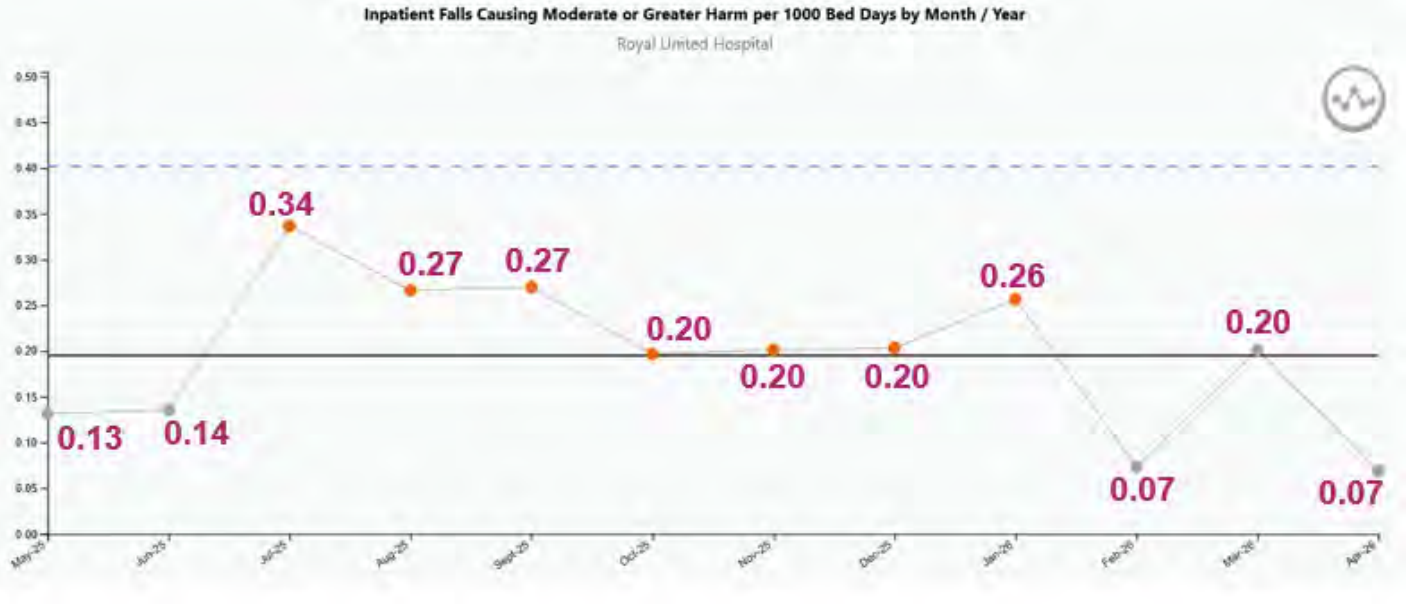
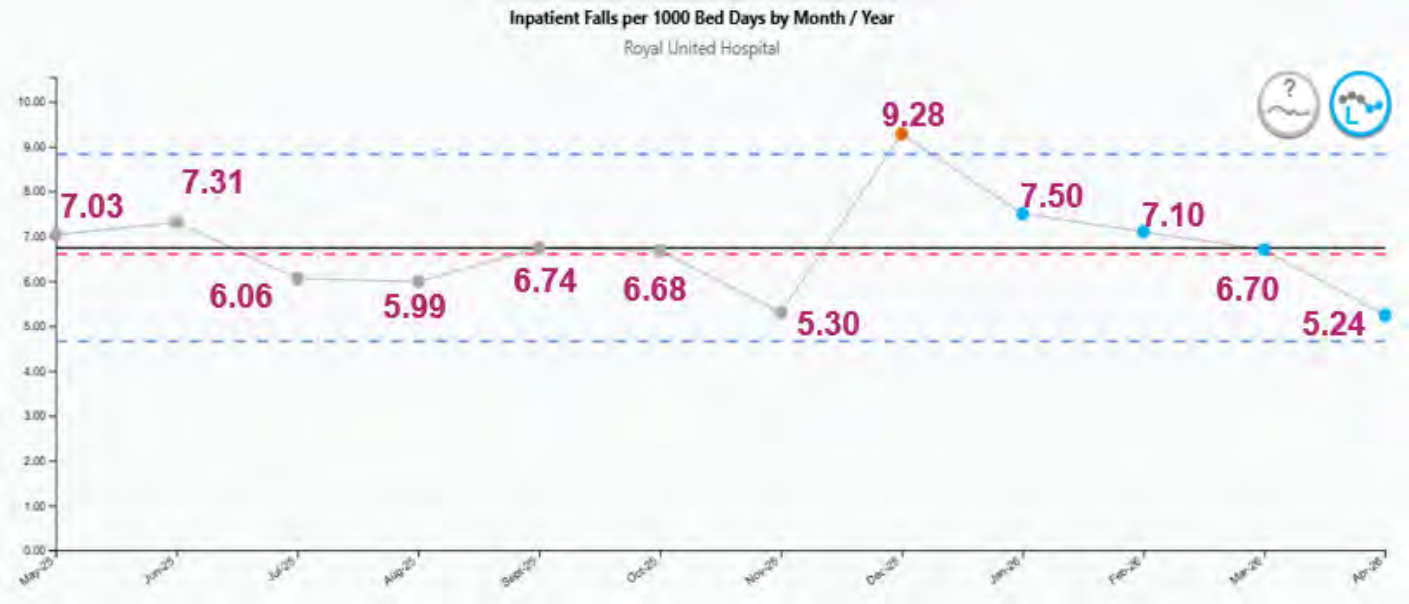
Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
For April 2026, the RUH reported 1.2 pressure ulcers per 1,000 bed days (19 pressure ulcers). The RUH reported nine category 3 pressure ulcers and six category 2 pressure ulcers. There were four category 2 medical device related pressure ulcers and two mucosal membrane ulcers that are reported but not categorise as per National guidelines. The patient themes were compliance variance to care delivery, multiple co morbidities, prolonged use of medical equipment and high acuity. The system themes were lapses in skin checking, prolonged stay in ED, lapses in effective repositioning e.g. back-to-back instead of right to left. The Divisions are working closely with specific wards on action plans for improvement and the TVN team are supporting practical educational visits to wards with an emphasis on working together to improve preventative practices.	ED to escalate those vulnerable patients to bed management at an early stage to expediate a ward bed as soon as possible. Pressure Ulcer task and finish group using quality process including listening exercises with staff to understand the barriers for providing preventative measures. The Divisions are monitoring safer staffing levels against harm events and escalating where necessary. The TVNs are running MAY awareness month focussing on pressure ulcer/wounds awareness month with different activities every day and refreshing/strengthening the TV Ambassador network.	ED Matrons Lisa Hocking/Jane Davies Matrons Tissue Viability Team	Ongoing September 2026 Ongoing May 2026	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.

Improving the experience of those who use our service

Falls

We are driving this metric because..

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



Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
Data shows that during April 98.67% of inpatients did not fall in our care. Trust wide in April 89.95% of adult inpatients had a falls risk assessment completed within 6 hours of admission. There was 1 reported fall that resulted in moderate (or above) harm to a patient, this occurred on a Surgical ward . Falls per 1,000 bed days in April were below the National Audit for inpatient falls (NAIF) benchmark of 6.6. 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.	Increase compliance in lying and standing blood pressure trust wide to 50% – Trust wide compliance in April was 45% up from 36% in February. Specific improvement projects currently in place in several wards.10 wards have achieved month on month improvement in compliance since Jan 26. Themes from Trust wide PSII are now include in the Falls prevention and improvement group workplan. These include enhanced care, use of bed rails,use of professional judgment and red flags and compliance with falls retrieval equipment. Review of process to collate themes from all falls to further guide improvement prioritise for falls/supporting safer mobility.	Ward Manager Multiple owners QI Falls leads	Jul-26 Aug-26 Jul-26	Lying and standing blood pressure compliance had been reducing, but the past 4 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.

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%

Ward/Department	Fill Rate Day RN %	Fill Rate Day HCSW %	Fill Rate Night RN %	Fill Rate Night HCSW %
Acute Stroke	80%	100%	87%	123%
Surgical Assessment Unit	96%	104%	104%	100%
Cardiology	86%	91%	98%	108%
Coronary Care Unit	97%	74%	98%	83%
Charlotte	81%	118%	99%	103%
Cheselden	69%	99%	82%	127%
Children	91%	72%	92%	97%
Combe	69%	95%	81%	141%
Emergency Dept.	88%	90%	87%	102%
Forrester Brown	103%	81%	99%	99%
Haygarth	73%	95%	89%	118%
Helena	75%	113%	89%	123%

Ward/Department	Fill Rate Day RN %	Fill Rate Day HCSW %	Fill Rate Night RN %	Fill Rate Night HCSW %
Medical Assessment Unit	80%	88%	96%	105%
Medical Short Stay	86%	136%	102%	104%
Older Persons Assessment Unit	75%	98%	96%	101%
Older Persons Short Stay	82%	94%	95%	97%
Parry	85%	93%	94%	105%
Philip Yeoman	102%	46%	100%	0%
Pierce Ward	86%	92%	100%	102%
Pulteney	81%	83%	88%	87%
Respiratory	84%	82%	90%	103%
Robin Smith	88%	93%	99%	99%
Waterhouse	74%	100%	80%	100%
William Budd	72%	93%	95%	98%

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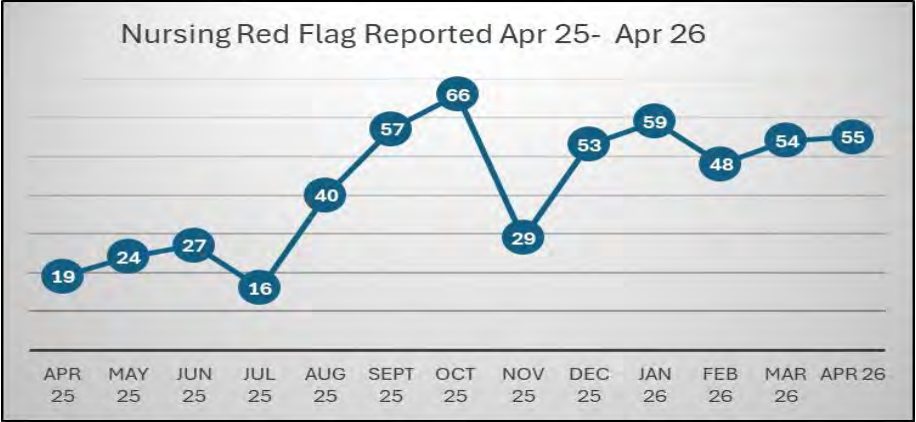
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Nursing Red Flag Reported Apr 25- Apr 26



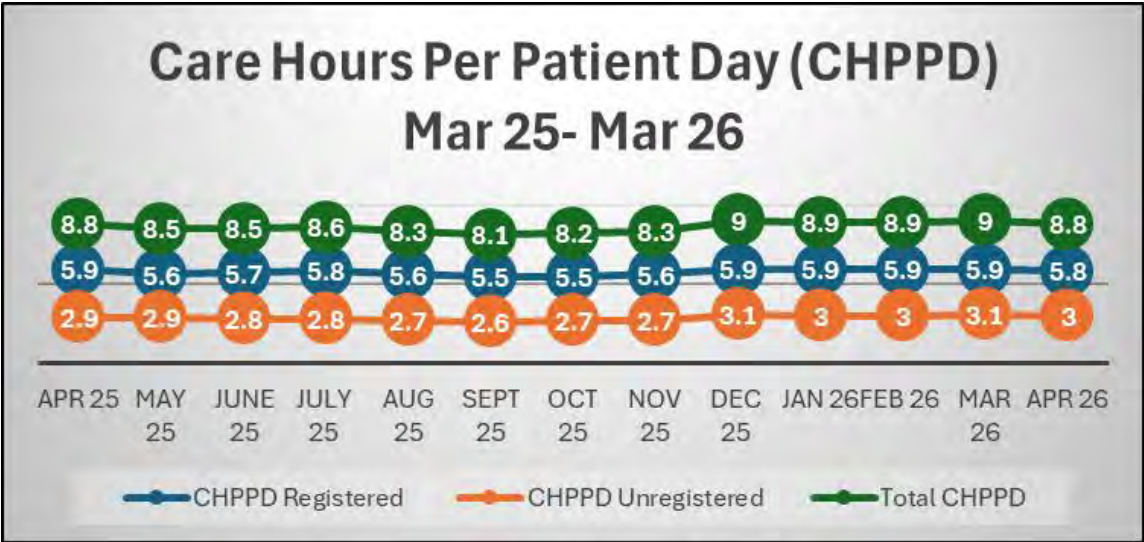
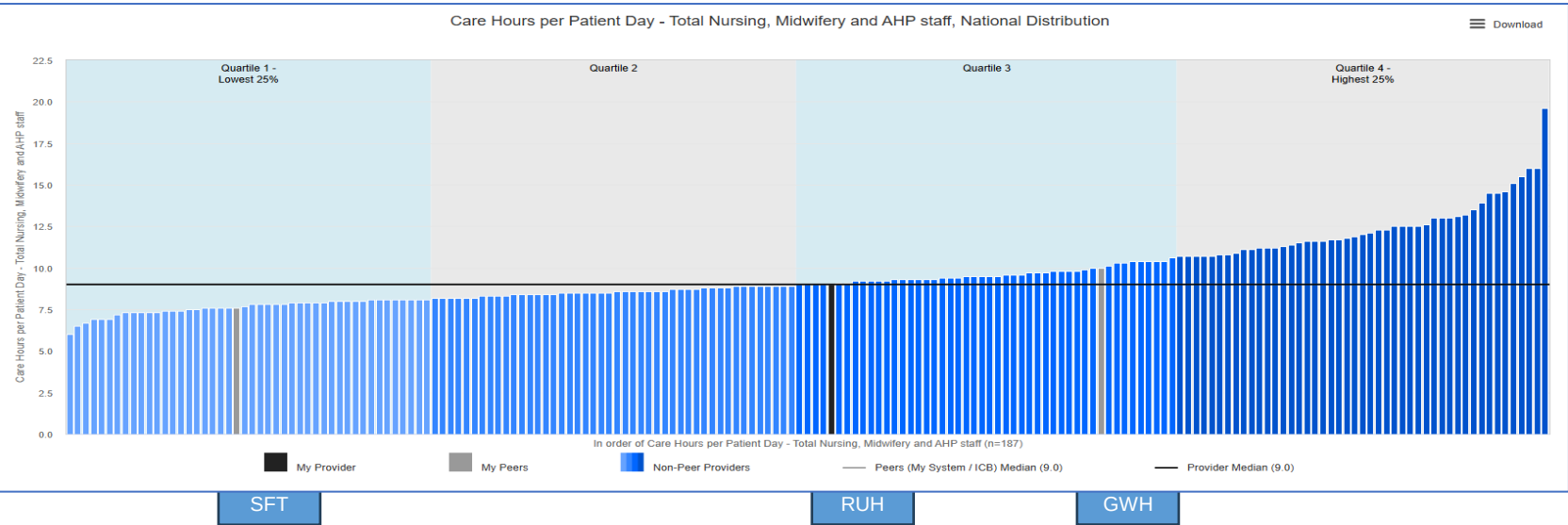
Day Shift Average Fill Rate		Night Shift Average Fill Rate	
RN	HCSW	RN	HCSW
83%	90%	93%	98%

Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigations
The combined day shift fill rates for RNs across the 24 inpatient wards was 83% and 93% respectively for nights. The combined day shift fill for HCSW was 90% and 98% for the night shift. The table above shows the monthly fill rate for the inpatient wards and emergency department. 19 wards fell below 90% fill rate for RN staffing on day shifts and 8 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. 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 <90% due to elective occupancy levels and planned staffing. The increase HCSW fill rate >101% particularly on night shifts reflects the deployment of additional staff in response to increased capacity, dependency, skill mix changes to support RN deficit, 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 and number of red flags raised across most wards. Sickness absence is being actively managed across the clinical divisions.	To recruit to remaining HCSW vacancies by September 2026. Surgical and Medical Divisional adverts live To recruit into Paediatric ward RN vacancies. Recruitment selection completed, with staff due to commence May – Sept 2026. To recruit into Emergency Department band 5/6/7 registered nurse vacancies. Band 5 recruitment event March 26 with all vacancies recruited into. Task & Finish Group to reduce Trust wide sickness/absence	Senior Sister/ Charge Nurse & Matrons Paediatric Matron & Senior Sister/ Charge Nurse Emergency Department Matron Matt Foxon	Sept 26 Sept-26 Sept-26 Oct-26	There is a risk that the current RN/HCSW vacancies will remain vacant and decreased fill rate <90% will continue. To mitigate this we have seen successful RN and HCSW recruitment across adult inpatient wards, ED and Paediatrics with staff due to start from May 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 55 red flags reported by wards in April a slight increase from 54 reported in March The breakdown of the 55 red flags was predominantly (66%) 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 April CHPPD is 8.8. 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 Dec 2025) we remain in quartile 3 and benchmark just below the peer median 9.0.

Caution: escalation areas are open with additional staff, for example SDEC areas which may skew the CHPPD.

Countermeasures

Active recruitment to HCSW and Registrant vacancies

Owner

Divisional Directors of Nursing / Matrons

Due Date

Ongoing

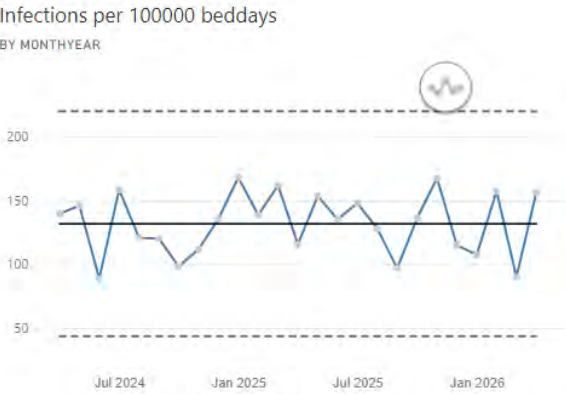
Risks and Mitigations

The risks identified from the roster in April show a sustained 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.

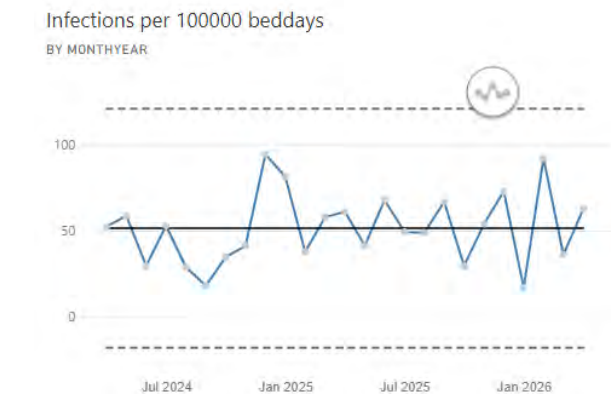
- Mitigations:
- Twice daily safe staffing meetings, reviewing both unfilled shifts alongside acuity and dependency of all wards.
 - Department specific HCSW and RN recruitment
 - Focused joint led (Nurse & HR) sickness reduction programme
 - Prospective and retrospective roster reviews
 - Safe staffing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

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



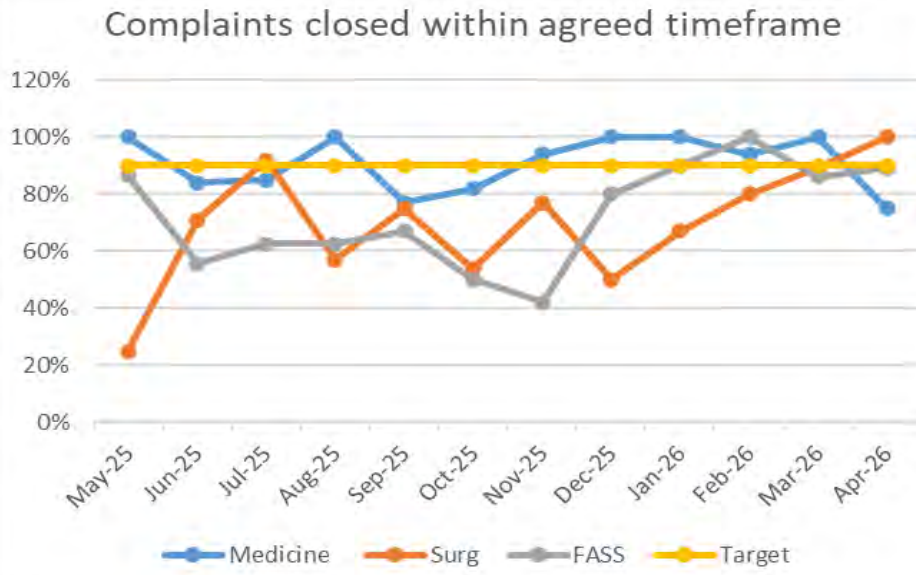
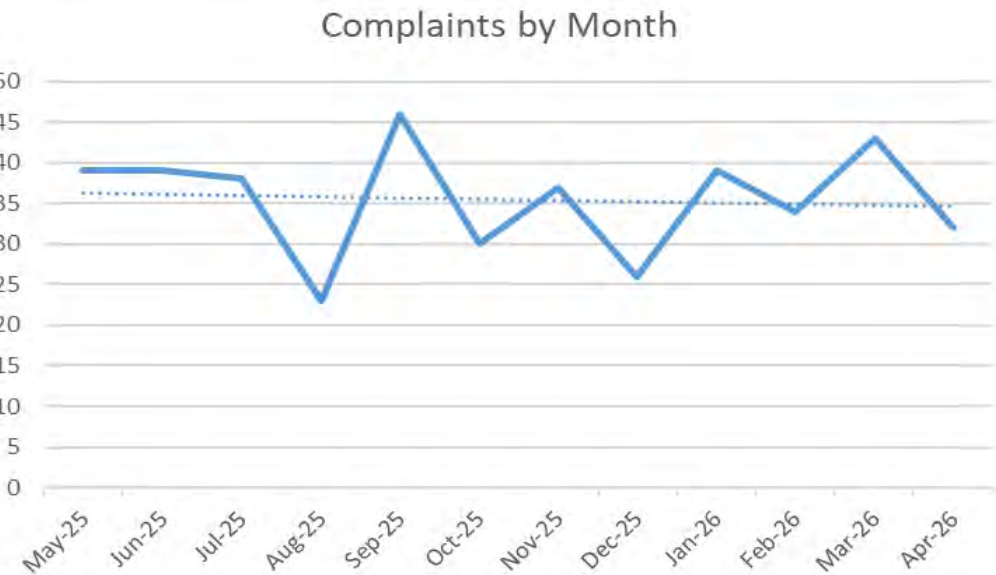
HOHA: Healthcare Onset Hospital Associated Community COHA:
Onset Healthcare Associated
PPE: Personal Protective Equipment

Understanding performance	Countermeasures	Owner	Due Date	Risks and Mitigation
To date there are no NHSE infection thresholds released for 2026/27. There was no healthcare associated MRSAB reported during April 2026 . There were 11 cases of <i>Clostridioides Difficile</i> infection (CDI) (8 HOHA and 3 COHA) reported during April 2026. This was a significant increase for no clear reason. One ward has triggered a period of increase incidence and Typing has been requested. There were 10 cases of <i>E. coli</i> infection (5 HOCA, 4 COHA) reported during April 2026. Key theme: 5 cases were urinary tract related. There were 4 MSSA infections during April 2026, 1 infection was associated to a cannula, 1 skin and soft tissue, 2 unknown.	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. Agree a suitable product format to progress further within the organisation.	Infection Prevention and Control	Ongoing workstream during 2026 with older persons units Progress review in Aug 26.	The high number of C.diff cases at the start of the reporting year is of concern. Cases have been distributed across the wards, clinical risk factors are being reviewed, cleaning requesting had been standardised and vapour cleaning implemented. The results from ribotyping have not been received yet. Improvement workstreams have slowed, clinicians have been unable to release time from clinical areas due to workload. Work continues to ensure alignment, minimise duplication, and maintain momentum across all improvement activities. 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.
	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 has been reduced by 10%.	Infection Prevention and Control	Ongoing Trust wide adoption 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. IT to host on clinical desktops.	Infection Prevention and Control	July 2026	

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.



Understanding Performance
In April 2026, the Trust received 32 new complaints. This was a decrease from March (n=43) – graph 1. The majority of complaints were about clinical care (n=19) consistent with previous months. The Medicine Division received the highest number of new complaints (n=14), Surgery (n=9) and F&SS (n=9). The complaint rate per 1000 patients in April was 0.50 which has decreased from 0.61 in March – graph 2. 97% of all concerns were acknowledged within 2 working days. The response times for formal complaints met the target of 90%, with 92% of the complaints closed in April responded to within the agreed timeframe – graph 3. Complaint closure rates varied by Division over February, F&SS increased slightly to 89%, the Surgical Division increased to 100% and the Medicine Division decreased to 75% for the month.

Countermeasures	Owner	Due Date
The Patient Experience Team will analyse a sample of 'clinical care' complaints received in Q4 and Q1 using inductive and deductive coding. The results will be presented to the Insights and Improvement Committee in July-26 to identify areas for improvement.	Patient Experience Team	July-26
Bi-monthly meetings to discuss the oversight and standardisation of the complaint process are progressing well. Areas of focus are early resolution, the management of PSII's and complaints, re-opened complaints and monitoring of actions.	Patient Experience Team/representatives from the Divisions	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.	F&SS	Ongoing

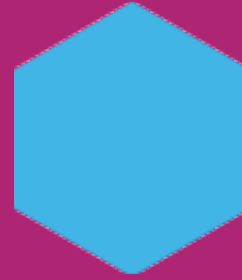
Risks and Mitigation
There are ongoing concerns about the responsiveness of staff to patient/family concerns requiring resolution. This relates to outpatient/test results queries. Early resolution telephone calls by a member of the clinical teams are not routinely made. This is a missed opportunity to manage the case proactively rather than as a formal complaint and could result in higher complaint numbers. The Patient Experience Team are beginning a training needs analysis exercise to scope out a training and support programme for staff dealing with early resolution and complaints telephone calls and meetings.

Perinatal Quality Support and Oversight Model (PQSOM)

May 26 (April 2026 data)

BSW PQOM v3.0

Listening to Women and Families



Insights

MNVP Service User Feedback:

Themes:

- Communication

Learning Points

- Consistency of communication throughout care is pivotal to a positive experience
- Even when birth deviates from the desired plan – validating people's values and adapting to facilitate even small wishes is essential for post birth wellbeing (*mother who planned homebirth and birthed by caesarean*)

Safety Champion walkaround 14/4/26

Themes:

- Staff feedback of positivity towards ongoing QI in Maternity Triage
- Positive impact of new twilight Triage shift
- Positivity for impending new obstetric consultant with SPA in Triage

Learning Points

- Environmental Signage needed refreshing

Complaints & Concerns:

Complaints Received	Summary & Themes
3	• Dissatisfaction with perineal care • Communication around delays • Tongue Tie service change
Concerns Received	Summary & Themes
6	• Postnatal care on Mary ward • (Baby labels and wristbands not checked) • Unable to get tongue tie appointments
2	• Time taken to get into unit challenging • One family felt staff under pressure and knew we were on 'Opel Red' didn't feel listened to

Trust Countermeasures:

- Following learning from a previous incident, the tongue-tie service underwent a temporary change to enable a comprehensive review of safety and quality. Full service provision is scheduled to resume in May 2026.
- Looking at options to improve parent access to NNU
- Workforce reviews in NICU and Maternity underway

Compliments:

Service User Compliments Received	Summary & Themes
6	Broad scope of service areas; screening, BBC, NNU Themes – personal thanks to staff and students - 'Reassuring', 'kind', 'encouraging in labour'
Neonatal Compliments Received	Summary & Themes
7 + numerous cards	• Personal thank-you and small gifts as tokens of thanks to staff. • On going written support for Bryony in her infant feeding role • Praise and thanks for the outreach service and the support shown

You Said, We Did:	
Delay in care when arriving for Induction of Labour (IoL) on Mary Ward	Introduced IOL suite and families offered appointment slots to ensure midwife can commence care upon arrival
Variance in information received around IOL	Working party discussion – leaflets to be discussed at term and again on arrival for IOL
Some people not wanting daily phone calls when on IOL list	Ensure safety conversations around FM's/SROM occur at term – add to list on date agreed with the individual
Teddy Bear Picnic engagement event	3rd successful event held. Supported by RUHX and MNVP
Meal voucher for 1 meal a day but no breakfast provision	Cereal now available for parents
Access to breast pumps and accessories in parent accommodation rooms	Breast pump, fridge and milk warmer in each parent accommodation room

Friends and Family Test Feedback:

Families highlighted compassionate and considerate attitudes of staff teams in EPAC and AN Screening – noting they were communicative, reassuring and welcoming

An anonymous respondent reported a negative experience overall and that she wouldn’t return to RUH for maternity care but declined to be contacted:

LEARNING POINT: If families appear aggrieved or raise concerns ensure they are offered opportunity to discuss their experience *at the time* (or at their convenience) to mitigate ongoing negativity.

Walk & Talk Feedback: Consistency of Caregivers

'Different people each shift said different things – very confusing' (*re. IOL*)
 'I never saw the same person twice' - (*Mary ward – 3 day stay*)

Actions for Consideration: Allocation of same team – core team for AN inpatients?



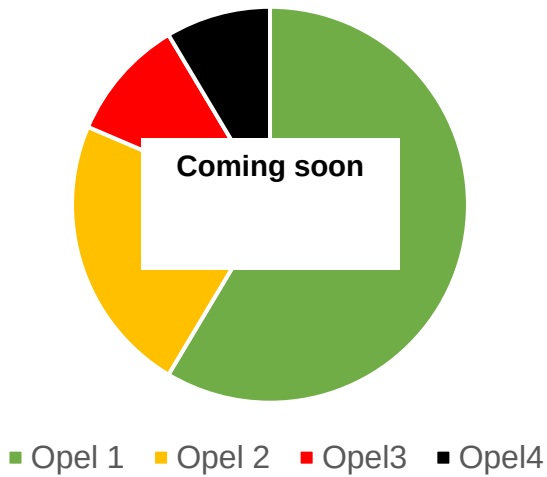
Workforce

Maternity Workforce – to update

	Target	Threshold		Feb 26	Mar 26	Apr 26	Comment
		G	R				
Midwife to birth ratio	1:24	<1:24	≥1:26	1:26	1:29	1:27	Trained staff only included in acuity data
Midwife to birth ratio (including bank)	1:24	<1:24	≥1:26	1:25	1:27	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	0	0	
Number of NICE red flags on BirthRate+	NICE 2015	-	-	12	1	3	2 red flag for BBC due to a delay in providing pain relief & delay between admission for IOL and beginning IOL. 1 red flag for Mary Ward due to delayed time critical activity
Percentage of 'staff meets Acuity' (BBC)	100%	>90%	<70%	69	70	68	
Percentage of 'staff meets Acuity' (Mary Ward - inpatient care)	100%	>90%	<70%	46	63	56	
Confidence factor in Birthrate+ recording (BBC)	60%	>60%	<50%	86	81	81	Percentage of episodes for which data recorded
Confidence factor in Birthrate+ recording (Mary Ward - inpatient care)	60%	>60%	<50%	92	90	90	Percentage of episodes for which data recorded
Percentage midwifery in month turnover	0.8%	<0.8%	>0.8%	0.21	0.57	0.35	
Percentage MSW in month turnover	0.8%	<0.8%	>0.8%	1.35	2.81	0.00	
Midwives in month sickness percentage	<5%	<5%	>5%	5.45	5.46	3.36	1 month lag
Maternity Support Workers in month sickness percentage	<5%	<5%	>5%	17.2	6.10	6.37	1 month lag

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

In month Opel Status



Maternity Midwifery Workforce Countermeasures to update

Overview Analysis:

- Birthrate+ confidence high completeness. BBC 81% and Mary ward 90% (April).
- 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.
- ELCS capacity and demand impacting both BBC and Mary ward acuity vs staffing.

Substantive MW vacancy	Secondment	Parenting leave	Fixed term in post	Budget V actual
4.9	2.78	10.95	2.27	-6.56
Substantive MSW vacancy	Secondment	Parenting leave	Fixed term in post	Budget V actual
-3.03	1.4	1.25	0.92	-6.60
Countermeasure / Action	Owner	Status	Due	Outcome/Update
Flexible working review to support roster planning/shift fill	Kerry Perkins Jo Coggins		June 26	Line managers meeting with staff
Birth rate establishment review (3 yearly)	Jodie Da Rosa		July 26	Birth numbers stable but complexity has changed
Review impact of percentage meets acuity challenges for Mary ward	Kerry Perkins		April 26	Gathering local intelligence data and intel to present to SLT
Reviewing staffing expectations SOP to support escalation steps.	Gemma Day Kerry Perkins		June 26	SOP in draft – to be informed by Birth rate review findings and agree care ratio minimum standard on Mary w
ELCS Capacity and demand project	Gemma Day Hayley Rossiter Hilary Arden		July 26	Scheduling agreed. Staffing amendments to be made to poplar team including recruitment.

Potential Cause:

- MSW vacancy – recruitment options to be considered alongside birth rate review
- High in month MSW sickness
- Mary ward midwife in charge not supervisory – outlier compared to other high flow areas

BBC management action (top 5) Data from Feb 2026	Times occurred	Percentage
Redeploy MW internally	42	44%
Operational support midwife included in BBC numbers	19	20%
Redeploy MW community	15	16%
Escalate to Matron/MOC	10	11%
Clinical Skills Facilitator MW included in BBC staffing number	5	5%

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

Neonatal Workforce

	Target	Threshold		Jan 26	Feb 26	Mar 26	April 26	Comment
		G	R					
Limitation in service / exemption report episodes				0	1/0	3/0	1/0	LIS over 1 episodes totally 9 days due to capacity
Nurse in charge supernumerary (%)		100%		75.81	59.26	51.61	64.41	
Percentage neonatal nursing shifts filled to BAPM standard (%)	100%	>90%	<80%	100	90.74	98.39	91.53	
Percentage neonatal QIS trained (%)	>70%	<70%	<60%	53.3	66	66	66	1 QIS student due confirmation of pass in May with expectation of increasing to 70.7%
Percentage neonatal turnover in month (%)	<5%	<5%	<7%	0	1.85	0	0	
Percentage of neonatal nursing in month vacancy (%)				2.14	2.31	2.31	2.28	Awaiting starters. B6 interview 2/52
Percentage neonatal in month sickness (%)	<5%	<5%	>5%	5.58	4.42	4.11	5.01	

Identified Risk	Background	Mitigating Action
Cot commissioning discussion on going – - current TC model staffed from NICU establishment	• Early implementor – missed national funding – 10 years ago • Current staffing model unsustainable • Increased cot pressures across SW compounded issue	ODN staffing review on going Review Neonatal staffing risk on risk register

Neonatal Workforce Countermeasures – to update

Overview Analysis:

- Sickness increase to 5.01% (76.9 FTE days lost), possibly due to remaining operational pressures .TC staffed at 100%, with pockets of vulnerability: 20% of shifts caring for 5–8 babies, 50% of these shifts met required nurse-to-baby ratios,
- Temporary workforce reliance remained moderate with 2.12 WTE of nursing shifts filled by bank/agency and 7% (3.54 WTE) unavailable due to parenting leave, impacting rota resilience.
- Escalation pressures continued, with one Limitation in Service (LIS) declaration (9 days), partial redeployment of specialist roles to clinical cover, and three external neonatal admissions contributing to activity levels.
- 50% days between 80-100% cot capacity

Substantive Neonatal Nursing Vacancy	Secondment	Parenting Leave	Fixed term in post	Budget V actual
2.28	0	3.54	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
- Awaiting new starters delayed start date.
- Temporary cot closures in Bristol throughout Jan- May 26 may impact acuity of patient

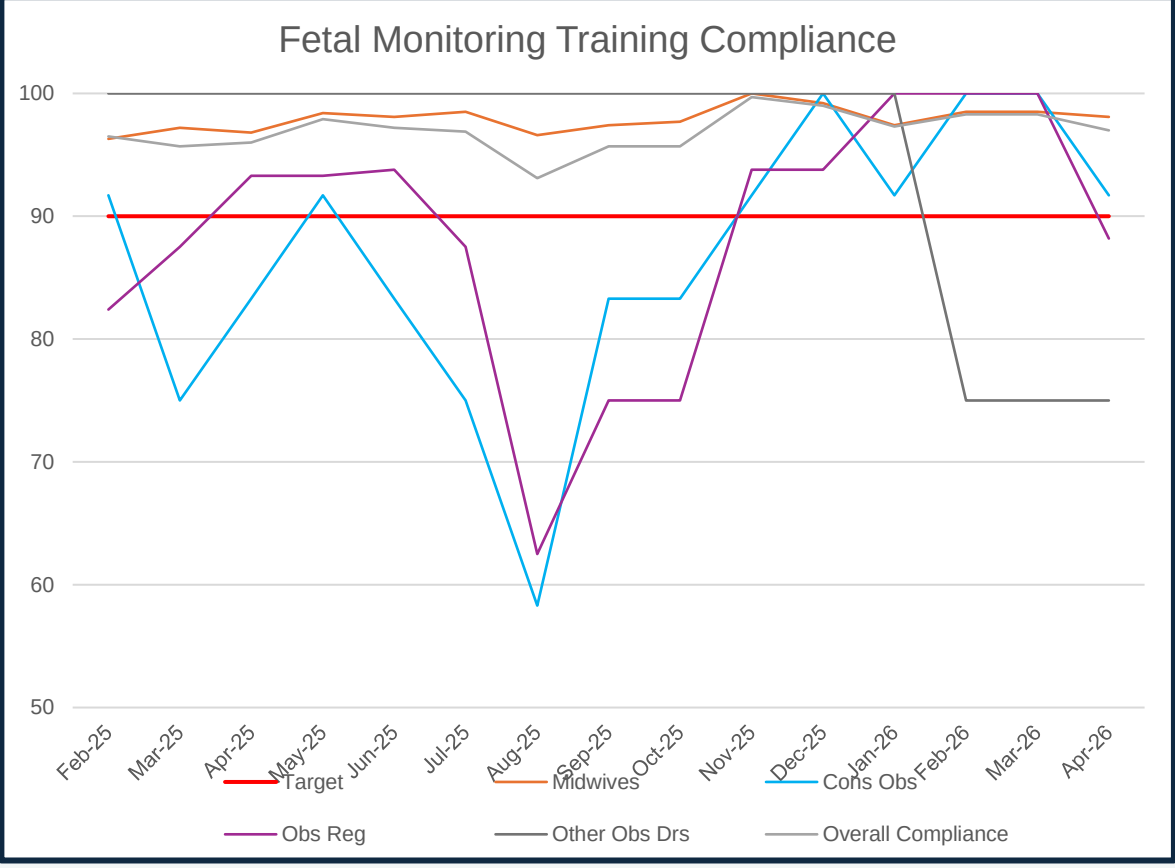
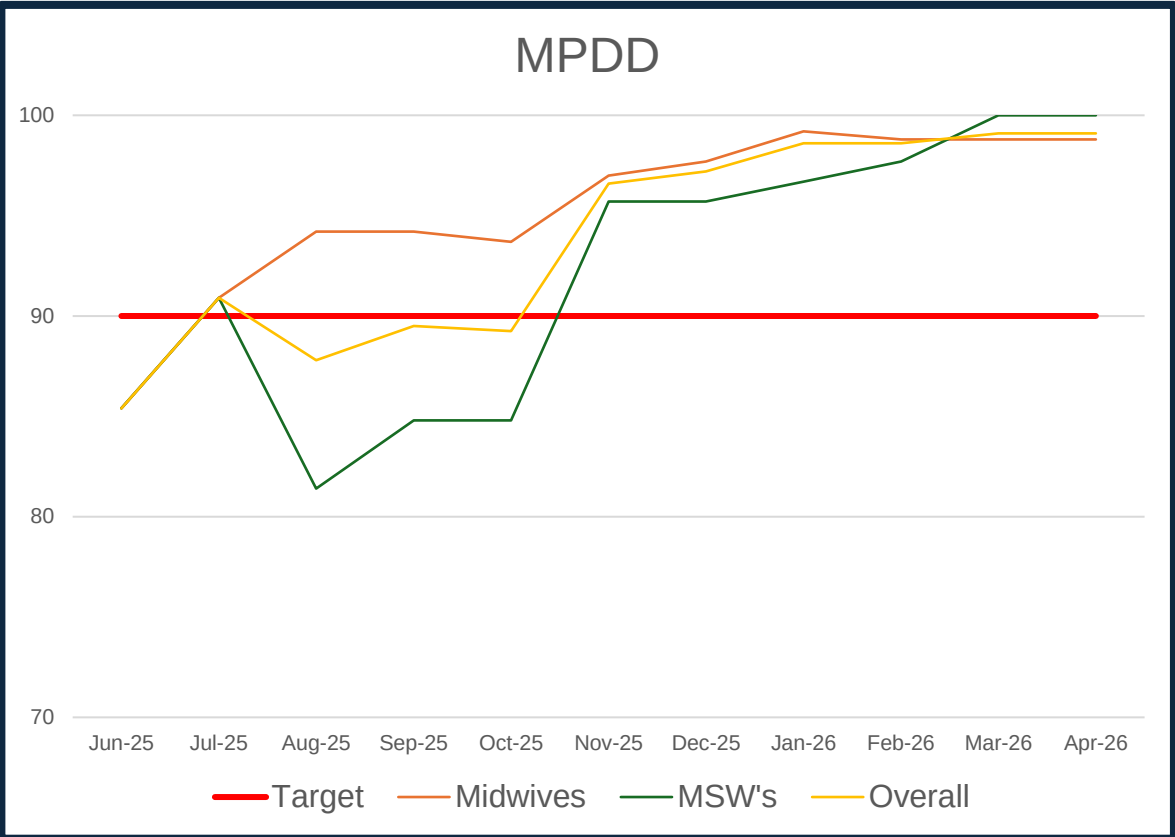
Mitigations and management actions to support safe staffing Data from Feb 2026	Number of occasions
Redeploy specialist neonatal nurses	3
Redeploy paediatric nurses	3
Shift out to Bank (filled/unfilled)	26/18
Shift out to Agency (filled/unfilled)	5/2

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

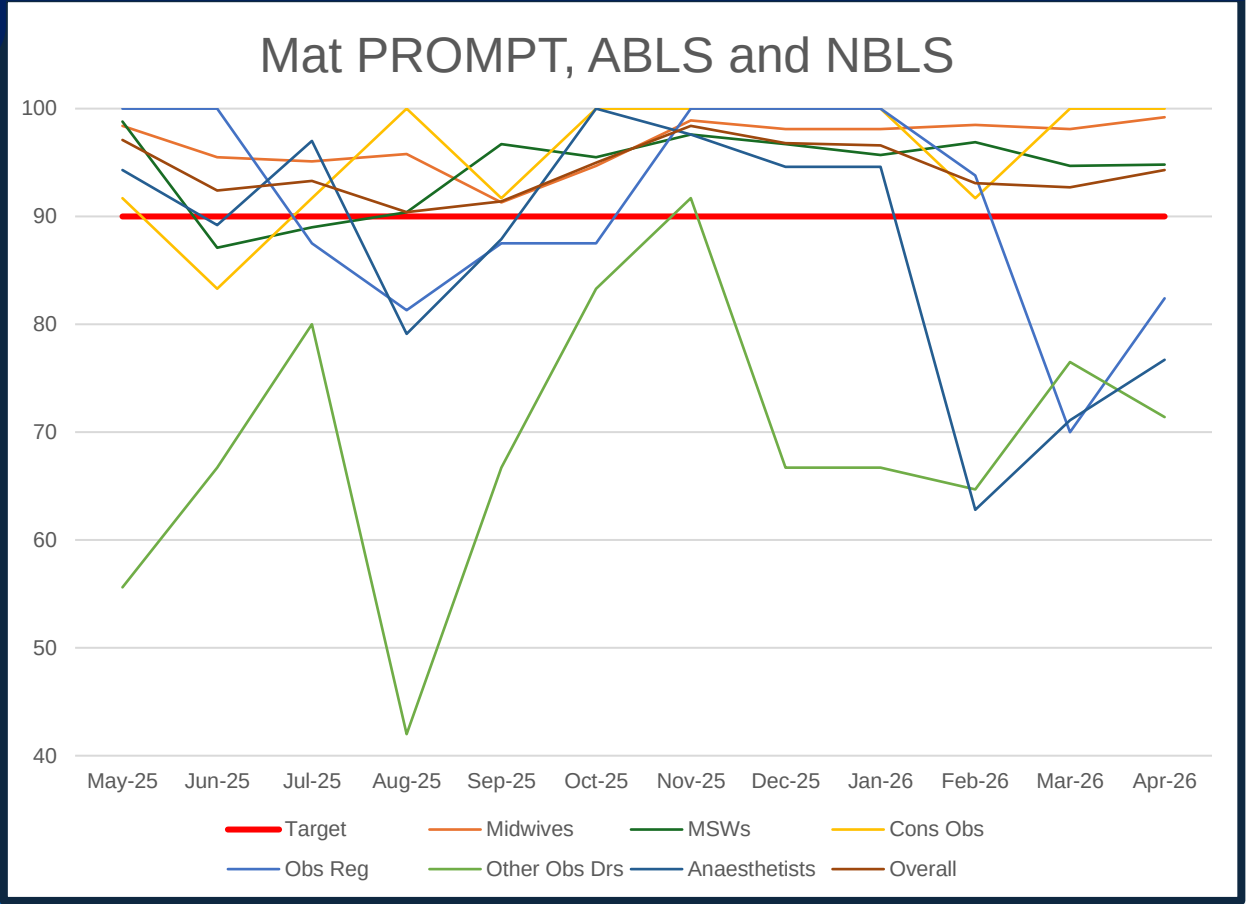
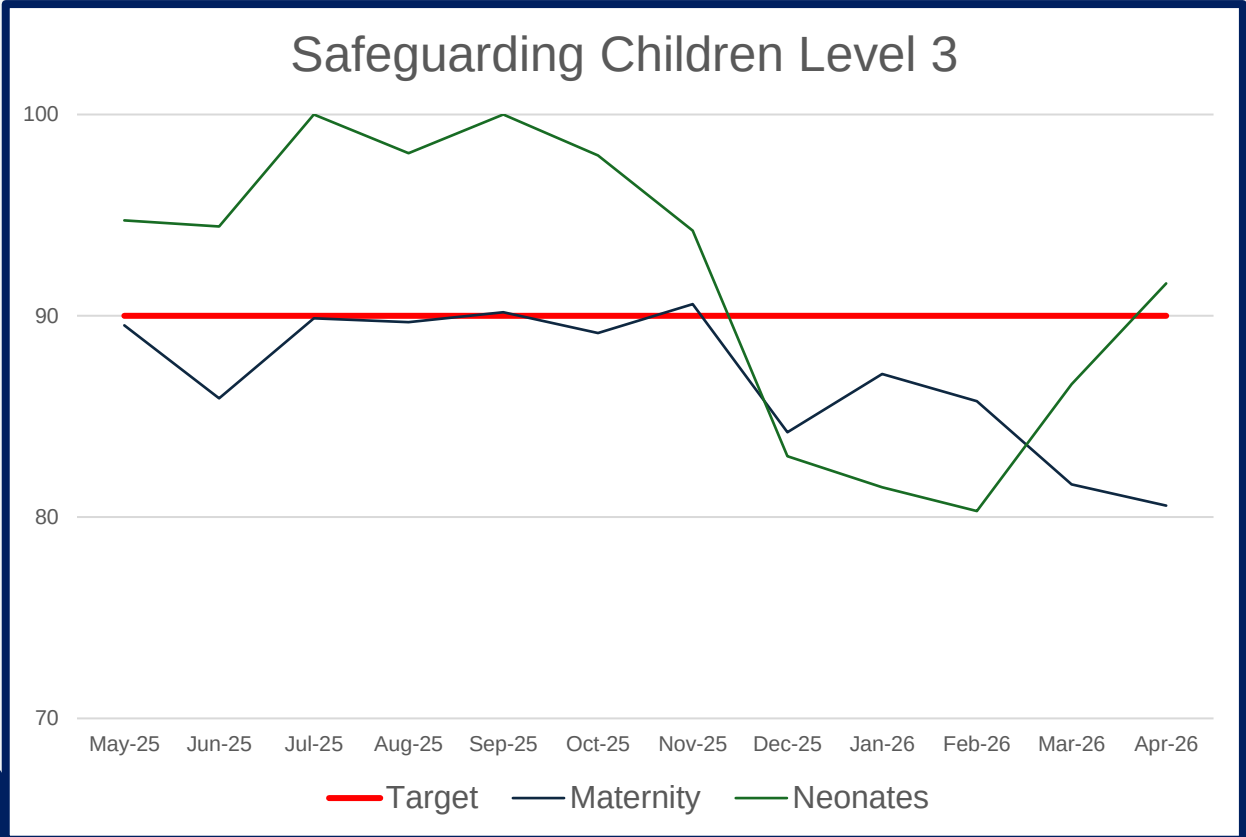
Medical & Anesthetics Workforce – to update

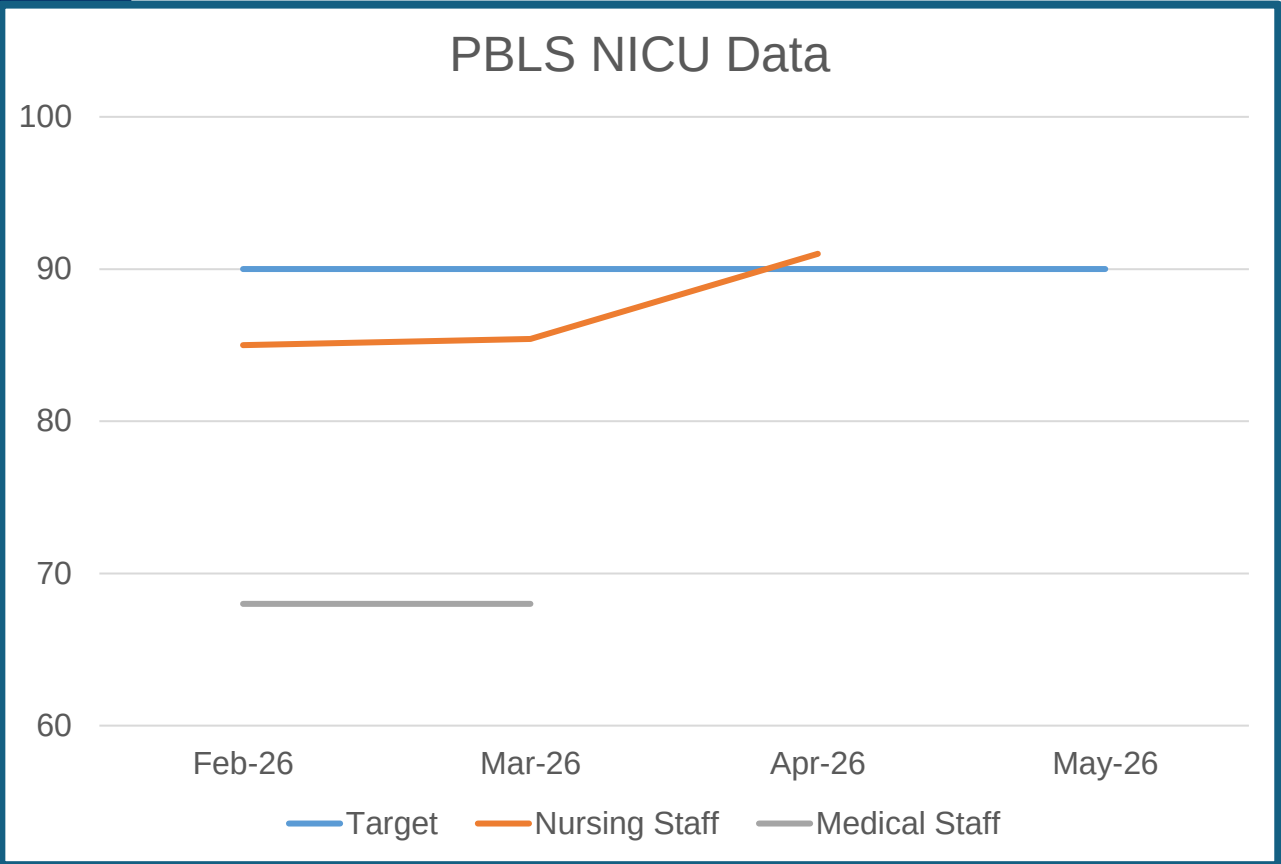
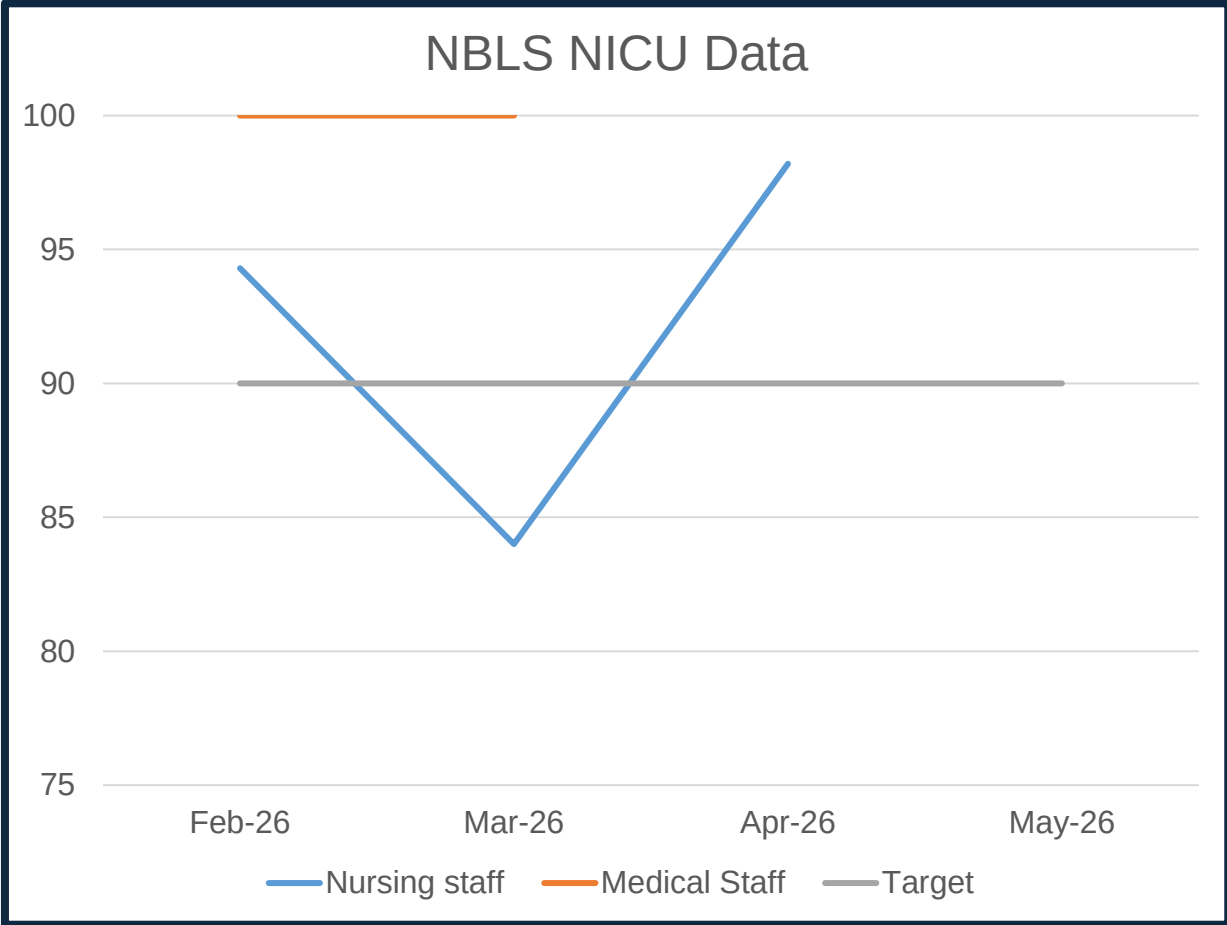
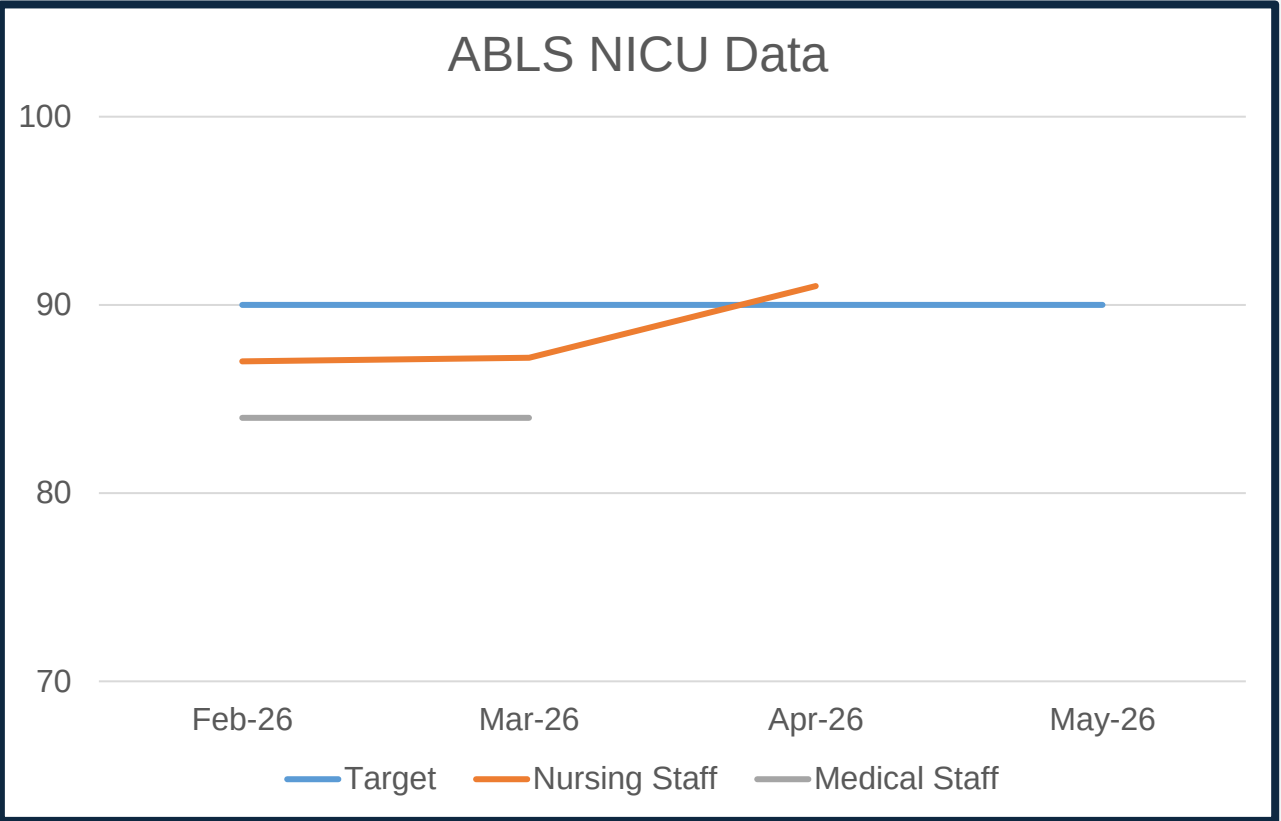
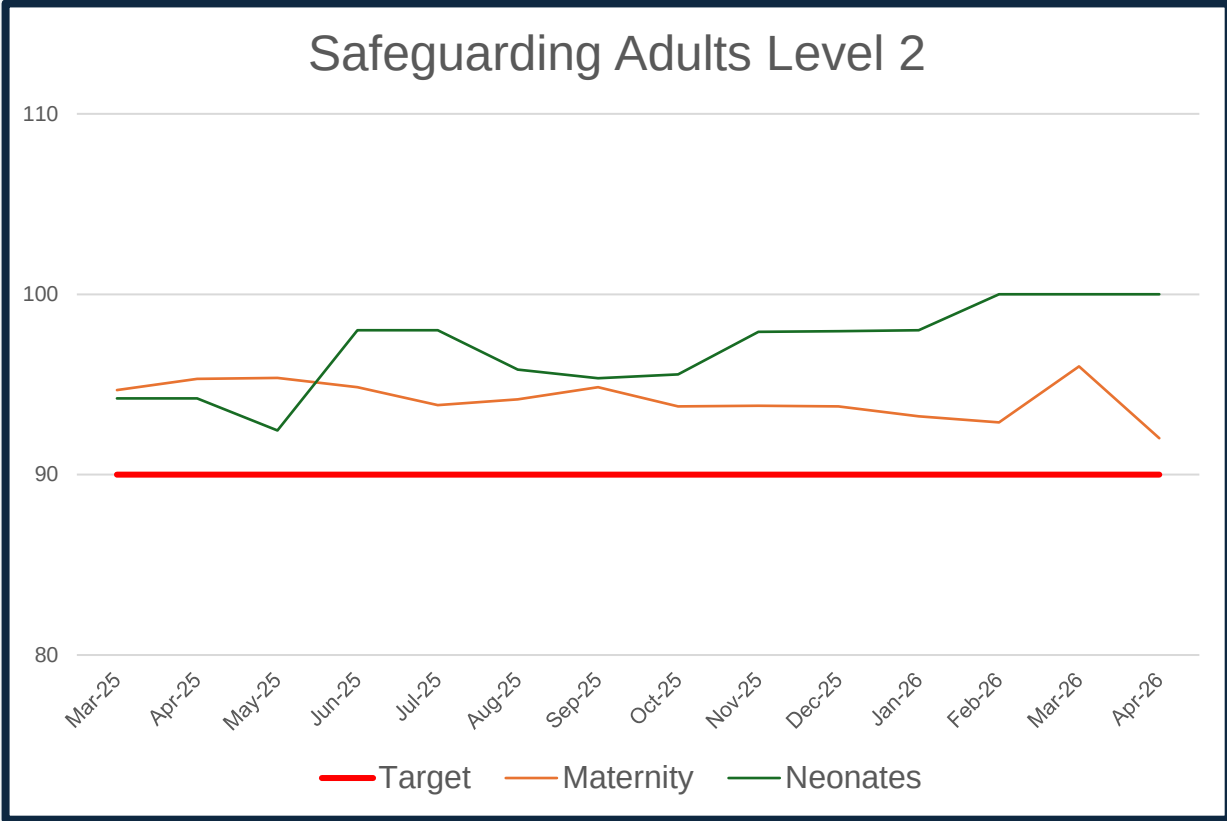
	Target	Threshold		Feb 26	Mar 26	April 26	Comment
		G	R				
Obstetric consultant presence on labour ward	60 hrs	>60 hrs	<60 hrs	96	96	96	
Compliance to RCOG ‘Must attend’ obstetric consultant roles and responsibilities guidance	100%	100 %	<100 %	100	100	100	
Obstetric MDT ward round twice daily percentage	100%	100 %	<100 %	100	100	100	Reviewed by LWC daily, MS forms completed if no ward round completed with immediate escalation.
Shifts filled by locum obstetric cover	0	-	-	0	0		
Anaesthetic rota compliance	70%	≥70 %	<70%	100	100	100	
Percentage medical shifts filled to BAPM minimum standards (2018)	100%	>90 %	<90%	90	90.3	93.3	
Shifts filled by locum/bank neonatal cover	0	-	-	20	10	9	8 Bank ANNP 1 Medical locum

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



Training





Training

Overview Analysis and Potential Causes:

- MIS 2nd Target set for end of August 2026. Agreed with Neonates. Target areas for us is medical staff. Need support from leads to ensure all Drs and Anaesthetists are booked on to attend.
- Compliance still under 90% for Safeguarding L3. Projected to drop to 77% with recent cancellation. Further cancellation from SG team. All staff booked on apart from 5 people. Unlikely to hit >90% until August 2026
- Manual Handling still under 90% - to be built into PROMPT next year
- New TNA in process
- New Bank Process – Education and Training concerns (How will staff be trained? Training records, Local training concerns, Compliance SOP, Will SFH/GWH be able to book bank for us? Etc.)

Training Picture - Neonates

Overview Analysis and Potential Causes:

- ABLS + PBLS + NBLS compliance now above 90%. Difficulty with accessing training during working day due to acuity. Compliance will continue to be variable until next year as training now added to Professional update SD
- Safeguarding Level 3 compliance has increased to 91.6%. Continued improving picture in next months with proactive booking.
- ALL mandatory training compliance good and above 90%
- TNA 2026 in progress

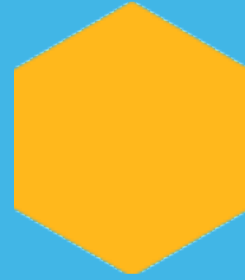
Countermeasure / Action	Owner	Status	Due Date
Build MH into mandated study day	JM/CR	In progress	May 2026
Extra L3 Safeguarding Days	JM/PL	In Progress	May 2026

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 – to bring to PRM
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.
New MIS compliance states all staff groups to achieve >90% twice in 6 months	Review with training team when this will be possible between now and Nov
Training and Education Standards for Bank Staff	To be raised and escalated at BSW group

Countermeasure / Action	Owner	Status	Due Date
Build ABLS + PBLS into mandatory update day from March	TS	Completed	Ongoing
SGL3 course early booking encouraged	TS	In progress	July 2026
NBLS built into mandatory update day	TS	Completed	Ongoing

Identified Risk	Mitigating Action
ABLS + PBLS compliance	Built into mandatory update day from March 2026 Adhoc 1:1 training as required.
Children's L3 Safeguarding compliance. Study days run monthly.	Options being explored for alternative options for delivering Level 3 training for perinatal services consideration of BSW resource.
MIS Yr 8 requirement for NBLS compliance >90% twice in six months	Built into professional update study day from March. 2nd compliance date identified as 28th Aug – whole team approach to achieve target for nursing group with 1:1 training (10 to be trained)

Culture of Learning, Safety and Support



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

Incidents & Investigations

Case Ref (Datix)	Incident Date	Category	Incident	Investigation update – Outcome/Learning/Actions	MNSI Ref	PSII
151945	25/04/26	Moderate	Baby admitted on day 3 with history of lethargy, poor feeding and jaundice. On admission hypoglycaemic, hypothermic, seizures – transferred tertiary unit for seizure management	MNSI referral completed Rapid review 07.05.26 – Magnetic Resonance Imaging showed hypoglycaemic brain insult (not Hypoxic Ischaemic Encephalopathy) Actions – audio recording of triage conversation to be reviewed for clarification of verbal information to inform place of review- re-review of Maternity Triage Neonatal concern pathways - Clarify with South West Ambulance Service Teams if paramedics can administer glucogel to neonate - Ascertain current guidance (BSW, Bristol) and literature search for blood sugar monitoring in high-risk neonates - Ongoing neonatal hypoglycaemia RUH workstream linked action plan –see draft report ID146963		
151532	14/04/26	Moderate	Maternal ITU admission severe pre-eclampsia	Rapid review 01.05.26 - appropriate care, no care concerns identified		
151604	15/04/26	Moderate	Shoulder dystocia and transfer for therapeutic hypothermia	MNSI Referral completed Rapid review 23.04.26 - Learning – WHO criteria to assess SGA prior to birth was not utilised linked risk register ID 3308 actions towards mitigation monitored via risk register - CTG interpretation in relation to the presence of late decelerations, action plan in place	MI-057309	
151206	03/04/26	Moderate	Maternal ITU admission for metabolic acidosis	Rapid review 23.04.26 - Appropriate care, no care concerns identified		
151397	09/04/26	Moderate	Intrauterine death at 32+5 weeks of twin, known congenital anomaly	MDT review 08.05.26 - Learning – Inaccurate risk assessment for LMWH – ongoing QI working group actions monitored via Mat-Neo Medicines Safety Group Good use of interpreters by Lotus team, less consistent within acute unit		
Ongoing Patient Safety Events Graded Moderate or Above						

Datix	Date	Category	Event	Investigation update – Immediate Learning/Actions		MNSI	PSI Ref
147338	08/12/25	Severe Harm	Transfer for active therapeutic cooling. Abnormal MRI	MNSI investigation ongoing DOC Lead: Obstetric Consultant Family Engagement Lead: Patient Safety review lead	Multi Professional Safety Review held on12/12/25. No Trust care concerns identified Report received for FA checking	MI-050463	
146963	20/11/25	Severe	Readmission to NICU with abnormal MRI	MNSI investigation ongoing DOC Lead: Neonatal Consultant Family Engagement Lead : Quality and Patient Safety Lead	Local PSIRF learning response ongoing – report in Draft – see shared learning slide	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	Completed MNSI report Ongoing PMRT to collate MNSI learning, locally identified learning, and family lines of enquiry DOC Lead: Bereavement Lead Obstetrician Family Engagement Lead : Bereavement Midwife	Final MNSI report received March 26 family meeting between Family and Patient Safety Lead Midwife in March 26 Agreed sharing of RUH action plan following PMRT report completion to generate cohesive full learning response and action plan from the service	MI-047238	

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

Closed Patient Safety Events Graded Moderate or Above

Incidents & Investigations

Case Ref (Datix)/MNSI/PSII	Incident Date	Category	Event	Learning identified	Monitoring Group
143919 See Risk 3308 slide	22/08/25	Severe	Unidentified fetal growth restriction with abnormal MRI	1. Improve Accuracy & Assurance in Ultrasound Reporting - Introduce verification/double-checking of key biometric data (HC, AC) - Undertake audit of transcription risks (Synapse → BadgerNet) and implement improvements - Place risk on service risk register to ensure oversight and mitigation 2. Strengthen Documentation & Visibility of Doppler Findings - Mandate recording of all Doppler results in BadgerNet - Introduce system prompts/mandatory fields for Doppler completion - Standardise Doppler assessment for all multiple pregnancies - Use safety bulletin to reinforce documentation standards 3. Reduce Digital System Risk - Progress integration between Synapse, Soliton, BadgerNet and Millennium - Consider alternative solutions if interoperability cannot be achieved 4. Align with National Standards (EFW Charts) - Transition fully to WHO EFW charts (per NHSE/RCOG guidance) - Enhance visibility of centile changes (numerical + graphical display) 5. Improve MDT Communication & Escalation - Introduce clear alert/flag systems for abnormal findings - Strengthen handover between sonographers and obstetricians	MNSG

Risk 3308- There is a risk of inaccurate risk assessments of fetal wellbeing and decreased staff wellbeing in response to usability issues within the current digital obstetric sonography structure.

Risk Evaluation (Current score): see attached guidance for determining likelihood and consequence of the risk. The current risk score should take into account the controls already in place.					
Domain	Consequence (1-5) or N/A	x	Likelihood (1-5) or N/A	=	Risk score (1-25) or N/A
Patient Safety & Quality	4	x	3	=	12
Health and Safety		x		=	
Patient Experience		x		=	
Workforce	4	x	3	=	12
Statutory, Legal or Reputational		x		=	
Estates and Facilities		x		=	
Finance including claims		x		=	
Service Delivery/ Performance		x		=	
Environmental					
Digital					
Information Governance					
RISK SCORE (take the highest risk score)				=	12

Current Controls

1.	Data validation checking in place
2.	Education workbook to standardise process
3.	Incident reporting

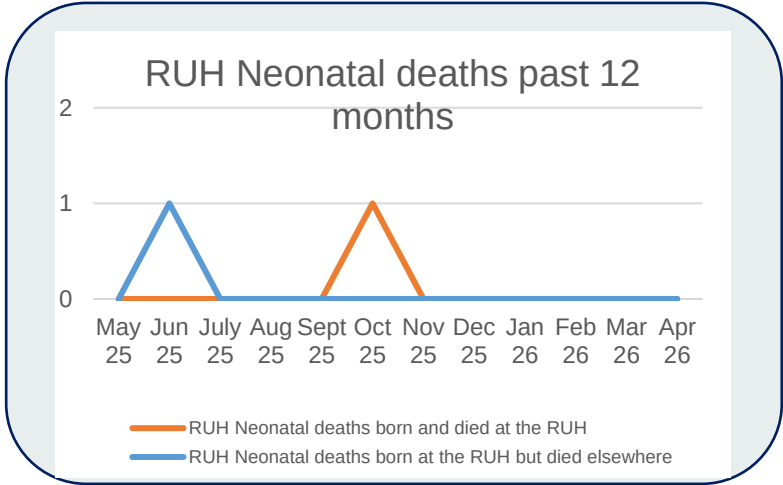
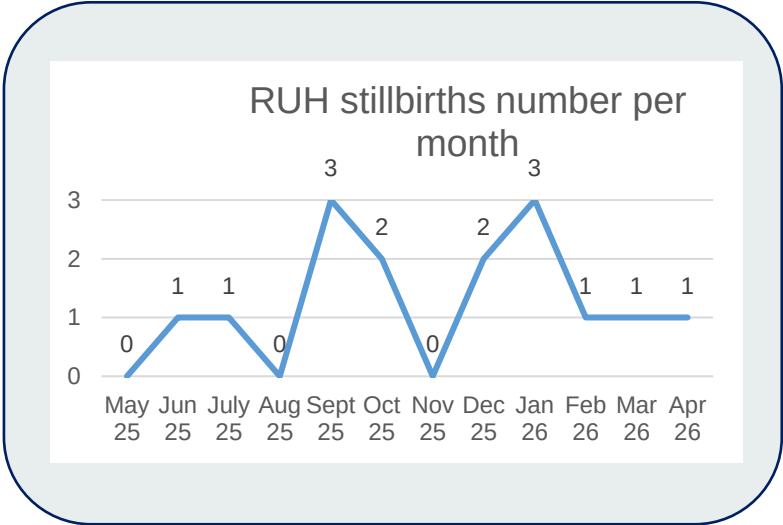
What should be in place?

1. Current USS system Usability Improvements	- Mandatory fields mandatory fields to indicate if a doppler assessment was completed within the USS workflow providing system feedback to the sonographer that clinical information may be missing within the report - Implementation of a ‘flag system’ to signpost/alert staff to particular recordings which are abnormal or need additional attention in BadgerNet USS reports. - Implementation of value parameters within the USS workflow of BadgerNet to alert users in real time to a potential inaccurate value entry. - Implement doppler assessment for ALL multiple pregnancy growth USS assessments irrespective of chronicity to support standardisation and expectation, reducing cognitive load for the obstetrician in assessing if a doppler report should be available. Furthermore supporting professional curiosity if dopplers not available in the badger.net USS report
2. Procurement of fully integrated digital system	- Explore solutions to allow Synapse, Soliton, Badger.net and Millenium to share data automatically to prevent the risk of manual data transfer. - If interoperability or Integration options are not available to consider alternative software procurement to mitigate the risks discussed in this report.

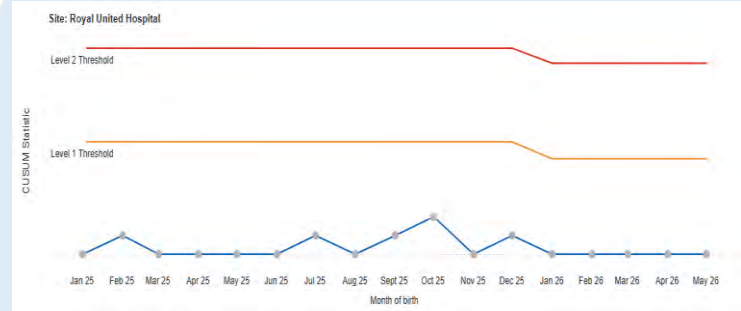
Actions to close the gaps?

1.	To raise Tickets with System C in response to identified Hazards
2.	Liaison with System C to action raised tickets to improve BadgerNet usability
3.	To commence audit of data transcription between synapse and BadgerNet to identify the likelihood and impact of this risk and actions taken.
4.	To commence weekly Multidisciplinary working group meetings to target improvement and progress safeguards and progress towards mitigation
5.	To develop business case to explore ViewPoint as alternative to fully mitigate risk

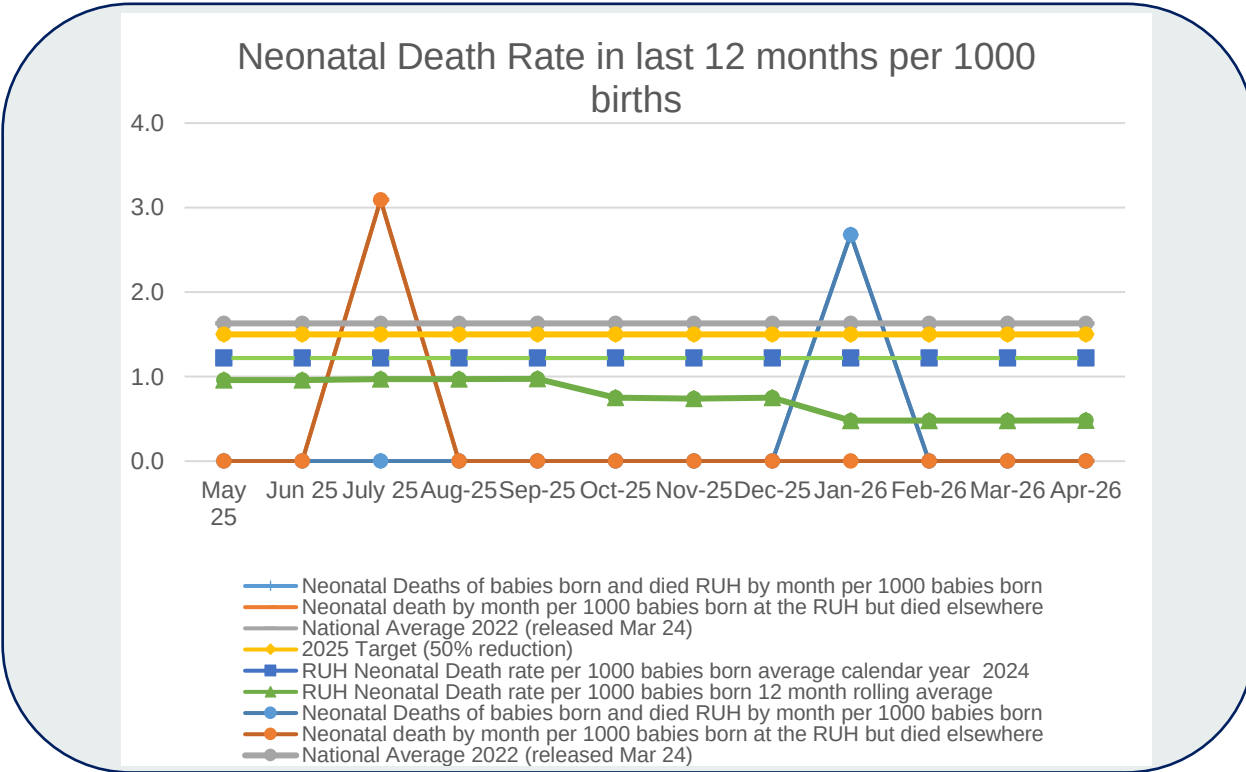
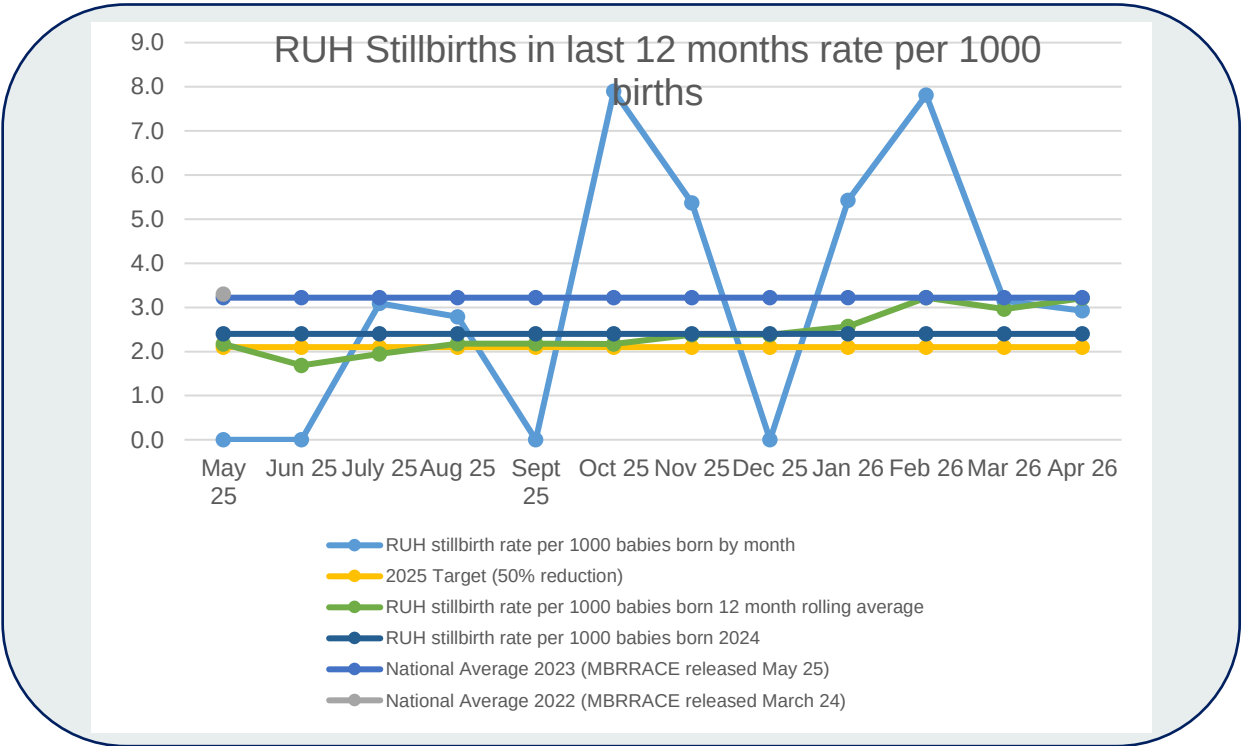
Perinatal Mortality Review Tool (PMRT)



MOSS



Please note- MOSS only monitors term (>37 week) stillbirths and Neonatal Deaths (NND) therefore the MOSS chart will not mirror the local stillbirth and NND trends



Annual Position

Annual calendar year RUH SB rate for 2025 is:

2.8 per 1000 births.

An increase from 2.4 per 1000 births during 2024, although remains lower than the latest MBRRACE reported national average of 3.2 per 1000 for births in 2023 (MBRRACE, 2025) A case cohort review has been completed aiming to identify areas of focus for ongoing improvement. No commonalities were identified.

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.

Monthly update

see incident slide

1 stillbirth and 0 NND in April 26–

Identified learning

See PMRT slide- no cases have reached completion in the month of Apr. No immediate learning identified from the Rapid review of the 1 in month stillbirth.

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
Nil completed cases in the month of Apr – 14 families awaiting Post-Mortem Result leading to delays in PMRT report completion – Linked Risk 3251							



MIS Y8- Preliminary Benchmarking

Overview of progress on MIS year 8 safety action requirements



Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	2	1	3	1	0	7
B	0	1	3	1	0	5
C	0	0	5	1	0	6
D	0	0	2	0	0	2
E	0	0	2	0	1	3
F	0	1	2	1	0	4
Local work	0	0	0	0	0	0
National	0	0	0	0	0	0
Total	2	3	17	4	1	

Summary

- Reporting period: April–November 2026 | Compliance declaration due: March 2027
 - A-Workforce and Capacity
 - B- Training
 - C- Learning from reviews and investigations
 - D- Service user voice and equity
 - E – Care Bundles
 - F – Board Oversight Governance and Culture

The Trust has undertaken an initial benchmarking review against the newly published Maternity Incentive Scheme (MIS) Year 8 standards (March 2026), providing an early assessment of progress across all six safety action domains.

Overall, the current position demonstrates that the majority of sub-actions (17 of 27) are in progress and on track, with a smaller proportion achieving meeting compliance (4) or being fully embedded (1). A limited number of areas have been identified as , requiring targeted mitigation to support full delivery ahead of the March 2027 declaration.

These include:

- Strengthening workforce capacity and compliance evidence, particularly in relation to consultant presence and anaesthetic workforce cover
- Recovery and assurance of training delivery, notably neonatal resuscitation following disruption due to operational pressures
- Development of formalised governance and reporting frameworks, including a refreshed Perinatal Culture Improvement Plan with regular Board oversight
- Progressing equity, voice, and service user engagement to align with emerging reporting requirements
- Advancing collaborative care bundle implementation plans with ICB support and associated generation of action plans
- Addressing data quality and definitional clarity challenges impacting benchmarking reliability in some domains

Actions to address these risks are in place or in development, with a clear trajectory towards compliance. Delivery during the remainder of the reporting period will focus on converting actions currently “in progress” to sustained compliance and embedding improvements within routine practice.

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

The RUH, where you matter

Workforce Summary

Summary of performance across the breakthrough objectives and key standards

The Trust's workforce position continues to present a degree of risk, with ongoing challenges in sickness absence and appraisal compliance constraining productivity, staff wellbeing, and overall organisational resilience.

Notwithstanding these pressures, vacancy levels remain low. This reflects the success of targeted recruitment campaigns, particularly within the Emergency Department and across Trust-wide Healthcare Support Worker roles. The Care Organisation continues to demonstrate strong attraction, supported by sustained low levels of turnover.

Work is in progress to develop a more focused, longer-term **People Strategy**, which will support delivery of the Trust's strategic priorities across quality, finance, operational performance, and group readiness.

Sickness Absence

Sickness absence remains structurally elevated; however, March 2026 saw a further reduction, with the rate decreasing to **5.62%**, representing a consecutive improvement. This reduction was primarily driven by a decline in seasonal illness, with cold, cough, and flu-related absence resulting in **440 fewer WTE days lost** compared to February. A key priority for 2026/27 will be the delivery of the **Healthier Workforce Programme**, identified as a breakthrough objective. Its purpose is to provide a clear and structured approach to improving the physical, mental, and emotional wellbeing of staff, thereby enabling a healthier, more resilient workforce and supporting the delivery of high-quality patient care.

Appraisal

Appraisal compliance has shown some improvement, with notable progress within Surgery. However, overall compliance has plateaued below the 90% target and lacks a sustained trajectory of improvement.

Without strengthened prioritisation, clearer accountability, and consistent leadership focus, current levels of appraisal compliance risk undermining broader workforce objectives, including efforts to reduce sickness absence, enhance staff engagement, and improve long-term workforce sustainability.

BSW Group Vision

Strategic Goal	Measure Group	Measure	Measure Category	Latest Survey	Latest Performance	Trend
People we work with	Employee Experience	% Recommend Trust as place to work (National)	Group Vision	2025	60.4%	
People we work with	Employee Experience	% Recommend Trust as place to work (Pulse)	Watch	26-27 Q1	50.1%	

BSW Group Breakthrough Objective

Strategic Goal	Measure Group	Measure	Measure Category	Latest Survey/ NOF Release	NOF Based on	Latest Performance	Trend
People we work with	NHS Oversight Framework	NOF: People and Workforce Domain Segment	Group Breakthrough	Q3 2025/26		2	
People we work with	NHS Oversight Framework	NOF: Staff Engagement (National)	Context	Q3 2025/26	2024	6.92	
People we work with	NHS Oversight Framework	NOF Metric Score: NHS Staff Survey Engagement Theme	Context	Q3 2025/26	2024	2.26	
People we work with	NHS Oversight Framework	NOF Rank: NHS Staff Survey Engagement Theme	Context	Q3 2025/26	2024	57	
People we work with	NHS Oversight Framework	NOF: Sickness Absence Rate (Rolling 3 Months)	Context	Q3 2025/26	Q2 2025/26	5.20%	
People we work with	NHS Oversight Framework	NOF Metric Score: Sickness Absence Rate	Context	Q3 2025/26	Q2 2025/26	2.44	
People we work with	NHS Oversight Framework	NOF Metric Rank: Sickness Absence Rate	Context	Q3 2025/26	Q2 2025/26	80	

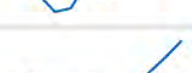
RUH Breakthrough Objective

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	12 Month Sickness	RUH Breakthrough	Mar-26	5.50%		<=4.70%		16			Special Cause Concerning - Run Above Mean
People we work with	Sickness Absence	In Month Sickness	Key Standard	Mar-26	5.62%		<=4.65%		10			Special Cause Concerning - Run Above Mean
People we work with	Sickness Absence	Short Term Sickness	Context	Mar-26	2.84%		N/A					
People we work with	Sickness Absence	Long Term Sickness	Context	Mar-26	2.78%		N/A					
People we work with	Sickness Absence	In Month ASD Sickness	Driver	Mar-26	1.65%		TBC					Special Cause Concerning - Run Above Mean

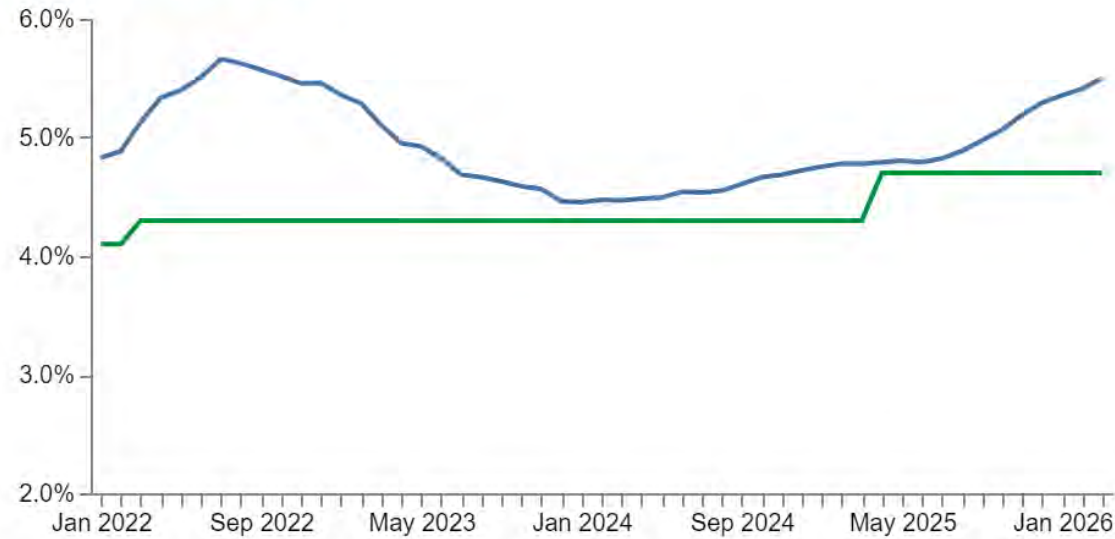
RUH Workforce KPI Summary

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	Apr-26	5787.8		<=5725.7		Pre-25/26			Common Cause
People we work with	Workforce Plan	Substantive WTE	Context	Apr-26	5490.8		<=5472.3		11			Common Cause
People we work with	Workforce Plan	Bank WTE	Context	Apr-26	283.7		<=245.8		Pre-25/26			Special Cause Improving - Run Below Mean
People we work with	Workforce Plan	Agency WTE	Context	Apr-26	13.3		<=7.7		11			Common Cause

RUH Workforce KPI Summary (Cont.)

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 in our community	Pay	Pay Bill % on Agency	Key Standard	Apr-26	1.07%		<=2.50%		0			Common Cause
People we work with	Vacancy	Vacancy Rate	Key Standard	Apr-26	-1.51%		<=4.00%		0			SPC not appropriate
People we work with	Vacancy	Vacancy WTE	Context	Apr-26	-83.3		N/A					
People we work with	Vacancy	Budget WTE	Context	Apr-26	5510.2		N/A					
People we work with	Vacancy	Contracted WTE	Context	Apr-26	5593.6		N/A					
People we work with	Turnover & Leavers	In Month Turnover	Key Standard	Apr-26	0.49%		<=0.92%		0			Special Cause Improving - Run Below Mean
People we work with	Turnover & Leavers	12 Month Turnover	Key Standard	Apr-26	7.06%		<=11.0%		0			Common Cause
People we work with	Turnover & Leavers	Leavers Inside 1st Year	Context	Apr-26	4.61		N/A					
People we work with	Appraisal	Appraisal Compliance	Key Standard	Apr-26	80.71%		>=90.0%		Pre-2021			Common Cause
People we work with	Appraisal	AfC Appraisal Compliance	Context	Apr-26	80.43%		>=90.0%		Pre-2021			Common Cause
People we work with	Appraisal	M&D Appraisal Compliance	Context	Apr-26	83.63%		>=90.0%		Pre-2021			Special Cause Improving - Two of Three High
People we work with	Training	Mandatory Training Compliance (Core)	Key Standard	Apr-26	89.71%		>=85.0%		0			Special Cause Improving - Above Upper Control Limit

Trust 12 Month Trend



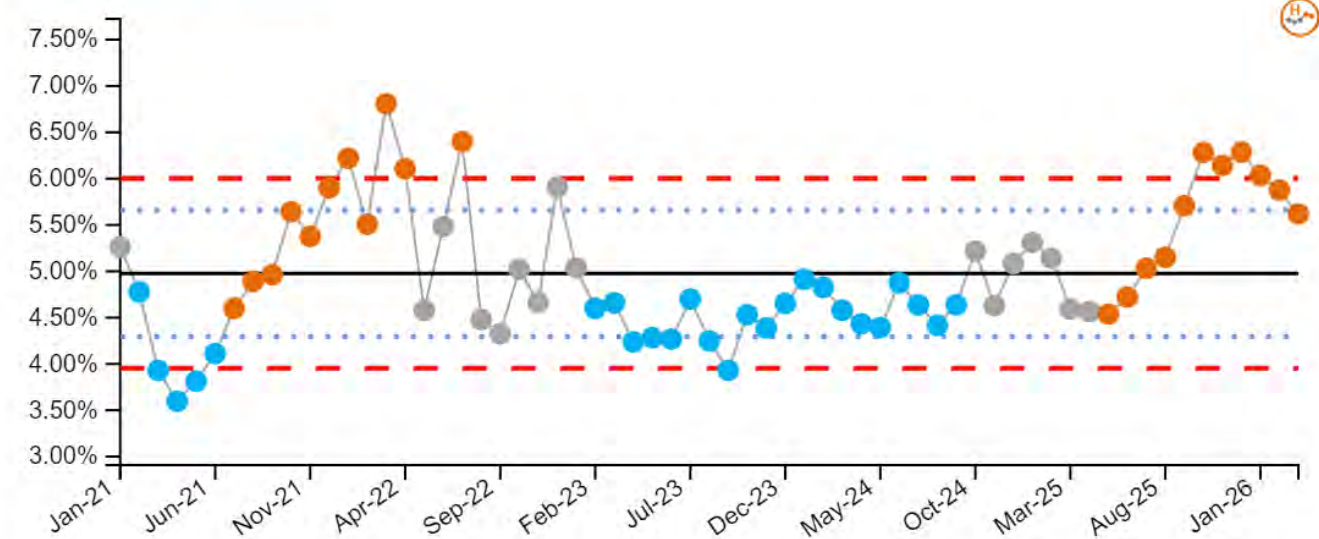
5.50%

Latest 12 Month Sickness

4.70%

Target

Trust In Month Trend



5.62%

Latest In Month Sickness

4.65%

Target

Understanding Performance

- March saw a third consecutive reduction in the in-month sickness rate to 5.62%, though this remains above last year's 4.59%, pushing the rolling 12-month rate up to 5.50%.
- Improvement was largely driven by reduced seasonal illness, with cold, cough and flu absence falling by 0.34pp to 0.58%, equating to c.440 fewer WTE days lost than in February.
- Anxiety, stress and depression accounted for 29.3% of all absence, the highest proportion since August 2024, with WTE days lost rising to 2,860.1, the highest since October 2025.
- Sickness levels were lower in Q4 than Q3, but both quarters were higher than Q2 which is the last reported for the National Oversight Framework. Thus, a reduced ranking and score over the next two reporting cycles is likely.

Countermeasures

- | |
|--|
| Trust Wide: MSK and Back Problem Sickness data review complete. Hot spot areas identified. |
| Surgery: Fishbone analysis completed of factors effecting sickness management. Linking in with other divisions to expand this to trust wide actions. |
| Medicine: Reviewed sickness during Easter holidays and notified managers of patterns of concern. Undertaking interviews with returners from long term sick and will implement learning. Additional HR resource provided to hot spot areas. |
| Trust wide: Scope opportunities to implement Team Engagement and Development tool (TED) to increase staff engagement in local team levels to contribute to increasing staff wellbeing. |

Owner

- | |
|-----------------------------------|
| People Partner |
| People Partner |
| People Partner |
| Head of leadership and Engagement |

Due Date

- | |
|----------|
| May 2026 |
| May 2026 |
| Ongoing |
| May 2026 |

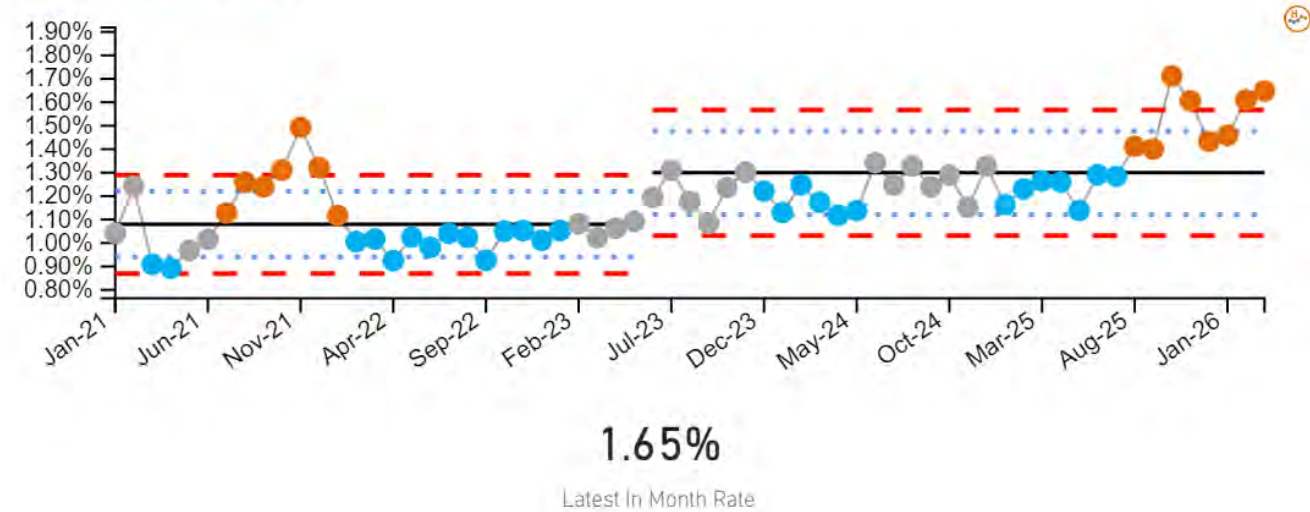
Risks and Mitigation

- Risk
- Insufficient progress in these core people measures limits the Trust's ability to intervene early, support staff effectively and sustain consistent performance.
- Mitigation
- Development of a programme of work to deliver the Healthier Workforce breakthrough objective for 2026/27

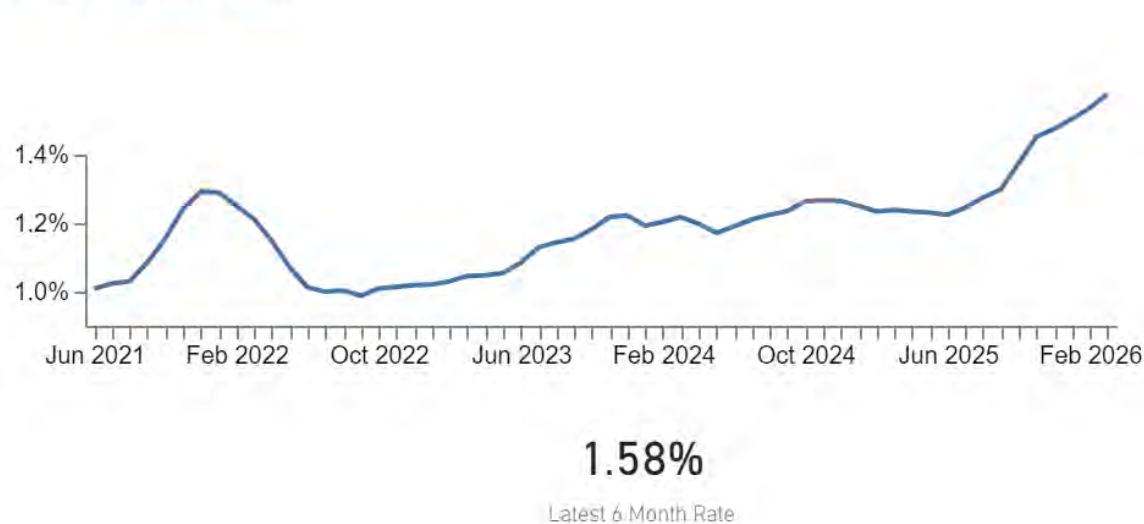
Anxiety, Stress and Depression Sickness

We are driving this metric because Compared to historical performance, the in-month Anxiety, Stress and Depression sickness rate has been unprecedently high in recent months and is a key driver of the high in month sickness rates overall. Successfully addressing this will be critical to the Trust realising its ambition of 4.8% for rolling 12-month sickness by March 27.

Trust In Month Rate



Trust 6 Month Trend



Understanding Performance

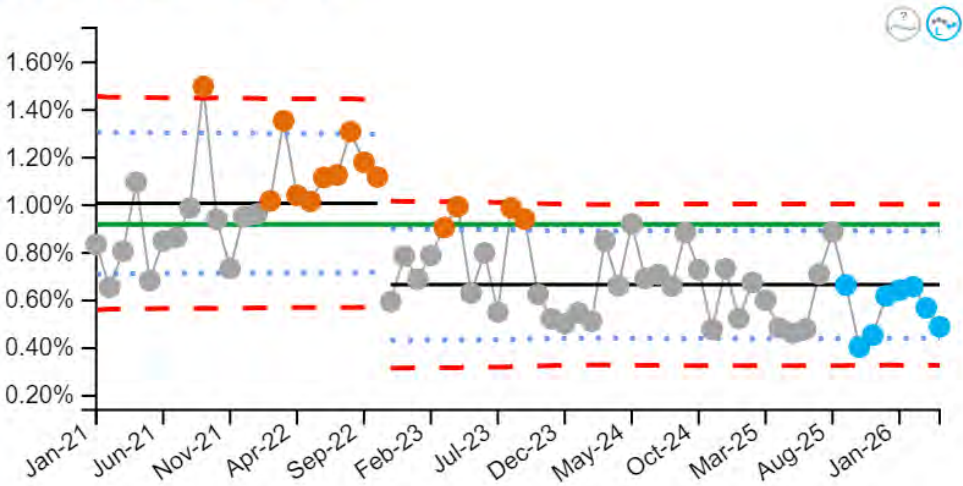
- The in-month sickness rate for anxiety, stress and depression increased by 0.04pp to 1.65%, extending the unprecedented run of rates above 1.40% to eight consecutive months.
- Estates and Facilities recorded the highest in-month rate across all divisions at 2.08%. The 325.2 WTE days lost in March represent their second-highest monthly total in the past two years.
- After exceeding 1.5% only once between January 2024 and January 2026, Surgery has now recorded two consecutive months above this threshold, with a month-on-month increase of 0.31pp to 1.91%.
- March's rate of 1.84% means that Medicine has recorded a rate above 1.7% for each month since August.
- Nursing and Midwifery Registered has the highest rate by staff group (2.14%), with Band 5 becoming more of a contributor in the last quarter.
- Admin and Clerical (1.94%) and Additional Clinical Services (1.78%) are the only other staff groups above 1.5%.

Countermeasures

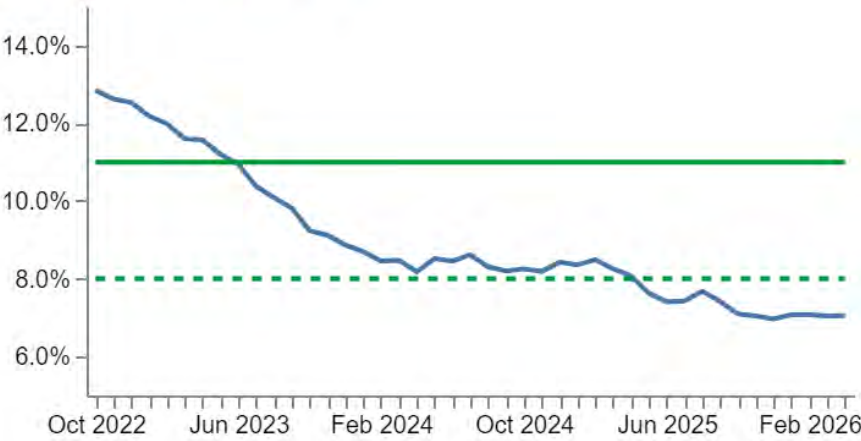
Countermeasures	Owner	Due Date
<i>Learning from group: New Head of Clinical Wellbeing in post. Sharing learning from across group.</i>	People Partner	June 2026
Trust Wide: Reviewing staff survey results and identifying countermeasures	Divisional Tri	June 2026
Health and Safety team: Continuing to review and identify hot spot areas and themes which are triangulated through the PP team.	H&S team/ People Partners	On going
Trust wide: Promote Perkbox and Wellbeing Hub comms plan to increase clarification and utilisation of wellbeing offer.	Culture Team	May 2026

Turnover

Trust In Month Turnover



Trust 12 Month Turnover



Division	In Month	12 Month
Capital Summary [Division]	3.38%	6.11%
Charity Summary [Division]	6.66%	13.69%
Corporate Division	0.36%	8.50%
Estates and Facilities Division	1.24%	8.39%
Family and Specialist Service Division	0.21%	7.85%
Medical Division	0.25%	5.40%
Research & Development [Division]	1.42%	8.87%
Surgical Division	0.84%	7.30%

Main Staff Group	In Month	12 Month
Add Prof Scientific and Technic	1.23%	12.37%
Additional Clinical Services	0.67%	9.58%
Administrative and Clerical	0.88%	10.11%
Allied Health Professionals	0.66%	6.48%
Estates and Ancillary	1.20%	8.95%
Healthcare Scientists	0.73%	11.90%
Medical and Dental	1.11%	4.15%
Nursing and Midwifery Registered	0.30%	3.76%

Understanding Performance

- In-month turnover was 0.49%. In isolation, this rate is within expectations. However, in combination with other points, it does trigger an SPC rule to indicate a shift down, with in-month rates above 0.7% becoming scarcer.
- 12-month turnover remains on a flat trajectory at 7.06%, with minimal variation since October.
- An argument exists that Turnover remains unhealthily low and may prove to be an obstacle to right-sizing the workforce organically, as well as affording opportunities for progression and career development to staff.

Countermeasures

- Surgery: slight increase in rolling 12 month turnover but still below Trust target. Reviewing turnover reasons through PRMs.
- FASS: Below Trust target. Reviewing turnover reasons through PRMs

Owner

- Divisional Tri
- Divisional Tri

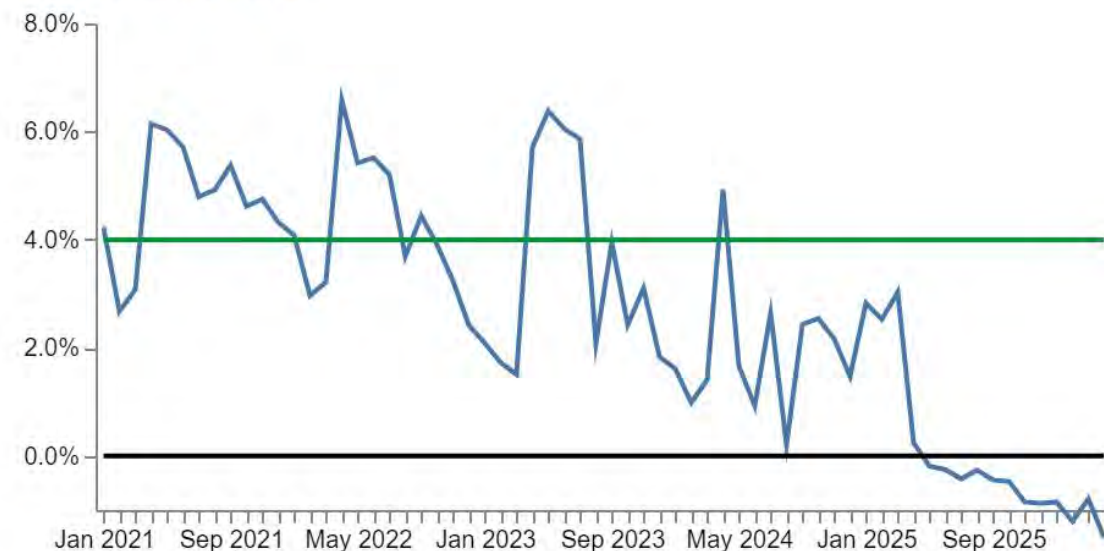
Due Date

- March 2027
- March 2027

Risks and Mitigation

Turnover continues to be low so no risks identified.

Trust Vacancy Rate



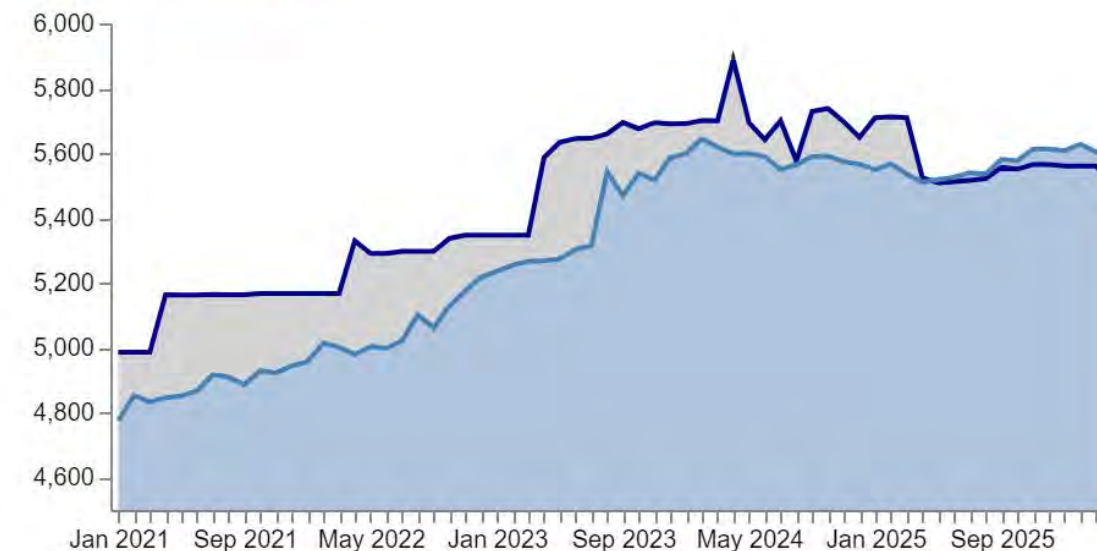
-1.51%

Latest Vacancy Rate

4.00%

Target

Budget v Contracted



5510.2

Latest Budget

5593.6

Latest Contracted

-83.3

Latest Vacancy

Understanding Performance

- With the reduction in budget for the new Financial Year outweighing the reduction in contracted WTE, Unit 4 data shows that the Trust is now over-established by 83.4 WTE (1.51%).
- Finance has, however, advised that budgets will be subject to further review and revision in month 2.
- At Divisional level, only Surgery (-1.13%; -16.1WTE) is over-established, with the overall Trust position shaped by -103.4 WTE of unidentified pay savings allocated to the Reserves.
- Corporate, FASS and Medicine all have vacancy rates below 1%, though this masks the variation at lower levels of analysis within these divisions.
- Estates and Facilities has the highest vacancy rate (4.37%). Almost half of the 22.9 WTE vacancy sits with Cleaning, though four other directorates have a vacancy of 3 WTE or more.
- The longer-term pattern with the bulk of the vacancy being associated with Clinical Support Workers Band 3 and Registered Nurses Band 5 continues.

Countermeasures

Trust wide: Vacancy control panels in place

Medical Establishment reviews: starting in surgery; Finance, HR and Medical staffing are starting to review establishments with the implementation of Health Rota. Once set up and initial areas complete plans are in place to roll this out across Trust.

Medicine: Emergency Department recruitment programme has closed vacancy gap to 1.7 WTE across the directorate, including appointment of Senior decision makers following business case approval in October 25.

Owner

Divisional Tri

Finance, HR and Medical staffing

Recruitment

Due Date

March 2027

March 2027

Complete

Risks and Mitigation

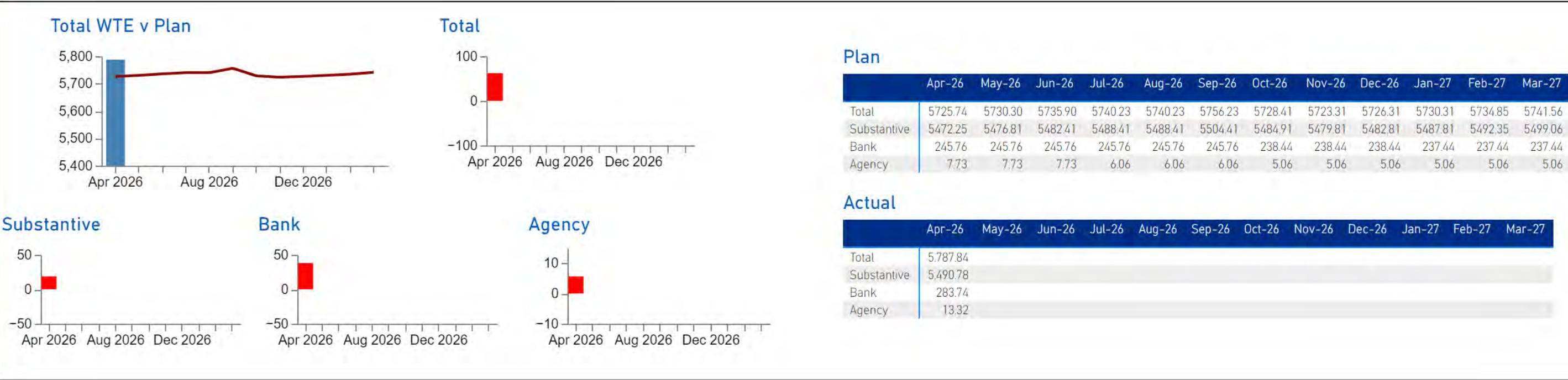
RECRUITMENT Estates – Cleaning campaign for 15 WTE closed in May – Interviews on 20/21 May to appoint so a provisional start date of July 2026.

RECRUITMENT HCSW for surgery campaign closed on 18 May with 600 applications – Interviews in late May – provisional start dates July/August 2026

RECRUITMENT B5 continuous campaigns running for B5 – good application rates and appointment rates.

Performance vs Workforce Plan

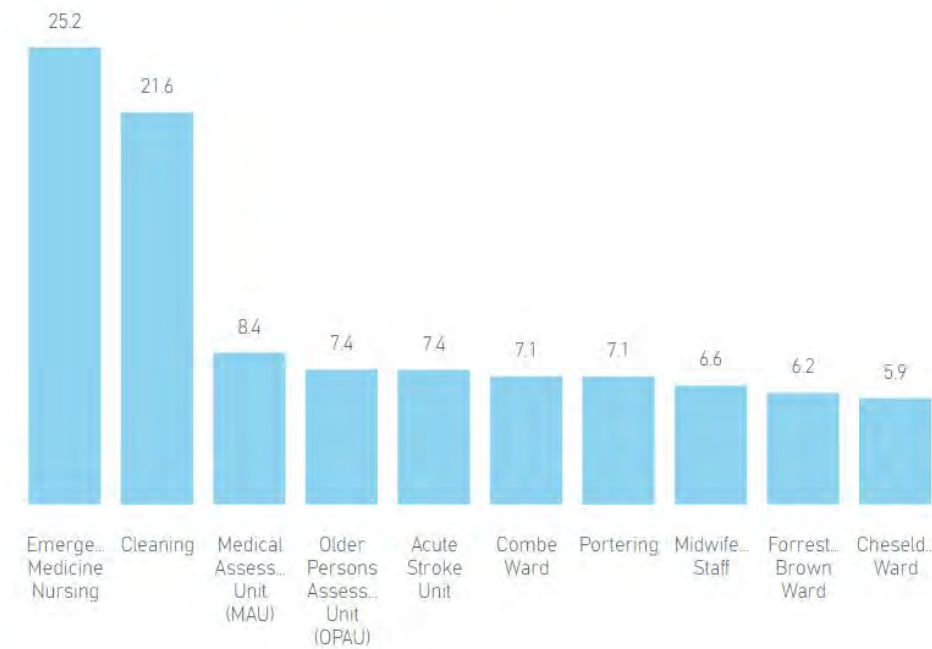
We are driving this metric because



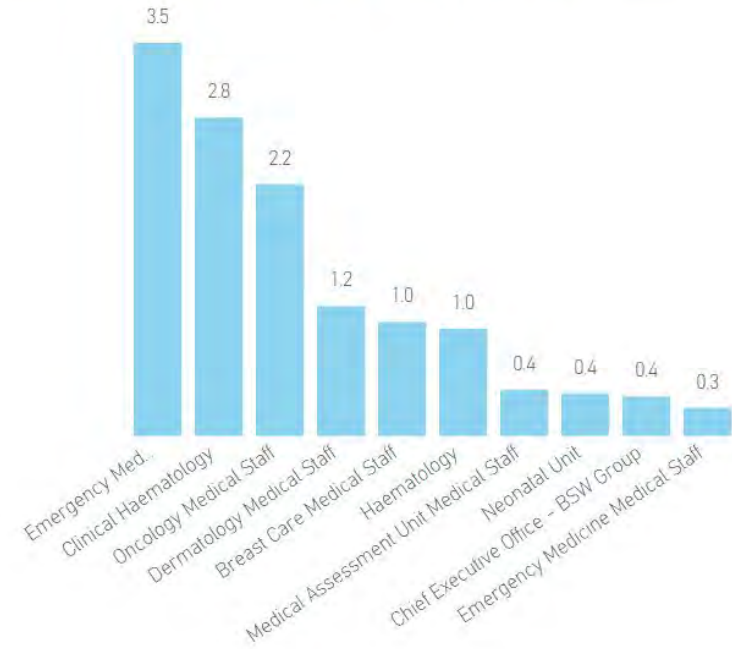
Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
• Total WTE usage exceeds plan by over 60 WTE, driven by temporary staffing utilisation. • April's bank usage (283.7 WTE) persists above the 270 WTE floor evident throughout the second half of 25/26, significantly exceeding the current target of 245.8 WTE. • Agency WTE has reduced from Q4 highs, but at 13.3 WTE remains 5.6 WTE above target. The current target, which is due to reduce over the financial year, was last bettered in June 2025. • Substantive WTE is marginally ahead of the in-month plan, but remains below the level required to meet the March 2027 target.	Each organisation has an opportunity to make any appropriate adjustments to plan that they were not aware of at the time of final submission. RUH will consider this.	Planning Team	June 2026	New business cases may increase workforce demand beyond what is mapped in the workforce plan – risking increased wte and performance compliance against plan. Robust linkage is required between growth in wte and the appropriate business case. This then allows for the appropriate narrative to support the growth and explain the activity or financial benefit to the wte growth.
	Cost improvement plans are being developed to ensure we have the workforce detail behind each plan.	Planning Team	June 2026	

Bank & Agency Use

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	20.4	7.7
Registered Nursing, Midwifery and Health Visiting Staff	96.5	3.9
Registered/ Qualified Scientific, Therapeutic and Technical staff	7.0	1.0
NHS Infrastructure support	13.5	0.4
Support to Clinical Staff	148.4	

Understanding Performance

- Emergency Medicine Nursing and Cleaning continue to be the top users of bank. Their respective usages (25.2 and 21.6 WTE) are reflective of natural variation that is broadly stable.
- Support to Clinical and Registered Nursing and Midwifery continue to be the prime areas for bank usage, with the rough ratio of 3:2 being a consistent recent trend.
- Agency use is predominantly for Medical and Dental in areas that are hard to recruit to. However, notably use is trending down month on month.

Countermeasures

- E&F- Cleaning and Portering remain high in month. Review and reduction of sickness absence is being prioritised to reduce Bank cover.
- Medicine – Emergency Department long line agency ended April 2025 following recruitment to nursing vacancies. Additional HR support assigned to reduce sickness rate and associated bank spend.
- Agency Medical Locums continue to support specialist areas within the Trust. Usage has decreased slightly into the new financial year.

Owner

- E&F Board / PP
- People Partner
- Staffing Solutions

Due Date

- August 2026
- July 2026
- September 2026

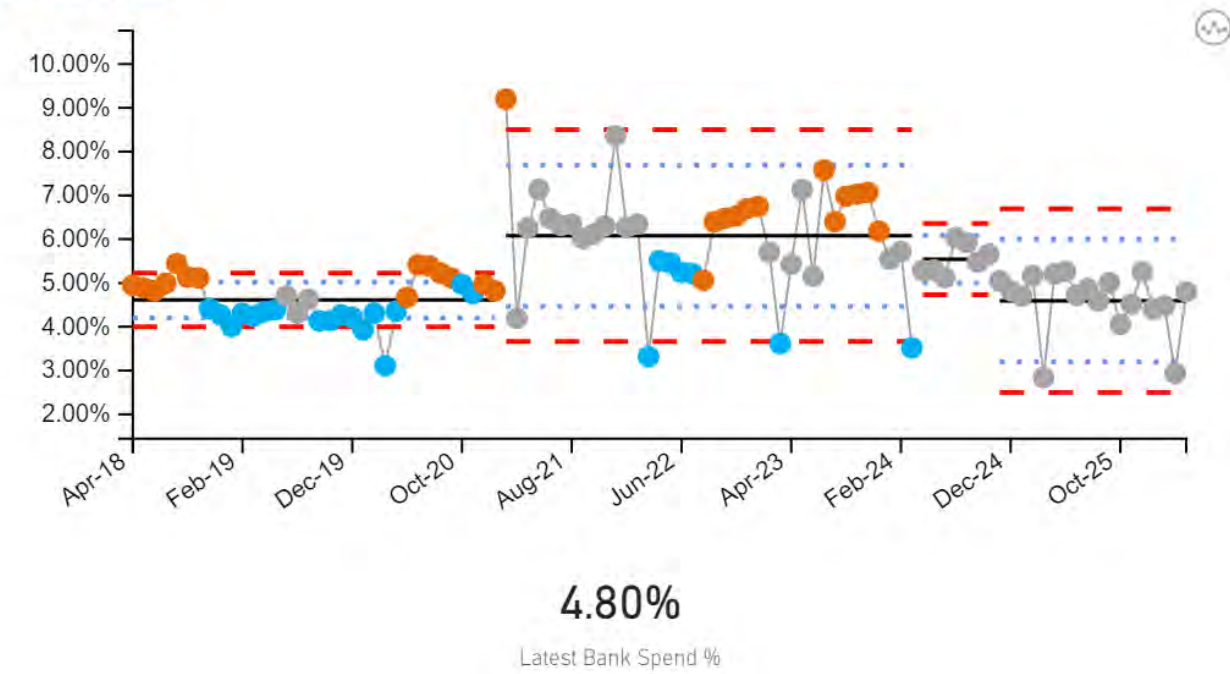
Risks and Mitigation

- Risk
 - There is a risk increased sickness absence will increase bank spend.
- Mitigation
 - Divisional and Trust VCARP controls. Targeted approach to health and wellbeing via the Healthier Workforce objective

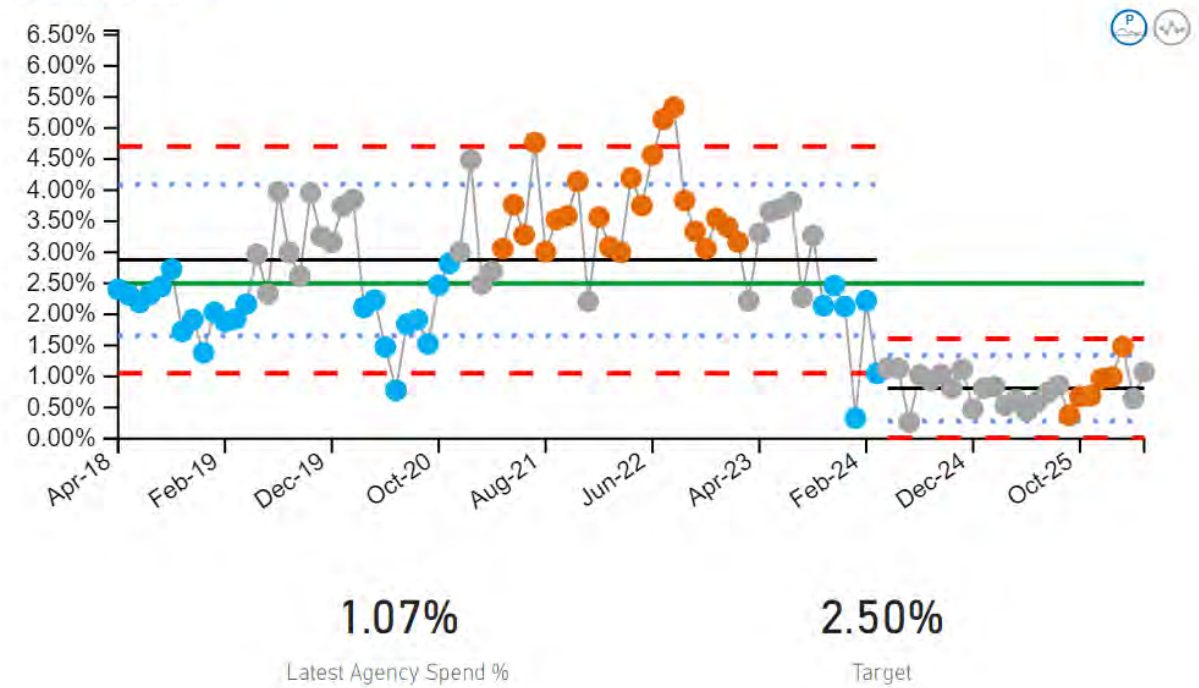
Temporary Staff Spend as % of Total Pay Bill

Key Standard

Bank Spend



Agency Spend

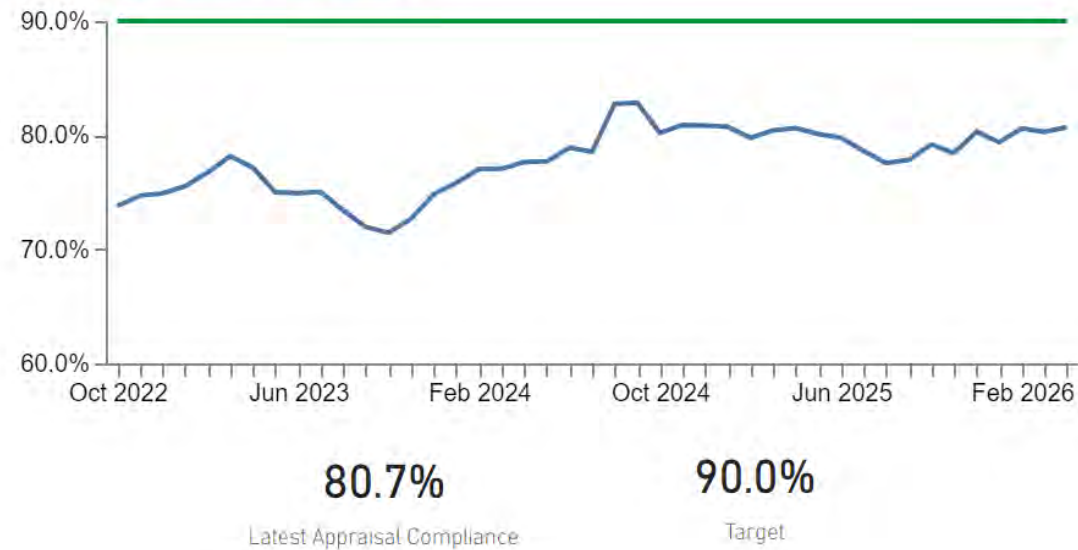


Understanding Performance
• Bank spend totalled £1.52m in April, representing 4.8% of the total pay bill. • Medicine Division accounted for £0.74m of bank spend, with Emergency Medicine Nursing and Medical Staff together contributing over £200k. Spend in the Division, however, is broad-based, with the top 15 departments all exceeding £20k, compared to five departments in Surgery (second highest divisional spend of £335k) • Agency spend was £339k (1.07% of pay bill), remaining below the targeted proportion. • Oncology Medical Staff and Clinical Haematology continue to be the main drivers of agency spend. Notably, Security and Car Parking agency costs increased significantly in April

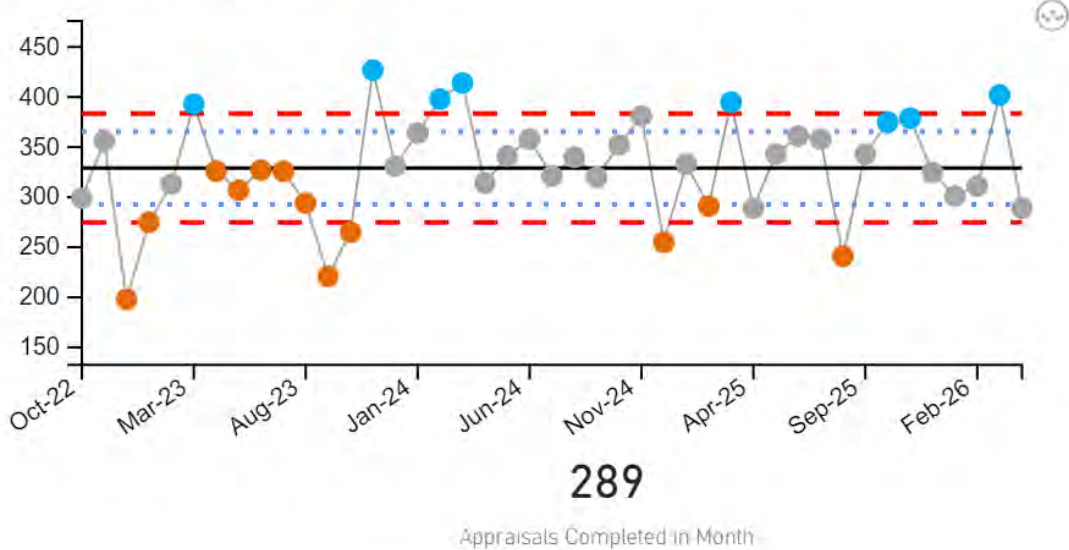
Countermeasures	Owner	Due Date
Emergency Department remain high users of bank staff due to the high demands on the service. Agency staff have been booked into the department on long lines of work until the new starters in the department have been on boarded by the recruitment team.	Staffing Solutions	July 2026
Cleaning requests for bank has reduced due to the recruitment of substantive staff into the team.	Staffing Solutions	May 2026
Agency Medical Locums continue to support specialist areas within the Trust. Usage has decreased slightly into the new financial year.	Staffing Solutions	

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



Appraisals Completed in Month



Understanding Performance

- Appraisal compliance is up 0.42pp on last month at 80.71%.
- Only R&D is achieving the 90% target at Divisional level.
- Surgery has experienced almost a 5pp improvement since January to achieve 86.3% compliance this month. Alongside Estates and Facilities, who saw a partial recovery to achieve 85.8% compliance, they are the only divisions within five percentage points of target.
- Medicine continues to be on a gradual upward trajectory, with compliance now at 83.3%.
- With only 20 appraisals completed in April, Corporate's compliance continues to fall and now stands at 59.4%. This represents a loss of almost 5 percentage across the past year.
- FASS are also down on last year, having dropped 3.55pp to 79.3%.

Countermeasures

Medicine: Appraisal managed through specialty PRM meetings and set as a driver for teams where performance is low. Divisional performance has increased to 83.3%, 5% increase since August 25.	Divisional Tri	September 2026
E&F- Appraisals has seen increase in month but still below compliance level. Appraisals continue to be priority at E&F Board.	E&F Board	Ongoing

Owner

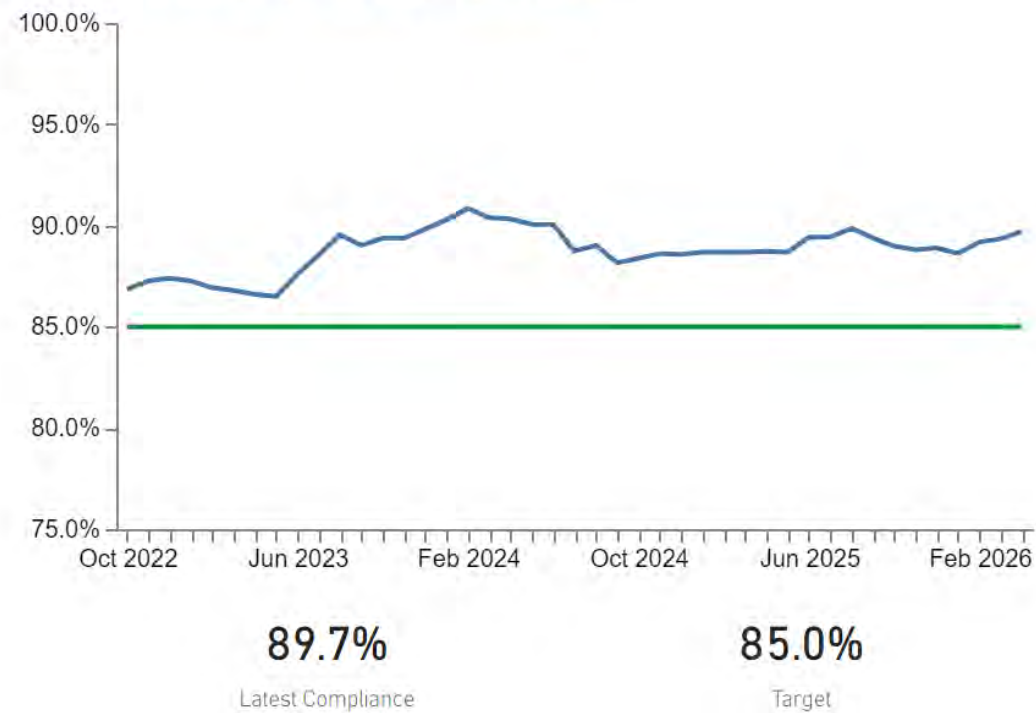
Due Date

Risks and Mitigation

- Risk
- low appraisal coverage may undermine efforts to address sickness absence and workforce sustainability.
- Mitigation
- Divisions continue to prioritise appraisals.

Mandatory Training

Mandatory Training (Core) Compliance



Understanding Performance
• Overall compliance continues on an upward trajectory, improving to 89.71%. • All Divisions are two percentage points or more above the 85% target • Resuscitation Newborn Basic Life Support has recovered to 92.7% after dropping below its 90% target last month • Resuscitation Adult Basic Life Support (76.5%) and Resuscitation Paediatric Basic Life Support (72.0%) both remain red against their 90% target but are slightly improved on last month. • Safeguarding Children Levels 2 and 3, Safeguarding Adults Level 3 and Moving and Handling Level 2 all remain amber against their respective targets, with all experiencing a slight deterioration in compliance.

Countermeasures	Owner	Due Date
Mandatory learning Oversight Group reviewing statutory / mandatory and essential for role TNA and frequencies. Group approach moving forward	Head of Education	September 26

Risks and Mitigation
Risk- Oliver McGowan Training temporarily paused by external provider. Mitigation- Resolution being worked through which should see training return around July 26. OMMT Group approach moved from proposal to full business case

Part 3 | People In Our Community

Deliver a sustainable financial position

Equity of access to
RUH for all

Carbon emission reduction

The RUH, where you matter

Financial Performance

May 2026
(April 2026 data)

The RUH, where you matter



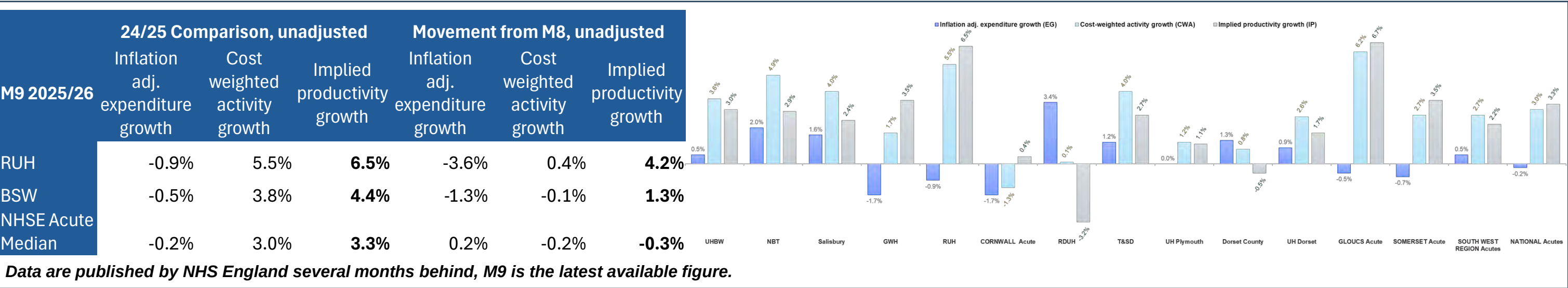
Executive Summary



Productivity	– Latest December data showed 3.7% improvement year on year, 2nd quartile nationally
Savings Plan	– 96% of plans identified, of which 37% are assessed as Green in delivery or fully developed
Risks (Downsides) and Mitigations (Upsides) to Plan	– Net unmitigated risk of £22.6m, with £6.2m consequences for lost transitional funding and revenue PDC charges
Variance to Plan YTD [Risk 3165 – Score 20]	- £1.3m adverse to plan, driven by £0.3m Industrial Action, £0.2m structural issues, £0.5m Savings shortfall and £0.1m Sulis
Key Drivers and Assumptions	- demand in excess of plan in all domains, notably Non Elective 10.9% compared to 2.4% planed growth; NCTR 89 and Sickness 5.5%
Commissioning Income	- Elective income £0.1m ahead of plan; UEC £0.8m ahead of pan with 20% marginal payment = £0.2m
Pay	- WTE in line with run rate; Pay £1.1m adverse to budget caused by £0.3m Industrial Action and £0.7m Savings
Non Pay	- £0.5m adverse to plan
Sulis	- £0.1m adverse to plan caused by self pay income and overhead costs
Underlying Financial Position	- Planned Underlying position of £12.6m, after £37.6m Savings. Includes Underfunded Block of £28.1m and NCC Index of 98
Capital [Risk 3288 – Score 16]	- £0.4m EPR underspend YTD, re-forecast underway aligned to 1+2 Option
	Board approval for £12m UTC scheme and proceeding at risk pending NHSE National approval
Cash [Risk 3289 – Score 20]	– £12.1m closing balance. Reduction of £11.1m in the month. Ahead of base case forecast but below £19m sustainable cash levels.
	Growing Inter-Group debtors with Sulis and BSW Hospitals Groups
BSW Hospitals Group	- £3.1m adverse to plan, with GWH £1.8m and RUH £1.3m and SFT on plan

Year to date % change in productivity compared to previous year

We are driving this metric because...	Productivity, measured as changes in real-terms costs compared to activity has deteriorated since 2019/20 pre-pandemic. NHSE has committed to improving Productivity has part of funding settlement with Central Government. NHSE have developed a metric ‘Change in Implied Productivity’ that enables benchmarking against other NHS organisations. This metrics informs the National Oversight Framework score
Performance Target: Improve Implied Productivity by 6.7% compared to 24/25	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.



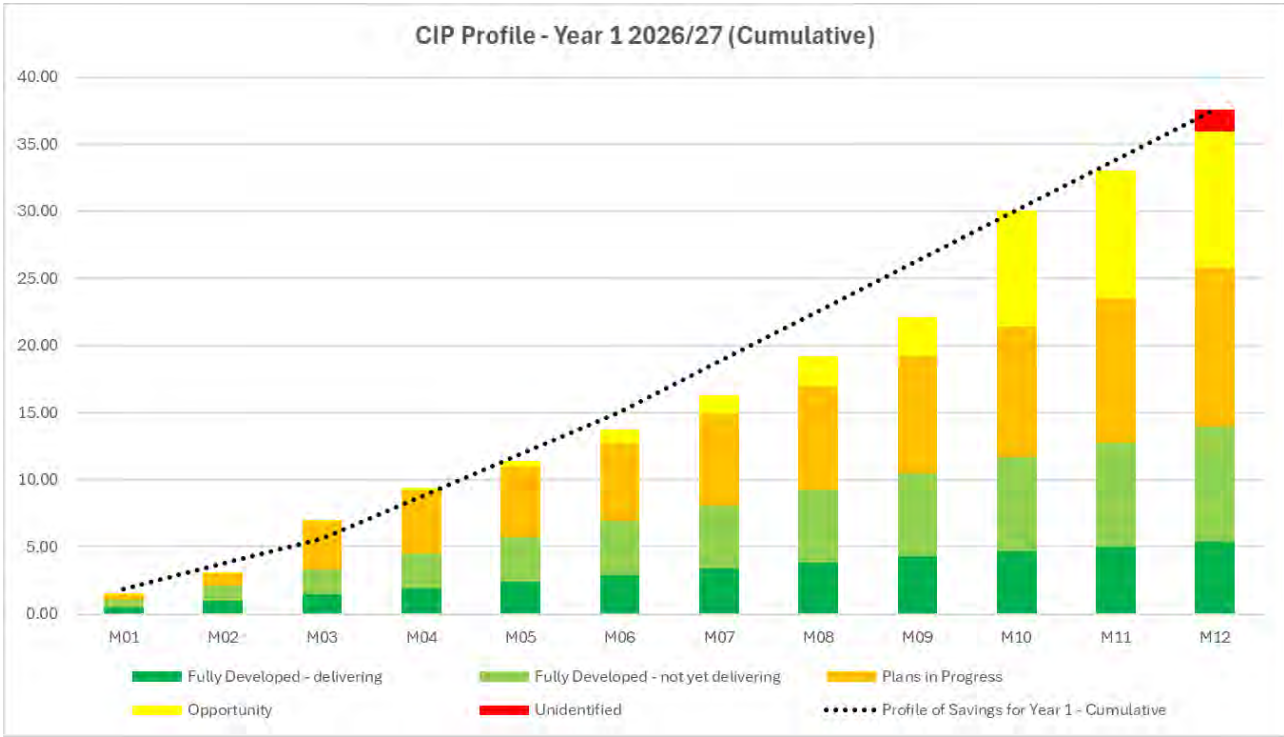
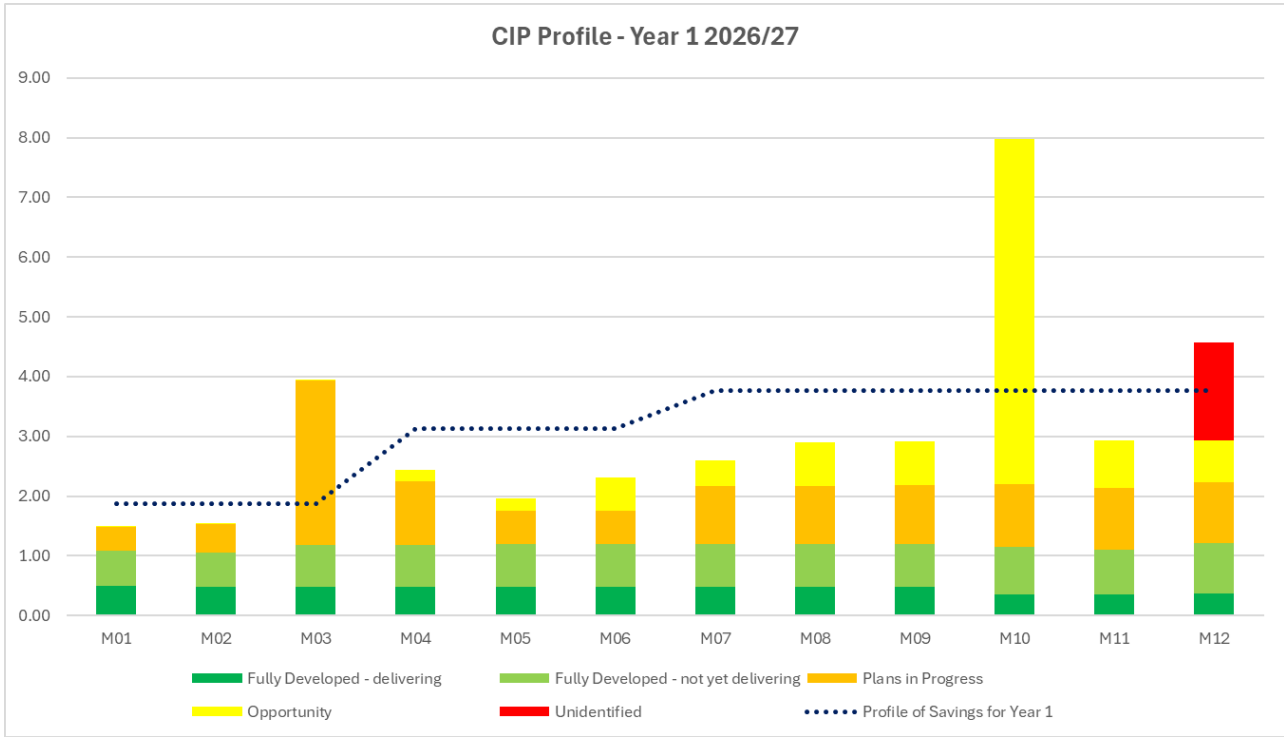
Data are published by NHS England several months behind, M9 is the latest available figure.

Understanding Performance	Countermeasures	Owner	Due Date	Update	Risks and Mitigation
Data for December 2025 show an implied year to date productivity growth of 6.5% compared to M9 24/25. , this ranks as the second largest productivity increase in the South-West Region (of 13 providers) and ranks 15/134 for national acute Trusts.	Delivery of £37.6m Savings target set out in Operational Plan for 26/27	Managing Director	Ongoing	See Savings and I&E Report	- 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
Local validation has identified some mis-codings related to financial year 24/25; mostly relating to inter-group balances between RUH and Sulis. Our amended analysis suggests: Real-terms cost increase of 1.8%, and therefore, Implied Productivity improvement of 3.7% Although lower than published figure: Better than national average and better than SW average. Would put RUH in 2nd Quartile nationally and inside top 50 trusts in the country	Develop metric to be based on real-time data Develop metric to be calculated at Division level	Head of Financial Projects	July 26	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.	

Breakthrough Objective

Savings Delivery Against Plan

Breakthrough Objective



Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
As at 20 May Opportunities for 96% of the £37.6m have been identified Of which, 37% (£14m) have been assessed as GREEN in delivering or fully developed. Risk assessed delivery is £20.27m leaving £17.32m unmitigated risk. A path to Q1 delivery of 15% has been identified, including Sales and Leaseback. This plan has a £710k shortfall at end of May, which is forecast o recover to June	Get to Green high priority list	FIPB	30 June	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. New governance structure and greater devolved ownership to support delivery.
	Sale and Leaseback scheme	Commercial Board	30 June	
	Communication of Savings plans and roll out via FIRMs and Commercial Board.	FIPB	30 June	
	Confirmation of Group led initiatives, system led initiatives and Care Org led initiatives; standardised approach across Group	Finance	30 June	

Savings Delivery Against Plan

Breakthrough Objective

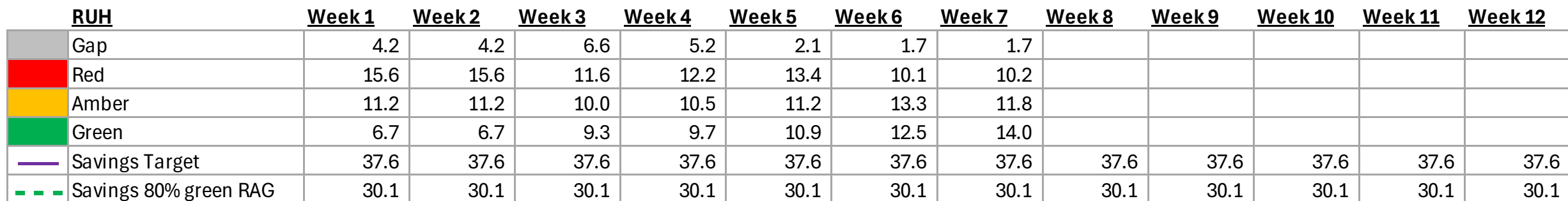
Row Labels	Fully Developed - delivering	Fully Developed - not yet delivering	Plans in Progress	Opportunity	Unidentified	Grand Total
Y	5.39	8.58	11.84	10.15	1.65	37.60
Sulis and Divisions	5.39	8.52	9.01	4.30	-0.11	27.10
Productivity & Invest to Save	0.80	3.39	2.27	2.78		9.23
Divisional & E&F run rate reductions	1.23	2.59	5.01	1.37		10.19
Workforce - Rostering , sickness, pay reward & recruitment	2.00	0.00	0.92	0.00		2.92
Digital			0.12	0.00		0.12
Corporate Services Redesign	0.22	1.55		0.15		1.92
Core - Sulis		0.89				0.89
High Cost Drugs & Devices	1.13	0.10	0.40	0.00		1.63
Income Capture			0.30			0.30
Gap to Close					-0.11	-0.11
Commercial Group		0.06	2.83	5.85	1.76	10.50
Commercial Group		0.06	2.83	5.85		8.74
Gap to Close					1.76	1.76
N	4.49	0.24	1.13			5.86
CDC			1.13			1.13
Income Capture			0.00			0.00
UTC		0.24				0.24
Budget Setting	4.49					4.49
Grand Total	9.88	8.82	12.96	10.15	1.65	43.46
Savings Maturity	100%	75%	50%	25%	0%	
Risk-adjusted Savings	5.39	6.43	5.92	2.54	0.00	20.27
Unmitigated Risk						-17.32
GREEN Savings	13.96					
% GREEN	37%					
Identified Savings	96%					
Unidentified Savings	4%					

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.

New governance structure and greater devolved ownership to support delivery.



Our Financial Breakthrough – Why It Matters

💰 The scale

- We spend £587m annually
- Need to save £55m over 3 years
- £37.6m required THIS year

⚠️ Key pressures

- £20.5m current deficit to recover
- Savings targets not fully delivered
- Pace of additional funding (ICBs)
- National 2% productivity requirement
- Ongoing recovery from pandemic losses
- Rising costs (inflation, CNST)

🔄 Strategic commitments

- Shift care from hospital → community
- Invest in future transformation
 - £140m estates
 - £50m digital (EPR)

✅ Why it matters

- Stay in control (avoid regulator intervention)
- Maintain cashflow
- Enable future investment

Our Financial Breakthrough – How we will deliver £37.6m

Delivery as an Integrated Care System	Demand Management		
	Reduce overall demand to c.2% per annum in line with funding growth		
	£13.7m Clinical Services Productivity and Transformation	£13.4m Cost Efficiency and Waste Reduction	£10.5m Commercial Strategy
	Delivery as a Group - Clinical Transformation Programme - Digital Enablers including EPR	Delivery as a Group - Corporate Services Redesign - Procurement	- External Income - Private Patients - R&D - Commercial Partnerships - Making the most of our Estate - Treasury Management
	Delivery as a Care Organisation - Sustainable service models – reduce insourcing/outourcing - Clinical Services Transformation – best value healthcare; provide more services in the community - Profits from Sulis - Maximising productivity of new investments – SOC, CDC, SDEC & Medical Short Stay, Discharge Lounge, Side Rooms, Urgent Treatment Centre, Medical equipment	Delivery as a Care Organisation - Workforce efficiency – sickness, rostering, skill-mix - Non Pay – discretionary spend, procurement and contract management - Digital solutions including AI, Paperless Inpatients	
Division level with support from small Turnaround and Programme Management Resource			Commercial Board

Savings Delivery Against Plan

Breakthrough Objective

Sum of Y1 26/27		Column Labels 				
Row Labels		Organisation	Requires System			Grand Total
		control	Group control	support	Unidentified (blank)	
 Y		13.33	7.10	15.51	1.65	37.60
 Sulis and Divisions		11.86	6.84	8.51	-0.11	27.10
 Operational Productivity		1.85		4.23	-0.11	5.97
 Bed Rationalisation				2.65		2.65
 Workforce Efficiencies		2.92				2.92
 Service Transformation			2.54			2.54
 Transactional Savings		7.08	4.30	1.63		13.01
 (blank)						
 Commercial Group		1.48	0.26	7.00	1.76	10.50
 Transactional Savings		1.48	0.26	7.00	1.76	10.50
 N		4.86		1.00		5.86
 (blank)					0.00	0.00
Grand Total		18.20	7.10	16.51	1.65	43.46

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	41.600	42.000	0.399	2.406	2.696	0.290	0.000	0.000	0.000	44.006	44.696	0.690
Clinical Education Income	1.622	1.626	0.003	0.000	0.000	0.000	0.000	0.000	0.000	1.622	1.626	0.003
Other Income	4.005	4.164	0.158	1.279	1.630	0.351	(0.399)	(0.124)	0.275	4.886	5.669	0.784
Pay	(30.951)	(32.026)	(1.075)	(2.107)	(2.379)	(0.272)	0.000	0.000	0.000	(33.058)	(34.405)	(1.347)
Non Pay	(14.887)	(15.374)	(0.487)	(1.474)	(1.977)	(0.503)	0.186	(0.088)	(0.274)	(16.175)	(17.439)	(1.264)
EBITDA	1.390	0.389	(1.000)	0.105	(0.030)	(0.135)	(0.213)	(0.212)	0.001	1.282	0.147	(1.134)
Depreciation & Amortisation	(1.972)	(1.972)	0.000	(0.241)	(0.302)	(0.061)	0.148	0.152	0.004	(2.066)	(2.123)	(0.057)
Impairments	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Net Finance Charges	(0.892)	(0.650)	0.242	(0.108)	(0.046)	0.063	0.013	0.023	0.010	(0.988)	(0.672)	0.315
Surplus/(Deficit)	(1.475)	(2.233)	(0.758)	(0.244)	(0.378)	(0.134)	(0.053)	(0.037)	0.015	(1.772)	(2.648)	(0.876)
Donated/Grant Income	(0.161)	0.239	0.401	0.000	0.000	0.000	0.000	0.000	0.000	(0.161)	0.239	0.401
Adjusted Financial Performance	(1.313)	(2.472)	(1.159)	(0.244)	(0.378)	(0.134)	(0.053)	(0.037)	0.015	(1.610)	(2.887)	(1.277)

The RUH submitted a balanced plan for 2026/27. This included £37.6m of savings with a profile of 15% delivered in Q1. To deliver a balanced plan the Trust is receiving £8.4m of Deficit Support funding in the form of ICB Transitional Funding. The Trust is also required to deliver £4.2m 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

Understanding Performance
The RUH is £1.16m. This is resulting from delays to delivery against the savings programme (£0.5m), industrial action costs (£0.3m), other pay costs (£0.2m) and funding challenges including CNST, CDC and High Cost Drugs growth (£0.2m). Sulis is adverse to plan by £0.1m. Self Pay below plan ad overheads over against budget

Countermeasures	Owner	Due Date
On-going: Acceleration of our saving plans that have been scoped with 80% of savings to have a plan by the of June	Trust Management Executive	On-going
Delivery of activity based income and productivity margin on RTT Investment	Divisional Tris	On-going

Budget – by Division

Budget by Division	In Month			
	RUH			
	Budget	Actual	Variance	Variance
	£'m	£'m	£'m	%
Commissioning Income	41.600	42.000	0.400	
Clinical Education Income	1.622	1.626	0.003	
Surgery	(11.533)	(11.257)	0.276	2.4%
Medicine	(11.891)	(12.180)	(0.289)	-2.4%
FASS	(11.091)	(11.635)	(0.544)	-4.9%
E&F	(2.988)	(3.049)	(0.061)	-2.0%
Corporate	(5.977)	(6.567)	(0.590)	-9.9%
HIWE	(0.007)	(0.007)	(0.000)	
R&D	(0.000)	0.000	0.000	
Unallocated Savings	0.575	0.000	(0.575)	
Reserves	0.724	0.630	(0.094)	
Finance Charges	(2.348)	(2.033)	0.314	
Adjusted Financial Performance - RUH	(1.313)	(2.472)	(1.159)	
Sulis	(0.244)	(0.378)	(0.134)	
Inter Group	(0.053)	(0.037)	0.015	
Adjusted Financial Performance - Group	(1.610)	(2.887)	(1.277)	
Impairment	0.000	0.000	0.000	
Donated/Grant Income	(0.161)	0.239	0.401	
Unadjusted Financial Performance	(1.771)	(2.648)	(0.877)	

Understanding Performance

This table shows the spend against current budgets. Note that annual savings target **have** now been devolved to Divisional budgets. However Commissioning Income , including high cost drugs has not yet been devolved, this is anticipated from Month 2 onwards.

Countermeasures	Owner	Due Date

2026/27 Business Plan Scorecard

Performance against trajectory (in year)				
Domain	Metric	26/27 NHSE Instruction	Current Month Trajectory	Apr-26
UEC	ED Attendance Growth	Per planning assumption	1.8%	5.8%
	NEL Admisison Growth	Per planning assumption	2.4%	10.9%
	Eliminating Corridor Care	0> 45mins by Nov '26	Trajectory	556 (15%)
	4-hour ED performance (type 1)	66.9% by Mar '27	58.7%	61.0%
	4-hour ED performance (all types)	82% by Mar '27	69.1%	71.1%
	12-hour ED performance	96.1%	Trajectory	92.0%
	Ambulance handover	Reduce toward 15 mins	33 mins	33.1 mins
Elective & Diagnostic	GP Referral Growth	Per planning assumption	0.00%	10.9%
	18w RTT Performance	74.7% for RUH	68.3%	70.3%
	52 Week Waiters	Reduction towards zero	331	183
	52 Week Waiters %	Improvement on 1%	0.9%	0.5%
	DM01	13.1% for RUH	14.6%	14.7%
Cancer	28 day FDS	80% annual ave	80.2%	80.7%
	31 day	94%	93.7%	95.0%
	62 day RTT	80%	75.3%	68.6%
Workforce	30% Reduction in agency use	30% improvement from M06	Trajectory	13.3 WTE
	10% reduction in bank spend	10% reduction from M06	Trajectory	283.7 WTE
	Sickness rate (rolling 12 month average)	Improvement	Trajectory	5.5%
Finance	2% productivity improvement	(min 2% improvement)	6.7%	6.5%
	Savings Plan	37.6m (£56.6m over 3 yrs)	1,883	1,400
	Balanced or surplus financial position	Balance or surplus	-1,610	-2,886
Discharge	Non Criteria to Reside (NC2R)	Number of NC2R	86	89
	Pathway 0 - Home	% within 24 hours		94.0%
	Pathway 1 - Home with support	% within 48 hours		50%
	Pathway 2 - Community setting	% within 48 hours		15%
	Pathway 3 - Residential care	% within 7 days		60%

RUH Commissioning Income

Funding Type	Plan £m	Actual £m	Gross Variance £m	Marginal Rate	Marginal Performance £m
Elective Variable	10.500	10.643	0.143	100%	0.143
Wider Variable	1.307	1.371	0.064	100%	0.064
Radiotherapy	0.282	0.266	(0.016)	50%	(0.008)
Urgent & Emergency Care	17.189	18.011	0.822	20%	0.164
Fixed	6.648	7.933	1.285	0%	0.000
Transitional & Depn Funding	0.913	0.913	0.000	100%	0.000
Other Commissioning Income	0.077	0.066	(0.012)	100%	(0.012)
Subtotal	36.916	39.202	2.286		0.352
High Cost Drugs & Devices	4.684	4.731	0.047	100%	0.047
Total Commissioning Income	41.600	43.933	2.333		0.399

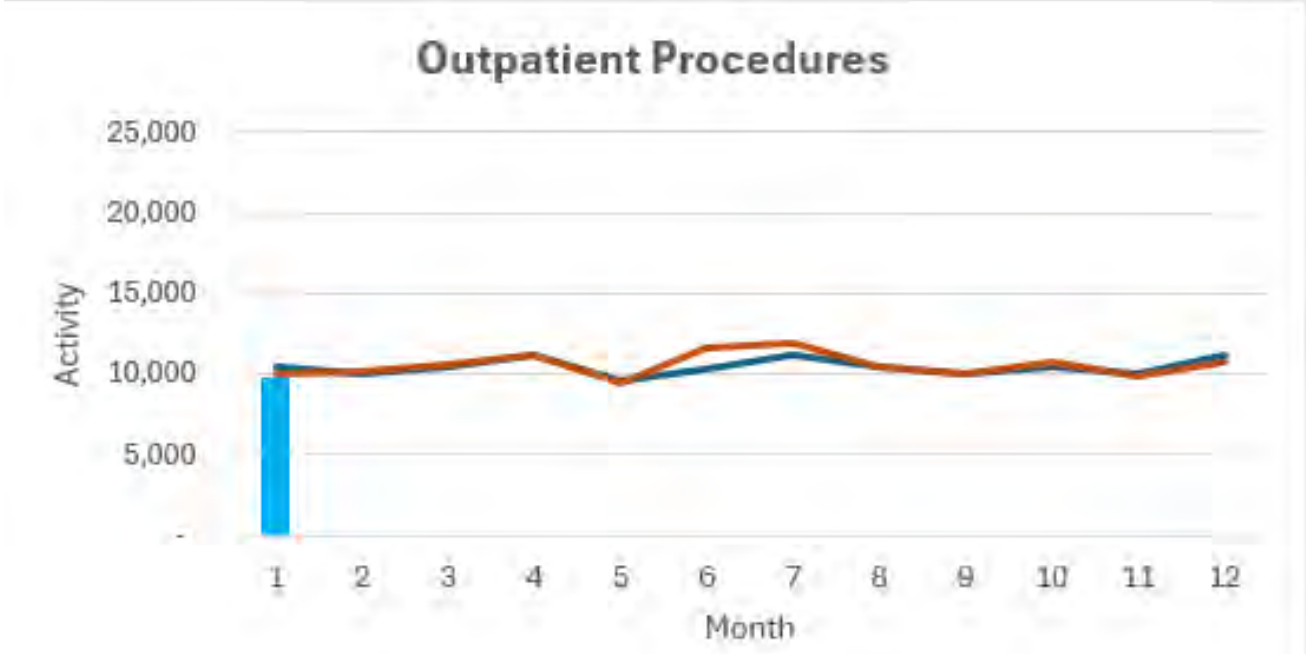
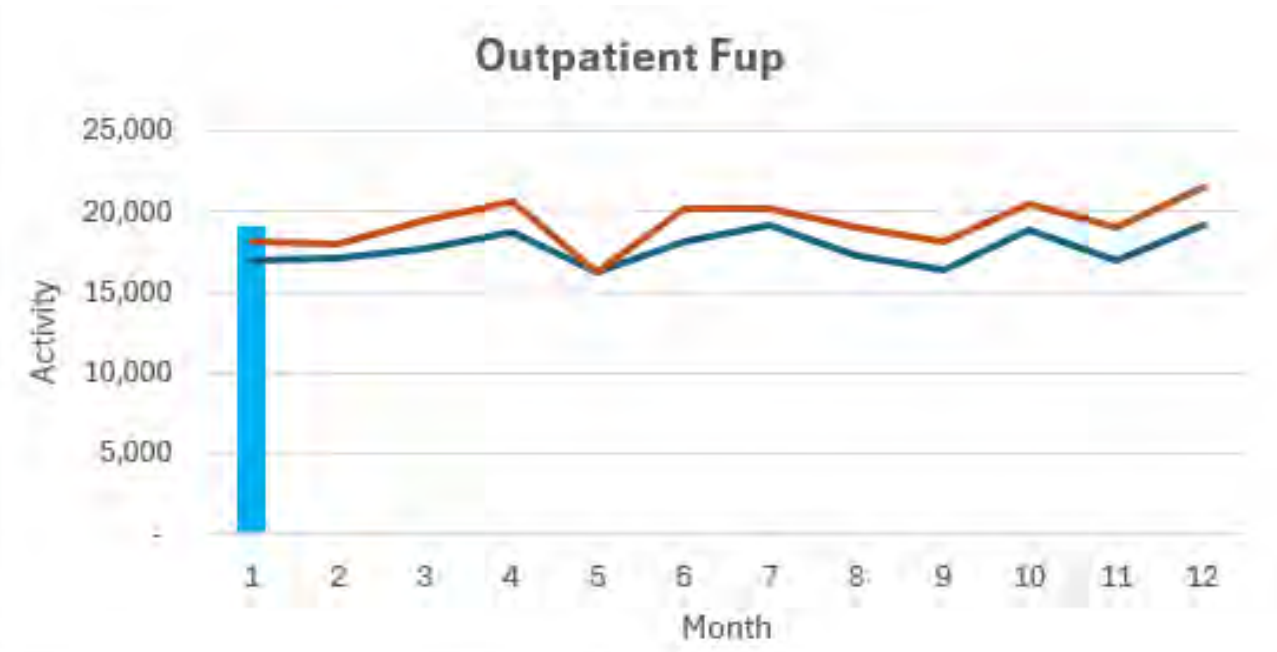
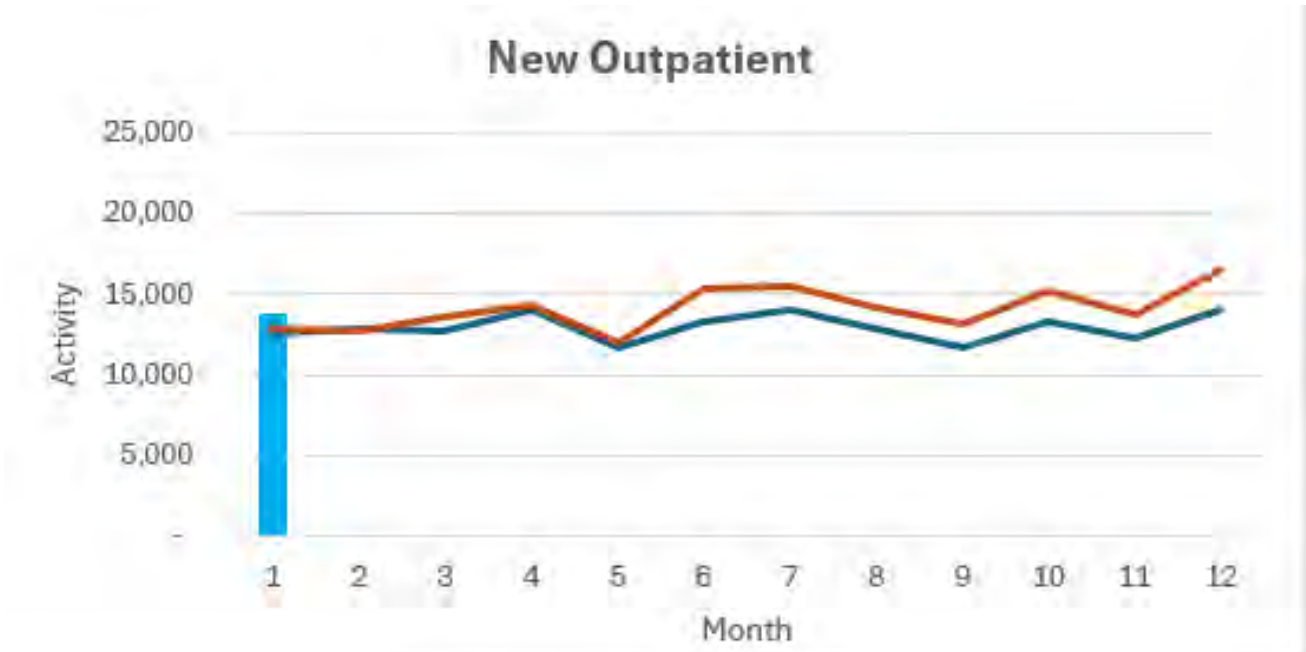
Understanding Performance
Income under the contract is funded across a range of mechanisms, ranging from fully variable, through payment on a marginal tariff basis to fixed. There was an overperformance in month of £399k, this was driven by an over performance against plan for planned care and UEC. UEC gross performance was £822k, however this is only subject to 20% tariff payment so only contributed £164k to the income overdelivery.

Countermeasures	Owner	Due Date
Investigate details of UEC over performance to share with commissioners to discuss progress and plans for demand management.	Contracting Team	31/06/26
Recruit to now vacant Integrated Pharmacist role to ensure ongoing support for data challenges and HCDD savings delivery	Income/ Pharmacy	31/05/26
Sign contracts with the ICB and NHS E to secure plans and payment due for activity delivered.	Income Team	31/05/26

Risks and Mitigation
- Stranded fixed costs where variable income is not reimbursed due to Activity Management Plan process - Ensure activity is delivered where needed to comply with RTT performance. - Secure agreement in the contract for additional payments for UEC, HCDD and Wider Variable over performance

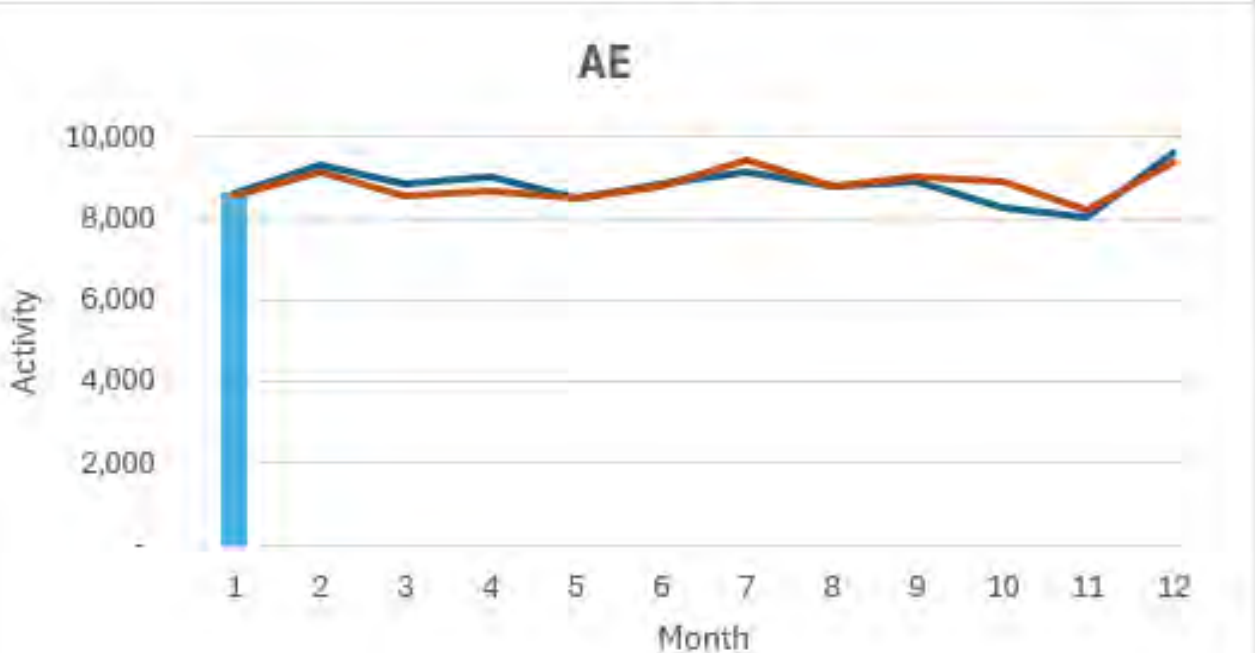
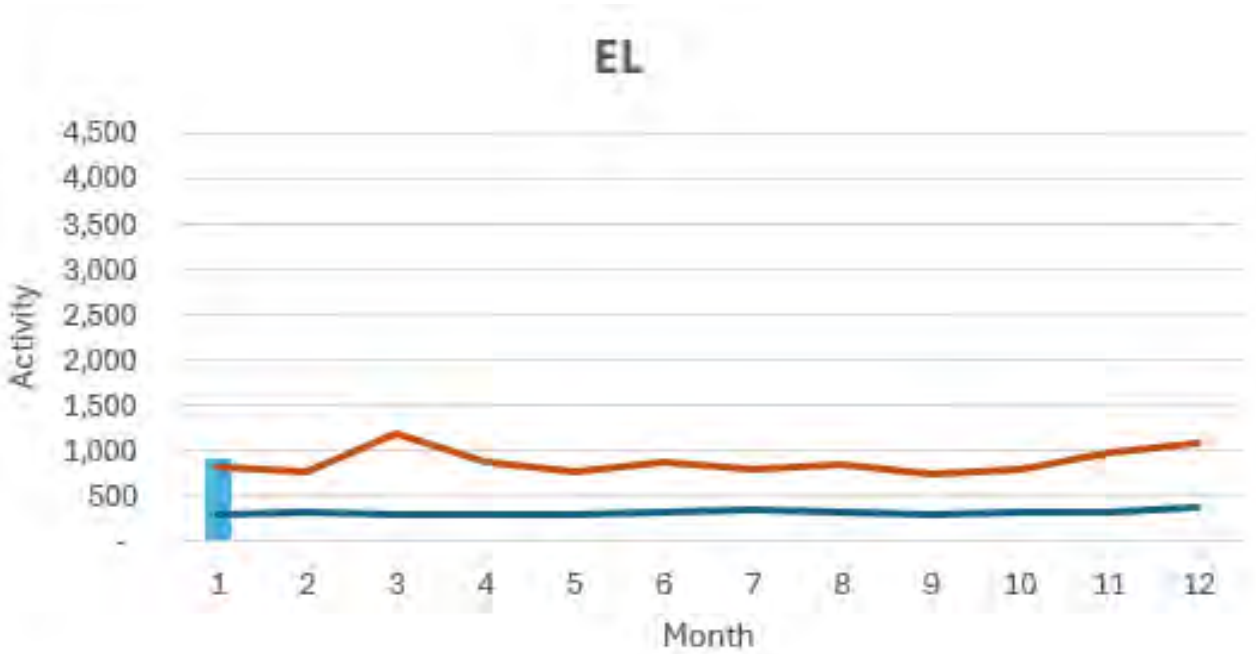
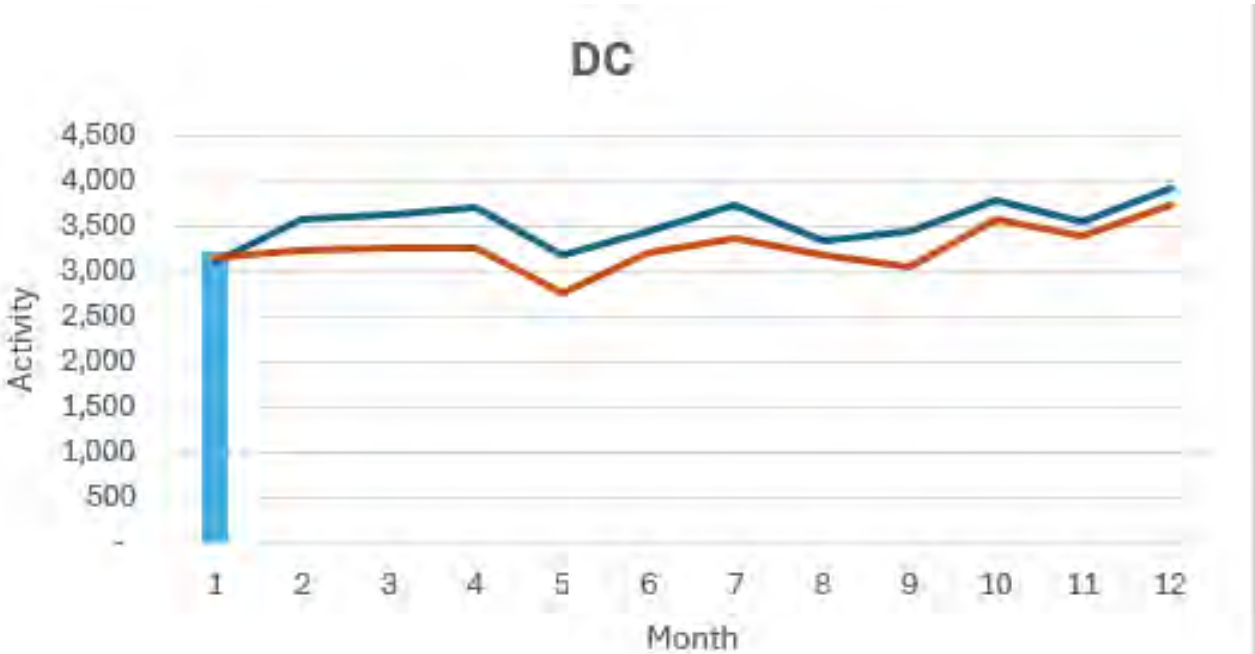
YTD Performance vs 26/27 Plan vs 25/26 Outturn (Activity)

26/27 YTD 26/27 Plan 25/26 Actual



YTD Performance vs 26/27 Plan vs 25/26 Outturn (Activity)

26/27 YTD 26/27 Plan 25/26 Actual



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	(5.676)	(5.859)	(0.183)	(5.676)	(5.859)	(0.183)
Junior Medical	(3.667)	(3.891)	(0.224)	(3.667)	(3.891)	(0.224)
Registered Nursing and Midwifery	(9.233)	(9.320)	(0.087)	(9.233)	(9.320)	(0.087)
Registered ST&T	(3.784)	(3.558)	0.226	(3.784)	(3.558)	0.226
Other Clinical Support	(5.096)	(5.122)	(0.026)	(5.096)	(5.122)	(0.026)
NHS Infrastructure Support	(4.140)	(4.111)	0.029	(4.140)	(4.111)	0.029
Other	(0.127)	(0.165)	(0.038)	(0.127)	(0.165)	(0.038)
Unallocated Savings	0.728	0.000	(0.728)	0.728	0.000	(0.728)
Reserves	0.045	0.000	(0.045)	0.045	0.000	(0.045)
Surplus/(Deficit)	(30.951)	(32.026)	(1.075)	(30.951)	(32.026)	(1.075)
Pay Vacancy Factor Included Above	1.364	0.000	(1.364)	1.364	0.000	(1.364)

Pay by Spend Type	In Month			Year to Date		
	RUH			RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Substantive	(32.026)	(29.921)	2.104	(32.026)	(29.921)	2.104
Pay Vacancy Factor	1.364	0.000	(1.364)	1.364	0.000	(1.364)
Net Budget	(30.662)	(29.921)	0.740	(30.662)	(29.921)	0.740
Bank	(0.120)	(1.513)	(1.393)	(0.120)	(1.513)	(1.393)
Agency	0.000	(0.352)	(0.352)	0.000	(0.352)	(0.352)
WLI	(0.052)	(0.117)	(0.065)	(0.052)	(0.117)	(0.065)
Other	(0.117)	(0.122)	(0.005)	(0.117)	(0.122)	(0.005)
Surplus/(Deficit)	(30.951)	(32.026)	(1.075)	(30.951)	(32.026)	(1.075)

Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
Pay budgets are overspent by £1.1m. The Pay vacancy factor (£1.4m) has been delivered but further recurrent Pay savings (£0.7m) were not achieved. Pay costs also include the estimated impact of industrial (£0.3m), with no additional funding being recognised for this in Month 1. Agency costs are 1.1% of the total pay costs, well below the 3% expectation. Bank costs are currently 4.7% of the total pay costs.				

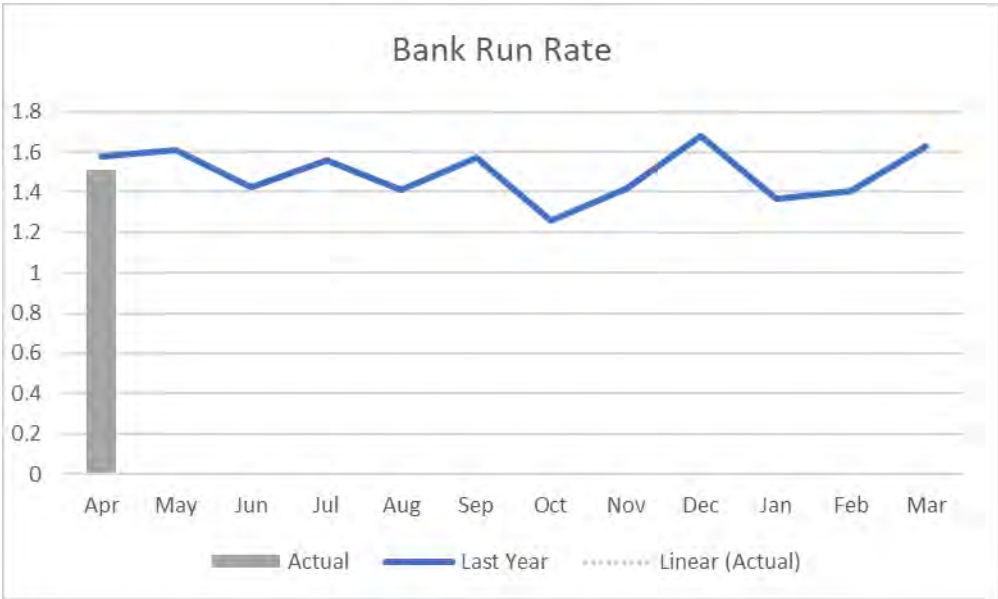
Budget – Pay by Division & Type

Pay by Division	In Month			Year to Date		
	RUH			RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Surgery	(8.283)	(8.334)	(0.051)	(8.283)	(8.334)	(0.051)
Medicine	(9.332)	(9.895)	(0.563)	(9.332)	(9.895)	(0.563)
FASS	(7.495)	(7.585)	(0.090)	(7.495)	(7.585)	(0.090)
E&F	(1.805)	(1.899)	(0.094)	(1.805)	(1.899)	(0.094)
Corporate	(3.318)	(3.443)	(0.125)	(3.318)	(3.443)	(0.125)
HIWE	(0.334)	(0.366)	(0.032)	(0.334)	(0.366)	(0.032)
R&D	(0.315)	(0.336)	(0.022)	(0.315)	(0.336)	(0.022)
Reserves	(0.355)	(0.158)	0.197	(0.355)	(0.158)	0.197
Unallocated Savings	0.288	0.000	(0.288)	0.288	0.000	(0.288)
Surplus/(Deficit)	(30.951)	(32.017)	(1.066)	(30.951)	(32.017)	(1.066)
Pay Vacancy Factor Included Above	1.364	0.000	(1.364)	1.364	0.000	(1.364)

Variance by Functional Area	In Month						Total
	Medical Staff	Ward	ED	Maternity	Other	Savings	
Substantive	0.101	0.682	0.166	0.091	0.364	(0.728)	0.675
Bank	(0.360)	(0.515)	(0.147)	(0.079)	(0.292)	0.000	(1.393)
Agency	(0.191)	(0.008)	(0.039)	0.000	(0.115)	0.000	(0.352)
Other	0.000	0.000	0.000	0.000	(0.005)	0.000	(0.005)
Surplus/(Deficit)	(0.449)	0.158	(0.020)	0.012	(0.048)	(0.728)	(1.075)

Variance by Functional Area	Year to Date						Total
	Medical Staff	Ward	ED	Maternity	Other	Savings	
Substantive	0.101	0.682	0.166	0.091	0.364	(0.728)	0.675
Bank	(0.360)	(0.515)	(0.147)	(0.079)	(0.292)	0.000	(1.393)
Agency	(0.191)	(0.008)	(0.039)	0.000	(0.115)	0.000	(0.352)
Other	0.000	0.000	0.000	0.000	(0.005)	0.000	(0.005)
Surplus/(Deficit)	(0.449)	0.158	(0.020)	0.012	(0.048)	(0.728)	(1.075)

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	Actual WTE	Variance WTE
Senior Medical	(341.9)	(323.1)	18.8
Junior Medical	(454.1)	(501.5)	(47.5)
Registered Nursing and Midwifery	(1,821.8)	(1,815.1)	6.7
Registered ST&T	(682.1)	(663.0)	19.1
Other Clinical Support	(1,623.3)	(1,610.8)	12.5
NHS Infrastructure Support	(909.1)	(880.0)	29.0
Other	(0.6)	(3.9)	(3.3)
Unallocated Savings	255.6	0.0	(255.6)
Reserves	0.0	0.0	0.0
Surplus/(Deficit)	(5,577.2)	(5,797.5)	(220.3)
Pay Vacancy Factor Included Above	213.1	0.0	(213.1)

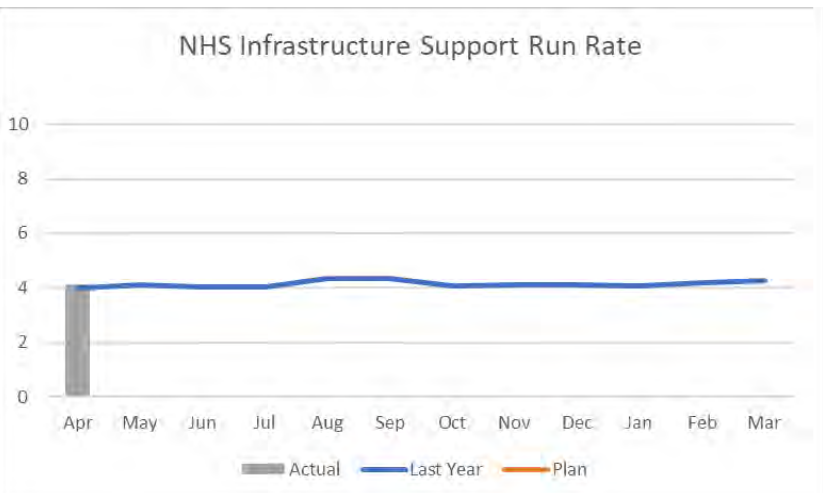
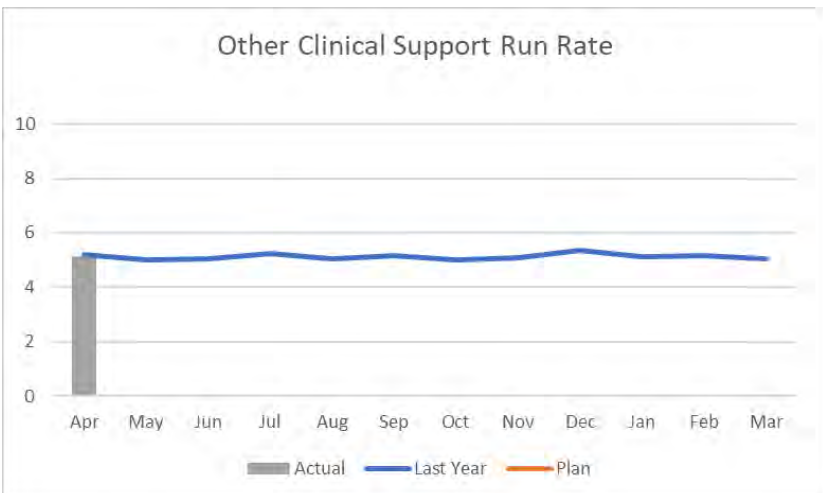
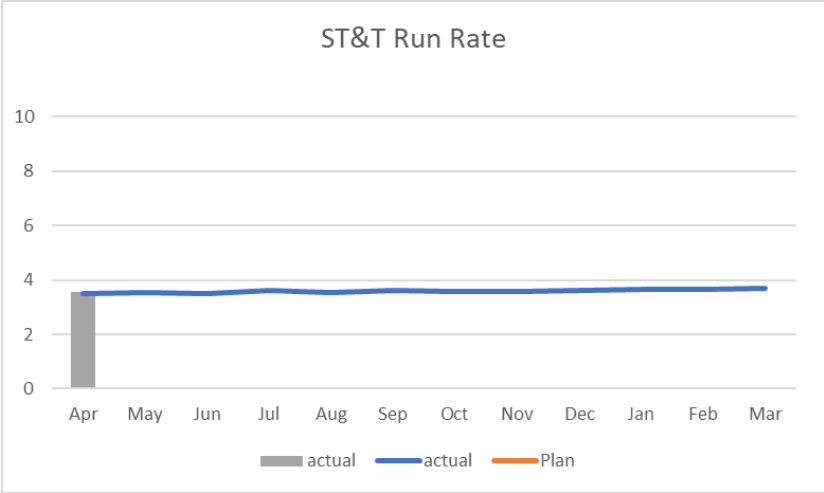
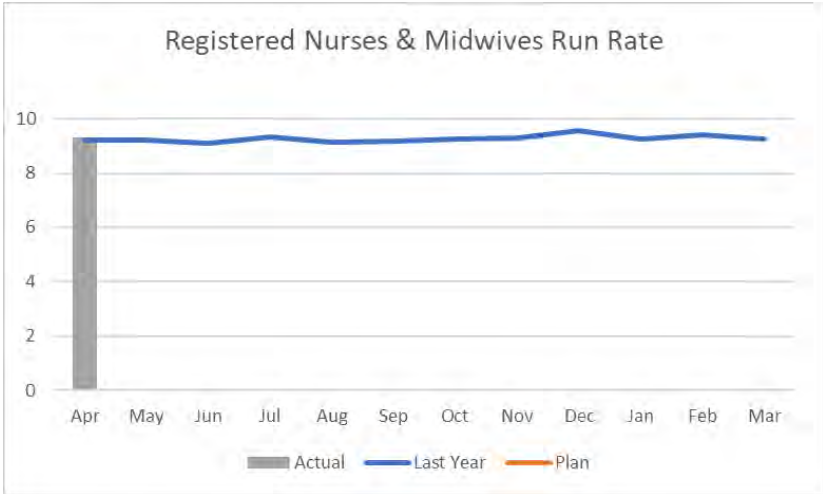
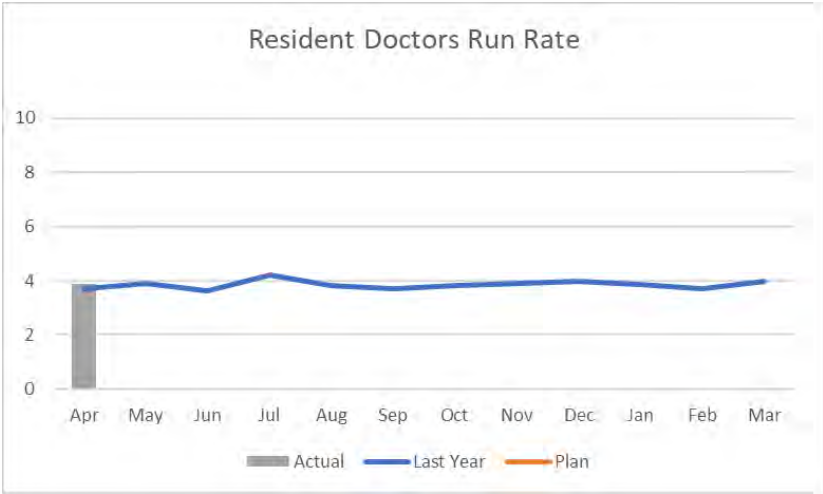
WTE by Spend Type	In Month		
	RUH		
	Budget WTE	Actual WTE	Variance WTE
Substantive	(5,771.7)	(5,494.8)	276.9
Pay Vacancy Factor	213.1	0.0	(213.1)
Net Budget	(5,558.6)	(5,494.8)	63.8
Bank	(18.6)	(289.4)	(270.8)
Agency	0.0	(13.3)	(13.3)
WLI	0.0	0.0	0.0
Other	0.0	0.0	0.0
Surplus/(Deficit)	(5,577.2)	(5,797.5)	(220.3)

WTE by Division	In Month		
	RUH		
	Budget WTE	Actual WTE	Variance WTE
Surgery	(1,424.8)	(1,451.9)	(27.2)
Medicine	(1,683.1)	(1,782.9)	(99.8)
FASS	(1,340.3)	(1,327.9)	12.4
E&F	(531.0)	(535.8)	(4.8)
Corporate	(589.1)	(588.7)	0.5
HIWE	(48.4)	(49.4)	(1.0)
R&D	(63.4)	(58.6)	4.8
Reserves	(1.0)	(2.3)	(1.3)
Unallocated Savings	103.8	0.0	(103.8)
Surplus/(Deficit)	(5,577.2)	(5,797.4)	(220.2)
Pay Vacancy Factor Included Above	213.1	0.0	(213.1)

WTE Variance by Functional Area	In Month						Total
	Medical Staff	Ward	ED	Maternity	Other	Savings	
Substantive	-4.47	139.37	30.26	8.92	145.34	-255.62	63.80
Bank	-19.67	-121.59	-28.02	-15.53	-85.97	0.00	(270.78)
Agency	-7.87	-0.38	-3.48	0.00	-1.59	0.00	(13.32)
Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Surplus/(Deficit)	-32.01	17.40	-1.24	-6.61	57.78	-255.62	(220.30)

Pay Run Rate Graphs

Last year comparators have been restated for impact of pay awards



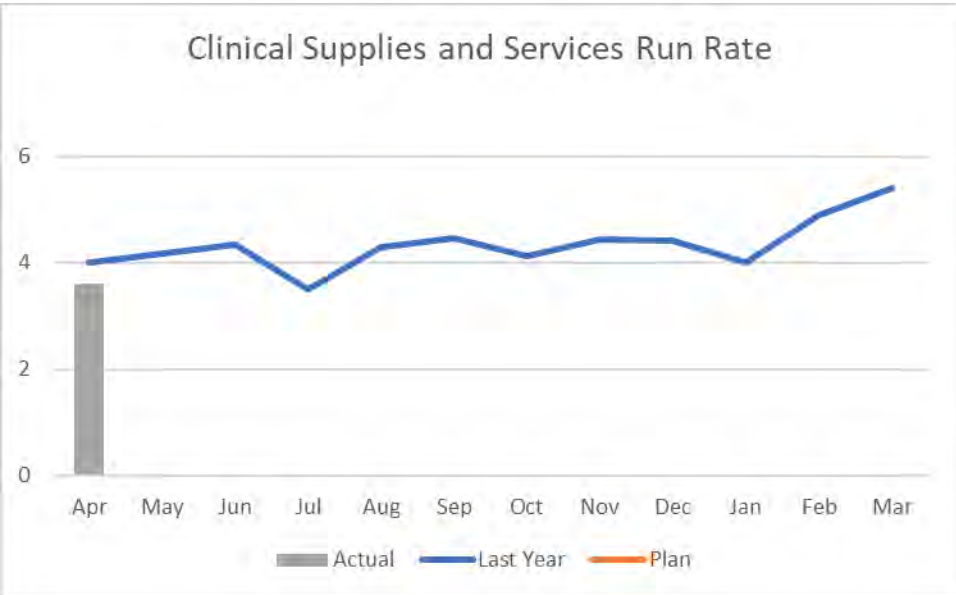
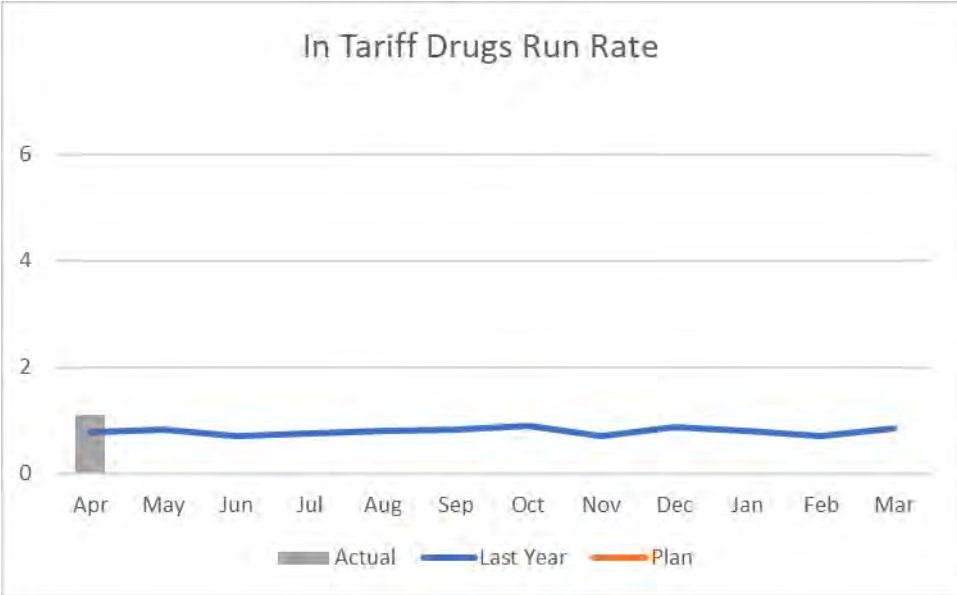
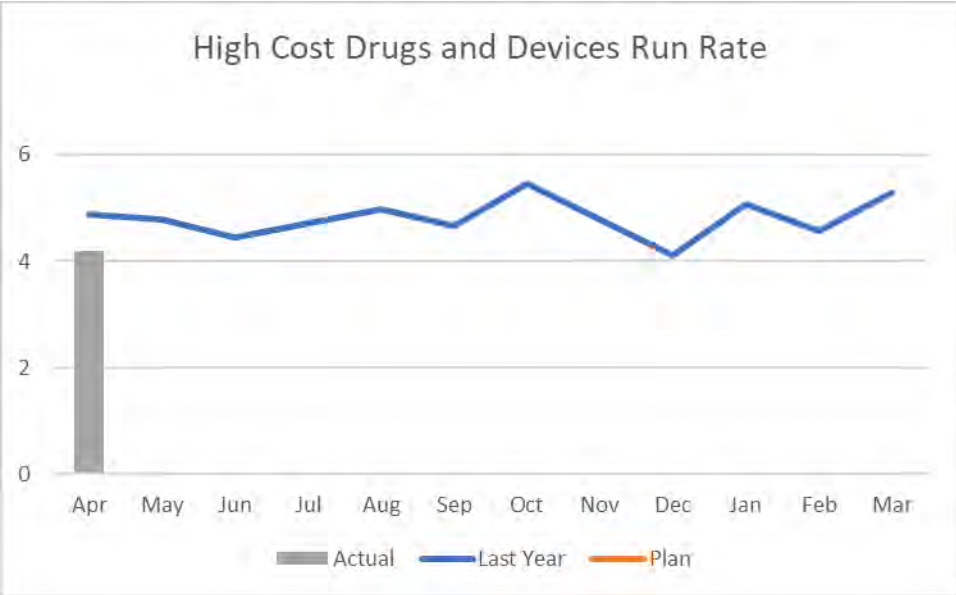
Budget – Non-Pay

Non-Pay by Type	In Month			Year to Date		
	RUH			RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
High Cost Drugs and Devices	(4.150)	(4.182)	(0.032)	(4.150)	(4.182)	(0.032)
In Tariff Drugs	(1.159)	(1.112)	0.047	(1.159)	(1.112)	0.047
Clinical Supplies and Services	(4.317)	(3.608)	0.709	(4.317)	(3.608)	0.709
Other Non Pay	(6.129)	(6.472)	(0.343)	(6.129)	(6.472)	(0.343)
Unallocated Savings	0.639	0.000	(0.639)	0.639	0.000	(0.639)
Reserves	0.229	0.000	(0.229)	0.229	0.000	(0.229)
Surplus/(Deficit)	(14.887)	(15.374)	(0.487)	(14.887)	(15.374)	(0.487)

Budget by Division	In Month			Year to Date		
	RUH			RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Surgery	(3.181)	(3.113)	0.067	(3.181)	(3.113)	0.067
Medicine	(1.428)	(1.492)	(0.063)	(1.428)	(1.492)	(0.063)
FASS	(1.420)	(1.587)	(0.167)	(1.420)	(1.587)	(0.167)
E&F	(1.710)	(1.650)	0.060	(1.710)	(1.650)	0.060
Corporate	(3.036)	(3.467)	(0.431)	(3.036)	(3.467)	(0.431)
HIWE	(0.096)	(0.071)	0.025	(0.096)	(0.071)	0.025
R&D	(0.054)	(0.028)	0.026	(0.054)	(0.028)	0.026
Capital Charges	(0.030)	0.067	0.097	(0.030)	0.067	0.097
High Cost Drugs and Devices	(4.150)	(4.182)	(0.032)	(4.150)	(4.182)	(0.032)
Unallocated Savings	0.288	0.000	(0.288)	0.288	0.000	(0.288)
Reserves	(0.070)	0.160	0.230	(0.070)	0.160	0.230
Surplus/(Deficit)	(14.887)	(15.363)	(0.475)	(14.887)	(15.363)	(0.475)

Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
Non-pay spend is £0.5m overspent against budget. £0.5m of this relates to undelivered recurrent savings with £0.2m of non-recurrent savings being delivered. High Cost Drugs and Devices are marginally over plan in month with this being offset by income. Estates and Facilities are underspent due to reduced utilities costs.				

Non Pay – Run Rate Graphs



Executive Summary – By Business Unit



Statement of Comprehensive Income	Sulis - BAU	CDC	SEOC	Sulis BAU,
Period to 202601	202601	202601	202601	202601
	Actual	Actual	Actual	Actual
	£'000	£'000	£'000	£'000
Commissioner Income (NHSE/CCG)	2,196	500	0	2,696
Other Patient Care Income	1,066	0	0	1,066
Other Operating Income	42	0	523	564
Unallocated	0	0	0	0
Income Total	3,305	500	523	4,327
Pay	(1,895)	(321)	(163)	(2,379)
Non Pay	(1,386)	(232)	(359)	(1,977)
Depreciation	(242)	(61)	0	(302)
Expenditure Total	(3,522)	(614)	(523)	(4,659)
Operating Surplus/(Deficit)	(218)	(114)	(0)	(332)
Other Finance Charges	(34)	(12)	0	(46)
Finance Charges	(34)	(12)	0	(46)
Surplus/(Deficit)	(251)	(126)	(0)	(377)

*Awaiting loading into Unit 4 to pull usual reporting

Underlying Financial Position (BAF Reference)

I&E to March 2027	Annual Budget
	Total Group
	Budget £'m
Income	626.640
Pay	(387.134)
Non Pay	(201.812)
Finance Charges	(35.688)
EBITDA	2.006
Donated/Grant Income	2.006
Adjusted Financial Performance	(0.000)
Transitional Funding	(8.400)
Technical Adjustments	(4.200)
Non-Recurrent Benefits	
Underlying Financial Performance	(12.600)

The Planned Underlying deficit for 26/27 is £12.6m. This is an improvement of £34.6m from 25/26.

This position is stated after delivery of £37.6m recurrent savings and sustaining 3.3% vacancy factor of £12.4m.

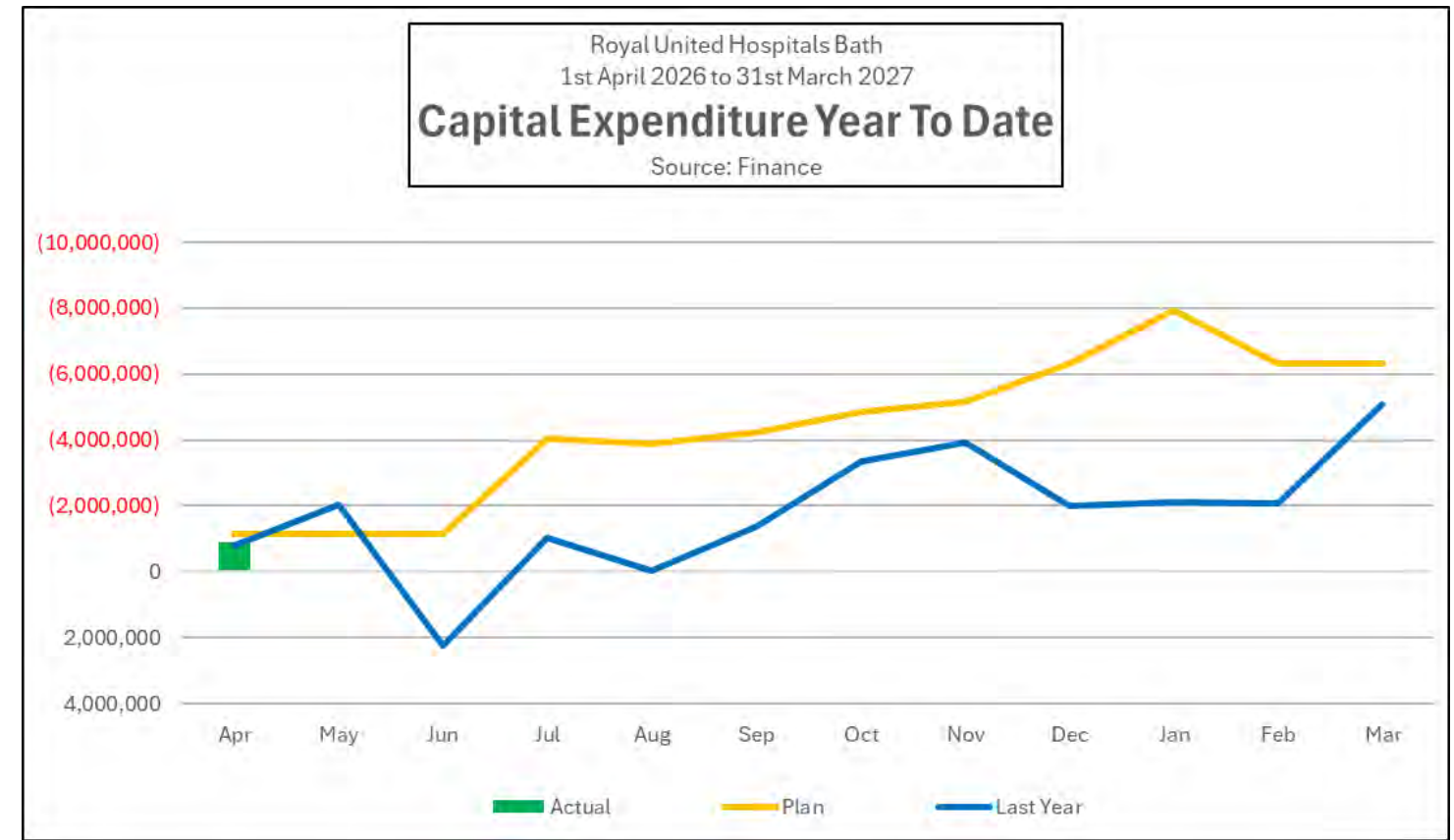
The position includes £28.1m block rebasing underfunding.

National Cost collection index 24/25 is 98. In 2nd quartile nationally.
Year on Year productivity in 25/26 up to December is clouted as 3.7%, 1.7% above national target and in 2nd quartile nationally

Medium Term Plan savings requirement is £55m, which is above £34.3m nationally identified productivity and efficiency opportunities.

Capital – Operational, Grant & Donated

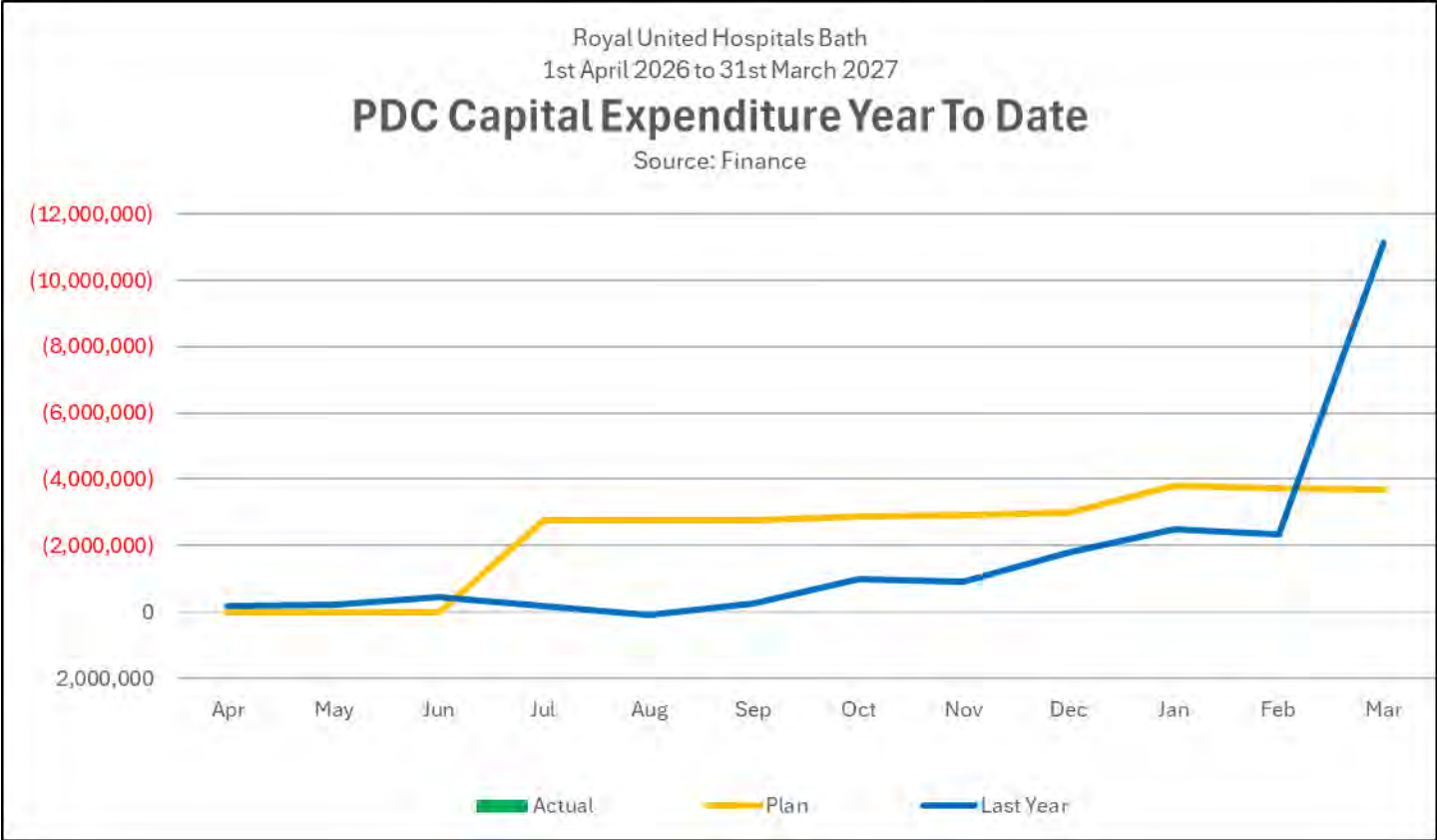
Position as at 30th April 2026	Annual Plan £'m	Forecast Outturn £'m	YTD Plan £'m	YTD Actuals £'m	YTD Variance £'m
BSW EPR	(7.474)	(7.474)	(0.623)	(0.244)	0.379
Sulis Hospital Lease	(1.500)	(1.500)	0.000	0.000	0.000
Green Heart	(0.500)	(0.500)	0.000	0.000	0.000
Strategic Schemes Total	(9.474)	(9.474)	(0.623)	(0.244)	0.379
IT	(2.574)	(2.574)	(0.063)	(0.093)	(0.030)
Medical Equipment (MEC)	(4.030)	(4.030)	(0.248)	(0.051)	0.197
Estates, CRG & Projects	(3.005)	(3.005)	(0.170)	(0.069)	0.101
Sulis	(0.474)	(0.474)	(0.024)	(0.006)	0.018
Right of Use Leases	(0.330)	(0.330)	0.000	(0.029)	(0.029)
Other	(0.103)	(0.103)	0.000	0.034	0.034
Disposals - NBV write off	0.000	0.000	0.000	0.000	0.000
Other Schemes Total	(10.516)	(10.516)	(0.505)	(0.213)	0.292
TOTAL : Operational Capital	(19.990)	(19.990)	(1.128)	(0.457)	0.671
Decarbonisation (Salix)	0.000	(1.266)	0.000	(0.429)	(0.429)
PET-CT	(3.440)	(3.440)	0.000	0.000	0.000
Green Heart (donated)	(0.500)	(0.500)	0.000	0.000	0.000
Other donated schemes	(0.300)	(1.701)	(0.025)	(0.002)	0.023
TOTAL : Donated & Grant Funded	(4.240)	(6.907)	(0.025)	(0.430)	(0.405)



Understanding performance	Countermeasures	Owner	Due Date	Risks and Mitigation
Spend on operational capital is behind plan, this relates both to a shortfall in EPR scheme spend and due to spend being held pending confirmation of any reduction in the trust's planned allocation The variance in Decarbonisation Grant will be offset by additional grant funding	Pending confirmation of changes to the capital plan and review of cash-flow, spend of no more than the submitted 2026/27 first quarters budget has been allowed to be taken forward	CPMG / Capital leads	Complete	Shortfall of Capital funding is a key risk to the organisation – Score EPR team have submitted a further business case for additional funding for the scheme. The Trust share of additional costs and any adjustment to the profile of the spend is to be confirmed by the EPR project board The capital plan is subject to amendment due to cash availability at RUH. BSW will need to reprioritise the capital funding across the group due to commitment to EPR scheme at group level. The Group CDEL Capital position is over-committed at present
	Cash-flow review and priority ranking of schemes is being undertaken	CPMG	June	
	EPR project team to confirm revised cost profile by trust	EPR Board	June	

Capital – PDC Funded

PDC Funded Capital Position as at 30th April 2026		Annual Plan	Forecast Outturn	YTD Plan	YTD Actuals	YTD Variance
		£'m	£'m	£'m	£'m	£'m
Estates:	Ward Refurbishment	(4.500)	(4.500)	0.000	0.000	0.000
	SSD Autoclave Replacement	(0.833)	(0.833)	0.000	0.000	0.000
Total Estates Safety		(5.333)	(5.333)	0.000	0.000	0.000
UEC:	Urgent Treatment Centre	(12.000)	(12.000)	0.000	0.000	0.000
	Integrated front door	(5.000)	(5.000)	0.000	0.000	0.000
	SDEC	(0.850)	(0.850)	0.000	0.000	0.000
CDC Diagnostics:	Neighbourhood Hubs	(0.500)	(0.500)	0.000	0.000	0.000
	CT/MRI/ENDO at Trowbridge	(4.100)	(4.100)	0.000	0.000	0.000
Diagnostics Equip:	Neurology Equipment	(0.026)	(0.026)	0.000	0.000	0.000
	GI Services Equipment	(0.207)	(0.207)	0.000	0.000	0.000
	Cardiology Equipment	(0.170)	(0.170)	0.000	0.000	0.000
	Hearing Equipment	(0.135)	(0.135)	0.000	0.000	0.000
Total Constitutional Standards		(22.988)	(22.988)	0.000	0.000	0.000
TOTAL : PDC Funded		(28.321)	(28.321)	0.000	0.000	0.000



Understanding Performance
There is no spend on PDC schemes, this is in line with plan pending approval of schemes. It is expected that the CDC schemes which relate to will transfer to GWH along with the funding.

Countermeasures	Owner	Due Date

Risks and Mitigation
Where capital funding is used for seed funding to develop business case including spend in prior year, should the project not proceed there is risk to the revenue position as the capital investment will get written off to the revenue. Return to Constitutional standards schemes are subject to national approval. The CDC and UTC scheme are rag rated amber with further details required by the national team. The other Return to Constitutional standards schemes are rag rated green.

Trust - Statement of Financial Position

Statement of financial position	M1 FY 2026-27 30/04/2026 £'m	FY 2025-26 31/03/2026 £'m	Variance £'m	% Variance
Non current assets				
Intangible assets	11.436	11.458	(0.022)	(0.192)%
Property, Plant & Equipment	281.958	282.792	(0.834)	(0.295)%
Right of use assets - leased assets for lessee	50.003	50.237	(0.234)	(0.466)%
Investments in associates and joint ventures	3.941	3.941	0.000	0.000%
Trade and other receivables	7.317	7.383	(0.066)	(0.894)%
Total non current assets	354.655	355.811	(1.156)	(0.325)%
Current Assets				
Inventories	6.696	6.306	0.390	6.185%
Trade and other receivables	31.248	37.005	(5.757)	(15.557)%
Cash and cash equivalents	12.140	23.239	(11.099)	(47.760)%
Total current assets	50.084	66.550	(16.466)	(24.742)%
Current Liabilities				
Trade and other payables	(45.764)	(59.462)	13.698	(23.037)%
Other liabilities	(13.062)	(14.578)	1.516	(10.399)%
Provisions	(0.404)	(0.430)	0.026	(6.047)%
Borrowings	(2.374)	(2.349)	(0.025)	1.064%
Total current liabilities	(61.604)	(76.819)	15.215	(19.806)%
Total assets less current liabilities	343.135	345.542	(2.407)	(0.697)%
Non current liabilities				
Provisions	(4.299)	(4.311)	0.012	(0.278)%
Borrowings	(53.458)	(53.622)	0.164	(0.306)%
Total assets employed	285.378	287.609	(2.231)	(0.776)%
Financed by:				
Public Dividend Capital	306.599	306.599	0.000	0.000%
Income and Expenditure Reserve	(63.365)	(61.134)	(2.231)	3.649%
Revaluation reserve	42.144	42.144	0.000	0.000%
Total equity	285.378	287.609	(2.231)	(0.776)%

Understanding Performance

Non-Current Assets

Capital assets decreased by £1.1m (0.32%) as at April 2026, reflecting the net impact of capital expenditure offset by depreciation charges.

The reduction in non-current receivables primarily reflects movements in the lease receivable from Sulis Hospital.

Current Assets

Current assets decreased by £16.5m (24.74%) to £50.1m in April 2026. This was largely driven by an £11.1m (47.76%) reduction in cash and cash equivalents.

Trade and other receivables also decreased by £5.8m, due to the settlement of outstanding invoices and a reduction in accrued income.

Current Liabilities

Trade and other payables decreased by £13.7m (23%), reflecting the settlement of both capital and non-capital creditor balances.

Other liabilities fell by £1.5m (10.40%), primarily due to the utilisation of deferred income through increased expenditure.

Non-Current Liabilities

Non-current liabilities decreased slightly overall, primarily due to the unwinding of provisions and lease liabilities associated with the SOC at Sulis Hospital.

Total Equity

The income and expenditure reserve decreased by £2.23m, reflecting the net deficit reported for April 2026.

Risks and Mitigation

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

Statements of Cash Flows	Actual £'m
EBITDA surplus	0.389
Income recognised in respect of capital donations (cash and non-cash)	(0.426)
Impairments	0.000
Working capital movement	(10.004)
Provisions	(0.038)
Net cash used in operating activities	(10.079)
Capital Expenditure	(0.852)
Cash receipts from asset sales	0.009
Donated cash for capital assets	0.000
Interest received	0.119
Net cash used in investing activities	(0.734)
Public dividend capital received	0.000
Movement in loans from the DHSC	0.000
Capital element of finance lease rental payments	(0.148)
Interest on loans	0.000
Interest element of finance lease	(0.149)
PDC dividend (paid)/refunded	0.000
Net cash generated from financing activities	(0.298)
Decrease in cash and cash equivalents	(11.099)
Opening cash balance	23.239
Closing cash balance	12.140
Adjusted for petty cash	(0.004)
Adjusted closing cash balance	12.136

Terms of Reference have been finalised for the establishment of a Group Cash Committee

If £22.6m of Revenue PDC was required to mitigate I&E risks this would equate to an additional PDC dividend charge of £369k

Understanding Performance
As at April 2026, the cash balance was £12.14m, which is £3.0m higher than the forecast balance of £9.14m.
Key drivers:
1. Education and training income was £3.4m above forecast due to timing differences with quarterly payments.
2. Other commissioning income exceeded forecast by £0.829m.
3. Other non-NHS income was £0.981m higher than forecast.
4. Invoiced payments including NHS and other government bodies, were £3.4m higher than forecast.

Countermeasures	Owner	Due Date	Risks and Mitigation
Delivery of £37.6m Savings Programme	Managing Director	Ongoing	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. Risk Register entry 3787 The cash will be monitored and reforecast based on the latest information. Mitigations include; - Withdrawal of operational capital funding - Withholding payments to suppliers through the No PO No Pay Policy. - Application for PDC Revenue support
Adherence to Better Payment Practise Code including adherence to No PO No Pay policy will support more accurate cash forecasting. Ongoing review of cash forecasts to reflect updated run-rates and payment patterns; updating payment run procedure notes, and maximising debt collection.	Head of Financial Services	Weekly	
Draft of Revenue PDC application process	Head of Financial Services	31 May	
Maximising payment terms of Commissioning Income	Head of Income	30 June	

Better Payment Practice Code

	Apr-26		Mar-26		% Variance	
	Volume ('m)	£'m	Volume ('m)	£'m	Volume ('m)	£'m
Non NHS						
Total bills paid in the year	6.637	41.989	74.023	392.705	-91%	-89%
Total bills paid within target	6.544	41.598	69.919	343.369	-91%	-88%
Percentage of bills paid within target	99%	99%	94%	87%	5%	12%
NHS						
Total bills paid in the year	0.139	3.092	1.562	19.047	-91%	-84%
Total bills paid within target	0.121	1.891	1.272	12.440	-90%	-85%
Percentage of bills paid within target	87%	61%	81%	65%	6%	-4%
Total						
Total bills paid in the year	6.776	45.081	75.585	411.752	-91%	-89%
Total bills paid within target	6.665	43.489	71.191	355.809	-91%	-88%
Percentage of bills paid within target	98%	96%	94%	86%	4%	10%

Understanding performance	Countermeasures	Owner	Due Date	Risks and Mitigation
As at April 2026, the Trust met the Better Payment Practice Code (BPPC) statutory threshold of 95%, achieving overall performance of 98% by volume and 96% by value, representing improvements of 4% and 10% respectively compared to March 2026. However, performance for NHS invoices, both by volume and value, remained below the statutory threshold.	Active management by Accounts Payable team with support from procurement.	Head of Financial services & Procurement	Continuous	The payment of amounts due will have an impact on the cash position and will have to be closely monitored in relation to the available cash balance.
	Adherence to Better Payment Practise Code including adherence to No PO No Pay policy will support more accurate cash forecasting.	All budget holders & Procurement Team	31 March	

Organisation	Surplus / (Deficit) £m	Variance to Plan £m
GWH	(3.5)	(1.8)
RUH	(2.9)	(1.3)
SFT	(2.1)	0.0
BSW Hospitals Group	(8.5)	(3.1)

Report to:	Public Board of Directors	Agenda item:	13
Date of Meeting:	3 June 2026		

Title of Report:	Care Quality Commission (CQC) Urgent and Emergency Care CQC Inspection
Status:	For discussion
Board Sponsor:	Toni Lynch, Chief Nursing Officer
Author:	Johanna Lloyd-Rees, Divisional Director of Nursing for Medicine Katia Montella, Quality Assurance Manager
Appendices	Appendix A: CQC UEC Assessment report October 2026

1. Executive Summary of the Report

The purpose of this paper is to update the Board of Directors on the outcomes from the published Care Quality Commission (CQC) unannounced inspection report of Urgent and Emergency Care in October 2025.

The inspection was conducted due to concerns raised to the CQC regarding overcrowding and patient safety from multiple sources. The inspection was undertaken using the CQC Single Assessment Framework and reviewed the safe, effective, caring, responsive, and well-led domains.

The CQC published the inspection report in May 2026 giving a rating of 'Requires Improvement' for Urgent and Emergency Services. The CQC downgraded the rating for 'Caring' from 'Good' to 'Requires Improvement.' The safe, responsive, and well-led domains were also rated as 'Requires Improvement' with effective rated as 'Good.'

The overall rating for the RUH Combe Park site is unaffected and remains 'Requires Improvement.' The rating for the Royal United Hospitals Bath NHS Foundation Trust is also unaffected and remains rated as 'Good.'

The inspection report identified three areas where the Health and Social Care Act 2008 Regulated Activities were not met:

- Regulation 12(1) Safe care and treatment of the Health and Social Care Act (Regulated Activities) Regulations 2014
- Regulation 17(2)(a) Good governance of the Health and Social Care Act (Regulated Activities) Regulations 2014
- Regulation 18(1) Staffing of the Health and Social Care Act (Regulated Activities) Regulations 2014

The Trust is required to submit an action plan to the CQC by 8 June 2026 to address these areas.

The improvement plan will be recorded and monitored using the Trust's digital audit platform, Audit Management and Tracking (AMaT). Progress in implementing the actions from the improvement plan will be reported on a quarterly basis at the Insight and Improvement Committee. The improvement plan has oversight from the Divisional Director, Director of Nursing and Divisional Director of Operations for the Medicine Division.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is requested to:

- Note the CQC inspection findings and requirement to develop an improvement plan to address the recommendations from the inspection report.

3. Legal / Regulatory Implications

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

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

A failure to demonstrate systematic quality improvement in the delivery of patient care could risk the Trust's registration with the Care Quality Commission.

5. Resources Implications (Financial / staffing)

These actions are being completed within existing resources.

6. Equality and Diversity

Equality and Diversity legislation is an integral component to registration.

7. References to previous reports

None

8. Freedom of Information

Public

9. Sustainability

None identified.

10. Digital

The transition to a shared EPR system will impact on compliance for completion of nursing documentation.

CQC Inspection Report

1 Introduction

- 1.1 The Care Quality Commission (CQC) undertook a focused unannounced inspection of the Urgent and Emergency Care (UEC) core service in October 2025 due to concerns raised to them relating to overcrowding and patient safety.
- 1.2 The CQC inspected the Safe, Effective, Responsive, Caring and Well Led quality statements using the CQC Single Assessment Framework.
- 1.3 The CQC published the inspection report in May 2026 giving a rating of 'Requires Improvement' for Urgent and Emergency Services. The CQC downgraded the rating for 'Caring' from 'Good' to 'Requires Improvement.' The safe, responsive, and well-led domains were also rated as 'Requires Improvement' with effective rated as 'Good.'
- 1.4 The overall rating for the RUH Combe Park site is unaffected and remains 'Requires Improvement.' The rating for the Royal United Hospitals Bath NHS Foundation Trust is also unaffected and remains rated as 'Good.'
- 1.5 The report found that staff treated people as individuals and with compassion, including tailoring care to meet the needs of autistic people and those with dementia or a learning disability.
- 1.6 The CQC also recognised the Trust's performance against unplanned reattendances, where the department performed better than the regional and national averages with people also discharged at the right time with the right treatment. There was also appropriate escalation of suspected sepsis, high NEWS2 scores and safeguarding concerns.
- 1.7 However, the inspection report identified the following areas where the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) were not met:

1.7.1 Regulation 12: Safe care and treatment Regulated activities: Treatment of disease, disorder, or injury

The Emergency Department was not ensuring care and treatment was provided in a safe way for service users. Due to crowding in the department from a lack of available hospital ward-based beds or waiting for specialty review to determine onward care, people were having to wait for unacceptable periods of time in a department not designed for this purpose, or on the back of an ambulance waiting for handover. This included and specifically affected patients who had mental health needs.

Author: Johanna Lloyd-Rees, Divisional Director of Nursing for Medicine Katia Montella, Quality Assurance Manager Document Approved by: Toni Lynch, Chief Nursing Officer Agenda Item: 13	Date: 3 June 2026 Version: one Page 3 of 4

1.7.2 Regulation 17: Good governance Regulated activities: Treatment of disease, disorder or injury

The Emergency Department did not provide sufficient evidence of how it assessed, monitored, and improved the quality and safety of the service provided in the carrying on of the regulated activity. It did not provide evidence of how it assessed, monitored, and mitigated the risks to the health, safety, and welfare of service users. The leadership team did not present a clear and well-understood overview of quality and safety which included some of the vital key metrics for determining assurance.

1.7.3 Regulation 18: Staffing Service Regulated activities: Treatment of disease, disorder, or injury

The Emergency Department did not have enough suitably qualified, competent, skilled, and experienced persons deployed. There were high levels of nursing vacancies, which would reduce through new starters, and the department did not meet the recommended level of consultant cover for an Emergency Department and had unsatisfactory and unsafe numbers of resident doctors as senior decision makers overnight.

2 CQC Improvement Plan

- 2.1 Both during and since the inspection, the Trust has addressed the immediate concerns raised by the CQC. There are now more senior decision makers in the Emergency Department overnight and 24/7 security presence; the departmental team has enhanced oversight of emergency access points to ensure they remain unobstructed; and are working with the Avon and Wiltshire Partnership so that patients who are attending the Emergency Department with mental health presentations are cared for appropriately. The Internal Professional Standards have been refreshed.
- 2.2 The Trust is required to submit an improvement plan to the CQC by 9 June 2026 detailing the actions that will be taken to address the CQC recommendations.
- 2.3 The improvement plan will be recorded and monitored using the Trust's digital audit platform, Audit Management and Tracking (AMaT). Progress in implementing the actions from the improvement plan will be reported on a quarterly basis at the Insight and Improvement Committee. The improvement plan has oversight from the Divisional Director, Divisional Director of Nursing and the Divisional Director of Operations for the Medicine Division.

3 Recommendations

- 3.1 The Board of Directors is requested to note the CQC inspection findings and requirement to develop an improvement plan to address the recommendations from the inspection report.

Author: Johanna Lloyd-Rees, Divisional Director of Nursing for Medicine Katia Montella, Quality Assurance Manager Document Approved by: Toni Lynch, Chief Nursing Officer Agenda Item: 13	Date: 3 June 2026 Version: one Page 4 of 4

Royal United Hospital Bath

LAP Assessment Report ID : LAP-01996

Inspection visit date(s): 21 and 22 October 2025

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Royal United Hospital Bath

Location findings

Ratings for this location

Overall	Requires improvement	
Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	

Overall location summary

Overall location summary: Date of assessment: 21 October 2025 to 28 November 2025. The Royal United Hospital Bath, provides a range of NHS hospital services. This assessment looked at Urgent and Emergency Services following multiple sources of information received about overcrowding and concerns regarding patient safety, which we rated as requires improvement. The rating of Urgent and Emergency Services has been combined with the ratings of all the other services from the last inspections. See our previous reports to get a full picture of all the other services at the Royal United Hospital Bath. The rating of the Royal United Hospital Bath, remains requires improvement.

At this assessment, we identified breaches of regulations in relation to safe care and treatment, staffing, and good governance.

Safe

Rating Requires improvement 

Royal United Hospital Bath

Location findings

Our overall rating of safe at the Royal United Hospital Bath, is requires improvement. Urgent and Emergency Services was rated as requires improvement.

Effective

Rating Good 

Our overall rating of effective at the Royal United Hospital Bath is good. Urgent and Emergency Services was rated as good.

Caring

Rating Good 

Our overall rating of caring at the Royal United Hospital Bath is good. Urgent and Emergency Services was rated as requires improvement.

Responsive

Rating Requires improvement 

Our overall rating of responsive at the Royal United Hospital Bath is requires improvement. Urgent and Emergency Services was rated as requires improvement.

Well-led

Rating Requires improvement 

Our overall rating of well led at the Royal United Hospital Bath is requires improvement. Urgent and Emergency Services was rated as requires improvement.

Urgent and emergency services

Overall	Requires improvement	
Safe	Requires improvement	
Effective	Good	
Caring	Requires improvement	
Responsive	Requires improvement	
Well-led	Requires improvement	

Our view of the service

Date of assessment: 21 October 2025 to 28 November 2025. We conducted a responsive assessment of Urgent and Emergency Services at the Royal United Hospital Bath, following multiple sources of information received about overcrowding and concerns regarding patient safety.

At the time of the inspection, we identified significant shortfalls with safe levels of staff, safe care for patients with mental ill-health, the environment, particularly when crowding and other storage problems resulted in the blocking of fire exits. We had concerns around infection prevention and control, specifically relating to inconsistent staff compliance with guidance, and the deteriorating physical condition of the emergency care facilities. There was a high vacancy and sickness rate for nurses, driven by intense pressures of overcrowding and the resulting higher workload. The number of senior decision makers fell below the Royal College of Emergency Medicine recommendations, leaving gaps in senior medical cover overnight. The process of triage for patients was confusing, as was access to the department and information provided for patients.

The department experienced significant pressure as high patient demand coincided with reduced bed

Urgent and emergency services

capacity. These factors, compounded by delayed discharges, led to long waiting times for many patients. There was a lack of privacy and dignity for patients waiting for long periods of time in the corridor. This was also a concern for patients who had mental health needs, often waiting many days for a specialist inpatient bed. Governance processes were carried out well in some areas, but there were significant gaps in audit and local risk management. However, most staff had no concerns about speaking up and worked well with others to give a multidisciplinary approach to patient care. Staff followed evidence-based care and treatment protocols. Staff talked to patients about their care and got their permission before starting treatment. Despite the challenges of a crowded environment, we observed staff treating patients with kindness and compassion. The culture of teamwork and wellbeing was evident. There were opportunities for learning, change and innovation whenever possible, but the high workload meant this did not always have the focus of attention it needed.

We rated the service as requires improvement. We found 3 breaches of the regulations in relation to safe care and treatment, staffing and governance.

People's experience of the service

Patients and any family or carers with them we met were mostly positive about the staff treating them with kindness and providing good care and treatment. However, not all said they were seen quickly on arrival and were anxious about waiting times and a lack of information or communication. Some said they were concerned they had waited over an hour for triage or been waiting for many hours in a corridor. Other patients we spoke with told us how compassionate staff were. They stated that although staff looked very busy, they were always helpful and kind.

Safe

Rating Requires improvement



This means we looked for evidence that people were protected from abuse and avoidable harm. At our last assessment we rated this key question as requires improvement. At this assessment the rating has remained requires improvement. This meant some aspects of the service were not always safe, and there was limited assurance about safety.

The service was in breach of regulation 12 for safe care and treatment and regulation 18 for staffing.

Learning culture

Score

2. Evidence shows some shortfalls in the standard of care

Description: We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Quality Statement Score: 2

We scored the service as 2. The evidence showed some shortfalls. The service did not always have a proactive and positive culture of safety. They did not always listen to concerns about safety. Lessons were not always learned to continually identify and embed good practice.

The emergency department's (ED) culture supported safety and learning, but the challenges and pressures staff were experiencing did not always enable this to happen effectively. Overcrowding and staffing gaps created an environment where staff struggled to maintain their focus on long-term safety improvements.

The service demonstrated a reactive learning culture where improvements were inconsistent and not always upheld department wide. For example, recent monthly audits of fluid balance records identified inconsistencies in patient care and monitoring. While these findings suggested gaps in the consistency of documentation, it was important to note that these observations were derived from a 2-month data sample. In August 2025, a new fluid balance chart audit was launched following improvements to their electronic patient record system.

The service identified shortfalls with the monitoring and management of intravenous cannulas (plastic tubes inserted into veins), which is essential to prevent bloodstream infections. Although audits highlighted consistently poor performance, leaders did not always turn that data into lasting change. An action plan had been implemented to address this shortfall (including adding information to a learning poster and emails sent to nursing staff), but this

Urgent and emergency services

was not sustained and did not result in improvements over time. This had a potential impact on patient safety as there was a risk of infections going unnoticed. However, we did see an example of sustained improvement following an investigation of a significant screening failure in late 2024, a targeted action plan was launched to improve the sepsis response. By the end of 2025, 100% of patients received their antibiotics within 1 hour.

The ED demonstrated a maturing safety culture by using the Patient Safety Incident Response Framework (PSIRF). Our review of 3 Patient Safety Incident Investigations confirmed the service translated some failures into effective learning. In one instance, a patient arrived with breathlessness and dizziness, but staff failed to escalate an electrocardiogram (ECG) finding that showed a heart attack. In response, the service launched an ECG interpretation competency assessment for ED clinicians to speed up reviews. Leaders applied the duty of candour in all 3 cases, ensuring patients and relatives received honest accounts and formal apologies. The duty of candour is the legal and ethical requirement for healthcare professionals to be open and honest with patients when something goes wrong with their treatment. This helped to create an improved culture of learning and ensured leaders investigated incidents thoroughly.

Staff were clear about what incidents should be reported and found the system relatively easy to use, however, staff told us they did not always have time to report all incidents due to the pressures of work. This meant there were missed opportunities for learning across the department and driving improvement around safety. When there were serious incidents or urgent concerns, staff said they were usually involved in any investigation and asked for their input. For example, clinicians used 'hot debriefs' (a short discussion immediately after a significant event) and 'cold debriefs' once the situation had resolved, to capture their reflections.

Communication of learned lessons from incidents remained inconsistent across the wider team. Feedback from incidents was via monthly emails from the investigating team, and safety briefings. Leaders acknowledged they had not yet identified the most effective process for ensuring learned lessons reached staff. However, the department had taken active steps to formalise and improve its oversight of mortality and morbidity to identify learning and drive improvement. Leaders held meetings 3 times a year and had launched joint case reviews with the Intensive Care Unit. The service also started an internal review of governance and reallocated consultant time to help increase the frequency of these sessions. These changes

aimed to turn clinical reviews into more frequent, actionable service improvements.

Safe systems, pathways and transitions

Score

1. Evidence shows significant shortfalls in the standard of care

Description: We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Quality Statement Score: 1

We scored the service as 1. The evidence showed significant shortfalls. The service did not work well with people and health system partners to establish and maintain safe systems of care. They did not manage or monitor people's safety. They did not make sure there was continuity of care, including when people moved between different services.

While staff prioritised safety and continuity of care, the department struggled to maintain these standards consistently due to severe capacity pressures. While hospital services had expanded, some patients (particularly those with mental health needs) experienced long waits in the emergency department (ED) before they could be moved to the most appropriate setting for their care. Leaders recognised the risks associated with delays in transferring patients presenting with mental health conditions. It has been identified that external mental health service capacity remained a challenge. Leaders made it a priority to work with partners to support the transfer of patients experiencing mental health crisis to specialist services as quickly as possible. Multiple daily meetings were held with mental health partners to manage transfers and maintain situational awareness (tracking how many patients were waiting and why). Staff continued to escalate and advocate for this patient cohort; however, the lack of external mental health services meant these patients faced longer waiting times.

There were excessive delays with patients' admission to wards which had a negative impact on the delivery of optimal care. Despite staff efforts, many patients stayed in the hospital longer

Urgent and emergency services

than necessary because the outside support they needed wasn't ready. On the first day of our inspection, 30 patients were waiting to be admitted to wards across the hospital from the ED, but there was no plan of where they would be admitted to. To manage this overflow, patients awaiting admission to a ward overnight were situated in the Urgent Treatment Centre (UTC), which was co-located for the treatment of minor injuries and illnesses. The department provided routine care for some patients in corridors because there were many patients waiting for ward admissions. This meant patients faced significantly higher risks due to prolonged waits and care being delivered outside of clinical areas.

Patients with both physical and mental health needs remained in the ED for long periods. In August 2025, 17.5% of mental health patients remained in the ED for over 12 hours. Although leaders told us there was access to mental health services 24 hours a day, this was provided remotely overnight from midnight to 8am, using a video call service. Staff stated this was rarely used or responsive, and most patients arriving in the evening would have to wait until at least the next morning to be seen. During our assessment, we identified an older patient who was in a small cubicle for 5 days waiting for a decision about their admission to a mental health bed. Staff identified that this presented a risk to the patient's safety, wellbeing, and effective treatment. This was an ongoing risk as beds or community support for mental health placements (managed by another NHS trust) were scarce in the area and wider region.

The systems for streaming, triage and oversight of patients were not always operating in a timely way. Triage times in the department were not meeting the clinical guidance for triage which was to see all walk-in patients within 15 minutes of arrival. Data from October 2024 to October 2025, showed the service achieved this for 59% of patients on average. During our inspection, this system became disorganised when the rostered triage nurse could not be located by colleagues, resulting in a maximum wait time of 1 hour and 6 minutes; a delay staff were unaware of until it was flagged. There were procedures for extra triage to be organised when waiting times were escalated, but staff told us this was rarely acted on or achieved.

Some patients expressed confusion regarding their clinical pathway. Upon arrival, most walk-in patients were registered at reception and triaged by an experienced practitioner (nurse/paramedic) to ensure they were in the right place to receive care and treatment. However, there was then a further secondary triage stage for observations (for example, blood pressure and temperature). This multi-layered approach left patients unclear about their progress to receive care and treatment in the department. One patient reported being seen 3 times within an hour

for repetitive questioning and testing, only to be returned to the waiting area without a clear plan. Another patient described being moved between different waiting zones, from the UTC to the ambulatory area, where they remained for over 2 hours without further communication.

Safeguarding

Score

3. Evidence shows a good standard of care

Description: We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect, and we make sure we share concerns quickly and appropriately.

Quality Statement Score: 3

We scored the service as 3. The evidence showed a good standard. The service worked with people and healthcare partners to understand what being safe meant to them and the best way to achieve that. They concentrated on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. The service shared concerns quickly and appropriately.

While staff showed high levels of practical knowledge, formal training compliance was inconsistent across different staff groups. As of October 2025, medical staff achieved 100% compliance in level 2 children's safeguarding, but nursing staff in the emergency department (ED) sat lower at 66.7%. While medical staff achieved 100% compliance for level 3 adult safeguarding training, nursing staff reached 72.58%. To address these gaps, the trust had an improvement plan. They scheduled monthly training sessions and sent emails to non-compliant staff and their managers as a reminder. By monitoring progress through the Vulnerable People Committee, the trust was on target to reach its 90% compliance by December 2025.

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There were systems and practices to make sure patients were protected from abuse and neglect. The service operated under a legal framework that held staff accountable for the safety and wellbeing of all patients. The service based its safeguarding actions on the Care Act 2014 for adults and the Children Act 2004 for children. These policies focused on a multi-agency approach to protecting adults and children at risk of harm. The Vulnerable People Committee provided quarterly oversight and governance around this, and the service used a Clinical Governance and Adult Safeguarding Flowchart to link clinical incidents directly to safeguarding lessons. This helped to ensure reporting remained consistent across the NHS, police, and local authorities.

The trust had senior clinicians with responsibility for safeguarding of adults and children, and staff knew how to contact them. Outside of the safeguarding team's core working hours, staff could access care plans and alerts via electronic patient records. Staff told us they felt comfortable speaking up if they had concerns about a patient or the person accompanying them. Staff in the ED demonstrated a good understanding of safeguarding and how to take immediate action when needed. Staff could explain that safeguarding meant protecting people from abuse and avoidable harm. They used a safeguarding screening tool for every child who entered the department. When a patient required a referral, the electronic system allowed creation of one based on the screening results. For example, clinicians completed a child protection referral for a patient they were concerned about to ensure immediate follow-up. This meant vulnerable patients were identified the moment they arrived, to help keep people safe.

Involving people to manage risks

Score

2. Evidence shows some shortfalls in the standard of care

Description: We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

Quality Statement Score: 2

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We scored the service as 2. The evidence showed some shortfalls. The service did not always work well with people to understand and manage risks. Staff did not always provide care to meet people's needs that was safe, supportive and enabled people to do the things that mattered to them.

Risks were not always managed effectively due to persistent delays in transferring patients from ambulances into the hospital. While the department used a 'Pitstop' area for initial evaluations, this system was often overwhelmed by the volume of arrivals. Between September 2024 and August 2025, the emergency department (ED) received nearly 30,000 patient handovers from ambulance crews with an average wait time of 72 minutes. This was more than double the national average of 34 minutes. Nearly 40% of all patient handovers were over 1 hour of the patient arriving. This meant patients waited twice as long for hospital treatment which increased the risk of their condition worsening. Despite these systemic pressures, hospital staff accepted full clinical accountability for patients waiting in ambulances.

Staff told us they used body-worn cameras and had de-escalation training to manage the growing risk of violence and aggression, but there was no permanent security provision. Because of lengthy delays for admission to wards and other services, there were agitated patients in the same areas as frail elderly patients. During our inspection, a person who was acutely distressed due to a mental health crisis displayed behaviours that can challenge, including shouting and throwing a chair in a shared observation area. There was also a frail patient admitted with a head injury in this area. Staff reported that such incidents were common and gave further examples of a nurse being scratched and a doctor being assaulted with hot coffee. We raised this with the senior leadership team as a significant concern. As a direct result, the service deployed a permanent security presence in the department and a planned programme of training in de-escalation techniques to upskill staff. The aim of this was to ensure a safer environment for staff and a more protected space for vulnerable patients.

Leaders ensured every staff member, from nurses to consultants, could see a patient's level of risk by displaying live National Early Warning Scores (NEWS2) on a digital whiteboard. The NEWS2 is a standardised tool used across the NHS to identify and respond to patients whose health is deteriorating. The system automatically displayed a red heart symbol next to a patient's name if their warning score reached 5 or above. This meant staff could instantly identify who was the sickest and move resources to help them. Similarly, ED leaders monitored the time between a patient's first vital signs (like pulse and blood pressure) and their sepsis

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screening.

The department followed professional standards to ensure patients were triaged based on their clinical urgency rather than their time of arrival. During our inspection, we consistently saw patients prioritised based on their needs. This approach helped to reduce the risk of staff missing a deteriorating condition in a busy environment.

The hospital had a Sepsis and Kidney Injury Specialist (SKIP) team and an Enhanced Care team to provide focused care for the most vulnerable patients. The Enhanced Care and Support team provided structured, therapeutic care across a range of observation levels, including one-to-one supervision, where deemed necessary and proportionate. Their role included continuous and cohort observation, active risk assessment, therapeutic engagement, de-escalation, and close liaison with the department and specialist services. This model ensured that patients with complex physical, cognitive, or mental health needs received timely, proportionate support, while enabling the wider department to maintain safe care for general emergencies and respond quickly to deterioration. This shared responsibility helped to ensure the most critical patients received immediate attention, preventing their conditions from worsening.

The ED matron represented the service within the trust's Deteriorating Patient Working Group, which met monthly. This collaboration brought together sepsis nurses and various service level leaders to share good practices and highlight areas for improvement. They used minutes and action plans to guide care for all deteriorating patients, ensuring that sepsis management stayed a top priority. This approach allowed the hospital to standardise escalation of care and maintain a focus on patient safety even during high-pressure months.

Safe environments

Score

1. Evidence shows significant shortfalls in the standard of care

Description: We detect and control potential risks in the care environment and make sure that the equipment, facilities and technology support the delivery of safe care.

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Quality Statement Score: 1

We scored the service as 1. The evidence showed significant shortfalls. The service did not always detect and control potential risks in the care environment. They did not make sure that equipment, facilities and technology supported the delivery of safe care.

Overcrowding within the department created environmental risks and obstructed emergency access routes. There were multiple physical hazards, particularly regarding access to the children's resuscitation area. This had worsened since the implementation of the '45-minute ambulance handover' process. During our inspection, we saw 2 patient trolleys situated directly in front of the door to the children's resuscitation room. These trolleys also obstructed a designated fire escape route. This blocked the primary access route for the resuscitation team in the event of a paediatric cardiac arrest, and placed children and young people at risk of harm. Staff members confirmed that they would normally divert an unwell child through the adult ambulatory waiting area (the back door entrance to the paediatric resuscitation room) because the main entrance was blocked. This rerouting delayed emergency care and compromised patient dignity. Following our inspection, the service took immediate action to clear these routes and implemented an action plan to ensure fire exits and emergency entrances remain unobstructed.

We observed clutter throughout the majors area such as linen trolleys, bins and chairs obstructing fire escape routes. We saw a fire escape route with a "Keep clear" sign was obstructed by staff sitting at a computer station. These concerns were immediately highlighted during and following our inspection and leaders responded quickly by clearing obstructions.

The department's facilities for mental health patients were not consistently safe or suitable. There were several rooms and cubicles used to admit patients with mental health conditions which may be treated alongside any physical health conditions. The mental health assessment rooms conformed to some of the guidance from the Royal College of Psychiatrists as they were ligature free, had doors which were not lockable and opened both ways to allow safe access. However, the emergency department's (ED) 2 mental health assessment rooms were non-compliant because they were joined by an internal door. They did not allow for observation of the patient from outside and were in a poor state of repair. The rooms were dark and we observed peeling paint and ingrained dirt on the walls. This did not provide a therapeutic space for patients experiencing mental health distress.

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The Rotary Observation Unit was an unsafe environment for patients in mental health crisis because the service relied on individual staff members rather than a standardised safety system to manage ligature risks. The unit's 8 bed spaces were not designed for mental health care, meaning staff had to manually remove equipment like oxygen tubing to make the space safe. On our first day, there were 7 patients in this area waiting for mental health placements. One patient we observed, who was at risk of suicide, still had easy access to oxygen tubing in their bedspace because it had not been removed. The hospital's Enhanced Care and Support team consisted of Registered Mental Health Nurses, Enhanced Care Practitioners and Enhanced Care Support Workers. However, there was no consistent checklist to ensure bed spaces were made safe. This created an avoidable risk of harm which relied on staff's experience to be aware of this risk, rather than a standardised environmental risk assessment tool. The trust had identified this and updated their ligature policy and operational guidelines. Following the inspection, the updated policy was immediately issued to the emergency department on 23 October 2025 and uploaded to the trust intranet. Additionally, the trust had invested in a lead nurse for mental health to oversee high-risk areas.

Severe overcrowding forced the service to provide care in corridors. On the first day of our inspection, there were 9 patients on trolleys in the corridor. Staff told us mobile patients could use the standard bathrooms, but those with limited mobility were taken to an assessment room should they need to use the bathroom. This meant the same room was being used for both personal care and clinical investigations, such as ECGs, which compromised the purpose of this space. We identified there was no standard operating procedure (SOP) for corridor care. This meant staff had no clear safety guidance to support, manage and risk assess the corridor care they provided. A standard operating procedure (SOP) was implemented on 24 October 2025 following our site visit. A SOP is a set of instructions created by organisations to guide staff on how to carry out routine tasks. Leaflets were given to patients to explain why they were in the corridor from 24 October 2025. There were no risk assessments to demonstrate that the 9 patients in the corridor were suitable to be there. However, we did note that these patients had stable observations, were not deteriorating, and received regular oversight from a designated nurse and support worker.

Despite the physical environmental shortfalls, the service managed its medical equipment effectively. There was a fully equipped and relatively new resuscitation area with closed bays (as it was built to deal with the Covid 19 pandemic). There was another separate resuscitation

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room for children. Equipment used to deliver care and treatment was safe and suitable for the intended purpose. There were resuscitation trolleys and emergency suction and oxygen located across the department.

Most patients were observed to ensure they were safe. There were numerous areas used for patients who were waiting for the next steps in their treatment or transfer. The main patient waiting area was overseen by reception staff who could see most of the room and there were cameras used for safety monitoring. Other areas where patients were waiting were in thoroughfares used constantly by staff and others, so patients were not hidden from view. In the Urgent Treatment Centre, patients were visible to staff who said they rarely closed curtains unless they were with a patient. Co-located services for patients were adjacent to the main ED areas. This included the X-ray department and other scanning facilities. There was a trauma assessment unit located close to the ED where patients could be directed as necessary.

Safe and effective staffing

Score

1. Evidence shows significant shortfalls in the standard of care

Description: We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development and work together effectively to provide safe care that meets people's individual needs.

Quality Statement Score: 1

We scored the service as 1. The evidence showed significant shortfalls. The service did not make sure there were enough qualified, skilled and experienced staff. They did not always make sure staff received effective support, supervision and development. They did not work together well to provide safe care that met people's individual needs.

The department failed to maintain enough qualified and experienced staff to keep patients safe. There was a heavy reliance on temporary workers with high sickness levels, and unfilled vacancies.

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The ED consistently did not meet Royal College of Emergency Medicine (RCEM) staffing guidelines. For a department of this size (approximately 77,259 patient attendances between January and September 2025), guidance recommends 2 to 4 Senior Decision Makers overnight. Medical staff told us they regularly worked nights with only 1 Senior Decision Maker, and our review of staffing rotas confirmed this. Leaders told us locum (bank) staff were sometimes used to fill gaps. However, this approach proved ineffective and we saw shifts were rarely filled - a concern that was consistently echoed by the staff we spoke with. When cover was secured, it often relied on staff who lacked the specific expertise required to manage complex emergency cases. We raised this as a significant concern, and the trust took immediate action following our inspection. To secure a safer workforce, leaders introduced higher pay rates for the 8 weeks following and began an urgent recruitment drive for permanent senior doctors with the support of the Chief Executive and the Integrated Care Board.

Nursing vacancies and sickness rates were identified by leaders as a primary concern. Vacancy rates consistently exceeded the trust's 4% target. Registered nurse and healthcare support worker vacancies were both 13.39%. As a result, staff told us they were regularly pulled from their training days or from the children's department to cover adult areas. Medical staff vacancy rates were recorded at 2.04%, which did not initially correlate with the medical staffing level of risk as identified on the risk register. This discrepancy existed because the baseline establishment required additional investment. Following the documentation of this risk, funding was secured, and the gap was being addressed with 7 Registrars scheduled to start in August 2026. Our review of medical staffing rotas noted a Registrar fill rate of 80.52% in October 2025. However, when considering medical staffing as a whole, the overall fill rate reached 95.1%. This was achieved through a strategy of over-establishing consultant roles to mitigate gaps found in individual Registrar roles.

Nursing staffing data showed significant shortages where the number of staff on duty rarely met safe requirements. Between July and September 2025, there was a 30% deficit in nursing hours, with permanent staff covering only 56% of shifts. To address these gaps, the service relied on temporary bank and agency workers, which increased the workload for the permanent team. Healthcare support worker coverage followed a similar trend where fill rates dropped from 82.5% in July to 73.1% by September 2025. Since the inspection, there has been a notable improvement in workforce stability. While the service previously struggled with declining coverage, more recent data shows staffing levels have reached a much safer

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threshold. For example, in March 2026, total fill rates rose to 95% for nurses and 93% for healthcare support workers. This was achieved by using bank staff to cover approximately 21% to 22% of the total planned hours. This meant there were more staff to provide care and treatment for patients.

A shortage of permanent nursing and healthcare support worker staff put patients at risk because not all temporary staff filling rota gaps were familiar with the department and how it operated. Rotas showed the skill mix of staff was not always as required and this was confirmed by staff. Staff who were not supposed to be providing direct patient care, known as supernumerary, were often needed to work with patients to cover shortages in nursing numbers, or stepped down from undertaking mandatory or other training. Staff would be requested from wards to help, although this had mixed success as ward managers were also managing their own staff shortages. The nursing staff shortage was on the department's risk register and recognised as impacted by the high turnover of staff and the increasing demand for services and capacity problems.

To support gaps in staffing adult areas of the department, managers regularly redeployed children's nurses to work in the adult areas. Staff told us this happened often. Staff also told us the nurse and healthcare assistant deployed to the corridor were pulled from their regular staffing numbers as they could not account for additional staff to cover this area. This meant other areas of the department were left short staffed regularly.

Sickness rates for nurses and support workers remained higher than the trust's target. In the ED, sickness levels peaked at 8.81% in August 2025 and 8.79% in April 2025 for Emergency Medical Nursing. Appraisal compliance across all staff groups remained significantly below the 90% target, with medical staff showing the lowest rate at 61.54%. While nurses (71.77%) and healthcare support workers (66.67%) were slightly better, efforts to improve these rates were often undermined by high vacancy rates, staff sickness, and increased patient attendances. Although leaders had recently allocated dedicated time for senior doctors to support with reviews, this shortfall indicated that a large portion of the workforce was not receiving formal professional oversight or developmental support.

We observed safety huddles where staffing was discussed. These meetings lacked a clear structure and were poorly attended which meant the team could not develop effective plans to manage daily staffing shortages. Mandatory training compliance across the service did not

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meet the trust's target of 90% compliance. As of September 2025, the average compliance score for medical staff across all mandatory training modules sat at 68.72%. registered nurses (RNs) and healthcare support workers (HCSWs) achieved slightly better compliance rates at 78.83%, and 75.38%. This meant the service could not be assured that staff had the right skills and knowledge to safely support patients. Leaders attributed these training shortfalls to operational pressures. To address this, the service introduced a recovery plan to protect training time and add extra sessions. Furthermore, the department has since introduced a robust supernumerary period for new starters and regular updates from the Clinical Practice Facilitators.

Operational pressures regularly impacted on training opportunities. While leaders valued education and learning, they sometimes had to pull nursing staff off their designated study days to cover clinical gaps in the department (due to low staffing levels). Managers told us training days were often cancelled to address workforce shortages. These cancellations prevented staff from engaging in the development activities designed to improve the service.

Infection prevention and control

Score

2. Evidence shows some shortfalls in the standard of care

Description: We assess and manage the risk of infection, detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.

Quality Statement Score: 2

We scored the service as 2. The evidence showed some shortfalls. The service did not always assess or manage the risk of infection. They did not always detect and control the risk of it spreading or share concerns with appropriate agencies promptly.

There were shortfalls adhering to infection prevention and control (IPC) practices by staff. For example, we saw limited handwashing or use of hand gels from many staff on the first day of our visit. This improved when it was fed back to leaders as a concern. Staff did not always

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challenge other healthcare professionals in their department who were not following IPC or uniform policy. Some staff were wearing gloves to carry out procedures when gloves were not indicated (such as taking blood pressure) and not changing them in between treating patients.

The department was badly worn in many areas and parts were poorly maintained. While we observed domestic staff cleaning regularly, the ageing infrastructure which included flooring ingrained with long-standing dirt, meant many areas remained visibly stained despite their efforts. In clinical spaces, such as the plaster room, we found significant damage to plasterwork, peeling paint, and worn flooring. This meant surfaces were difficult to keep clean and increased the risk of healthcare associated infections. We further observed heavy limescale around sinks throughout which gave a poor impression, and in some areas, posters were stuck to walls with adhesive tape which was often peeling away. This meant there was a risk to patient safety as the environment did not support effective infection control processes.

Staff did not always maintain the barriers required to stop the spread of infection. For example, in the resuscitation area, staff left the door to an isolation room open, even though signage stated the patient inside was an infection risk. The designated emergency decontamination room (donning and doffing, adjacent to resus 5) was cluttered and used as a general storage area. This meant isolation measures could not immediately be performed when needed as equipment would have to be moved out of the way.

To address IPC shortfalls, the service implemented an improvement plan focused on increased clinical oversight and staff accountability. A central part of this plan was to ensure all IPC audits were conducted on an electronic platform. This helped managers move away from spot checking, toward real-time data monitoring. This improved oversight led to an increased compliance for 'I am clean' stickers on vital signs machines rising from 0% in May to 100% in October 2025.

The service demonstrated positive outcomes in other areas of IPC practice. For example, the Paediatric area looked visibly clean, with staff observed washing hands correctly before procedures and managing clinical waste appropriately. Patients were otherwise screened at triage or rapid assessment for markers of infection such as temperature and resistance to certain medicines.

Medicines optimisation

Score

2. Evidence shows some shortfalls in the standard of care

Description: We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

Quality Statement Score: 2

We scored the service as 2. The evidence showed some shortfalls. The service did not always make sure that medicines and treatments were safe and met people's needs, capacities and preferences.

We reviewed 5 patient clinical records alongside inspections of controlled drug (CD) cupboards and resuscitation trolleys specifically across resuscitation and major treatment areas in the department.

We found that patients who stayed in the emergency department (ED) for longer periods were at an increased risk of receiving their medicines late, particularly time-critical medications. Data collected covering the period 4 January 2025 to 30 September 2025 identified that while standard medicines were given on time 89% of the time, time-critical drugs were given on time 74% of the time. With nearly 7,000 patients waiting over 12 hours, the department had found that these long stays led to fewer time-critical medications being administered within the safe 30-minute window. In response, the ED added this to their Risk Register for oversight purposes and launched a quality improvement project in October 2025 to prioritise medicines management during the initial triage process.

Inconsistent daily checks and staffing gaps weakened the oversight and monitoring of high-risk medicines. Audits identified missing daily checks for some controlled drugs cupboards and resuscitation trolleys. The department recorded 'unaccounted for' controlled drugs losses every month, with 3 incidents in August 2024, March 2025, and August 2025. Additionally, pharmacy coverage was limited to 4 days per week with no weekend presence, which reduced

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the level of professional oversight for medicine reconciliation. This was not in line with Royal College of Emergency Medicine (RCEM) guidelines in relation to pharmacy cover across an ED. To manage the risks, the department mandated a senior nurse (Band 6 or above) must participate in every controlled drug administration.

Despite these challenges, the ED had secure storage systems and maintained clear clinical guidelines. The installation of automated cabinets provided secure storage with digital audit trails for most medicines. Policies for sepsis, antimicrobial use, and rapid tranquilisation remained easily accessible to all staff. The trust initiated a Controlled Drugs Assurance Group that met monthly to review every discrepancy and identify trends. The use of automated cabinets helped to reduce the risk of manual documentation errors and improved overall drug security. The monthly governance meetings ensured the department remained accountable and could quickly address any sudden increase in medication incidents.

Effective

Rating Good



This means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. At our last assessment we rated this key question as good. At this assessment the rating has remained good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing needs

Score

2. Evidence shows some shortfalls in the standard of care

Description: We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Quality Statement Score: 2

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We scored the service as 2. The evidence showed some shortfalls. The service did not always make sure people's care and treatment were effective because they did not always check and discuss people's health, care, wellbeing and communication needs with them.

Although staff applied specific evidence-based assessment tools to assess and meet the needs of vulnerable patient groups, these were not always completed consistently. For example, a 4-month oversight gap occurred between April and July 2025, when the service stopped all fluid balance audits to update their electronic record system. This meant the service did not have any data regarding patient hydration during this time. For people using the service, this oversight left clinical needs unmonitored and directly compromised their safety. Once the department restarted auditing in August, leaders created an action plan and used 'Learning from Audits' posters to change practices.

For patients at risk of skin breakdown, a tool was used to trigger the use of pressure-relieving mattresses and tissue viability nurse referrals. During our inspection, we observed most patients in the major's area had been transferred onto beds. Staff told us this was standard practice to protect skin integrity and improve patient comfort. Staff achieved a 94% compliance rate for pressure ulcer risk assessments between 2024 and 2025. A targeted review of 45 patient records further confirmed this, showing that 89% of patients had a documented skin check. In addition, patients admitted with existing pressure damage were prioritised for transfer onto air mattresses, which were requested from the hospital's equipment library if not immediately available. This meant there was an embedded culture of assessing skin health quickly and staff acted on their findings to keep patients safe.

However, maintaining this standard was more challenging for patients in corridors. While staff reported patients with known pressure ulcers were prioritised for movement into majors to access a more comfortable bed, this did not protect patients with pre-existing damage who waited for long periods of time on trolleys. Data from July to September 2025 identified 2 incidents of hospital-acquired pressure damage within the department, both categorised as grade 1 (the initial stage of skin damage). One of these incidents involved an elderly patient who remained in a seating area, although the duration of their stay was not recorded. While the number of incidents was low, the corridor environment was fundamentally unable to support preventative care, posing an ongoing risk to vulnerable patients.

Specialist teams used targeted assessments to reduce the time frail patients spent in the department. The frailty team used a clinical frailty scale to evaluate an older person's overall

health and functional baseline. A high score triggered an immediate referral to specialist teams which would fast-track the patient's journey to a dedicated older person's ward, bypassing unnecessary delays. This helped to protect vulnerable patients from deconditioning (the physical decline and loss of independence that often occurs when frail individuals stay in a hospital bed for too long). By escalating assessments in the ED, the team helped to ensure patients received care in a quieter, more appropriate environment.

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

Description: We plan and deliver people's care and treatment with them, including what is important and what matters to them and in line with legislation and current evidence-based good practice and standards.

Quality Statement Score: 3

We scored the service as 3. The evidence showed a good standard. The service planned and delivered people's care and treatment with them, including what was important and mattered to them. They did this in line with legislation and current evidence-based good practice and standards.

Staff and the systems they used were up to date with national legislation, current guidance, and required standards. Medical staff followed clinical standards set by both the Royal College of Emergency Medicine (RCEM) and the National Institute for Health and Care Excellence (NICE). Staff were aware of legislation and guidance which protected patients' rights and knew how to apply this in practice. This included patients who were subject to mental health and mental capacity legislation or codes of practice, and people's human rights. Staff were also trained to support patients with cognitive impairment and advocate for them.

The service maintained a formal process to review and adopt NICE guidance. A Clinical Guidance Implementation Manager sent updated standards to department leaders, who then completed assessments to check for compliance. Records showed the department achieved

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full compliance in several areas. This helped to ensure the department's clinical policies remained up to date with the latest medical evidence.

How staff, teams and services work together

Score

3. Evidence shows a good standard of care

Description: We work effectively across teams and services to support people, making sure they only need to tell their story once by sharing their assessment of needs when they move between different services.

Quality Statement Score: 3

We scored the service as 3. The evidence showed a good standard. The service worked well across teams and services to support people.

The service demonstrated an effective, team-based approach to patient care by ensuring that various specialists worked together. Staff consistently used a multidisciplinary method to assess and plan treatments which meant that decisions were not made in isolation. Since teams had reliable access to the information they needed, patients benefitted from well-coordinated care that addressed their specific medical needs from the moment they arrived. This was particularly evident in the support provided to patients with learning disabilities or dementia. For instance, the trust's lead nurse for dementia made regular visits to the department to provide expert clinical guidance. Additionally, dedicated safeguarding staff were readily available to offer advice and support whenever concerns regarding the abuse or neglect of adults or children were identified.

Staff demonstrated a clear understanding of referral pathways for specialist input. As a designated trauma unit, the hospital provided 24/7 access to surgical trauma teams, emergency diagnostics, and scanning services. Detailed standard operating procedures guided staff in directing patients to the most appropriate specialty, including surgical and medical units, same day emergency care, and the trauma assessment unit. Furthermore, clinicians had immediate access to specialist advice, both in person and via telephone, from various

practitioners and allied health professionals. This meant patients received care appropriate to their needs and staff worked well together to achieve this.

Supporting people to live healthier lives

Score

3. Evidence shows a good standard of care

Description: We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives and where possible, reduce their future needs for care and support.

Quality Statement Score: 3

We scored the service as 3. The evidence showed a good standard. The service supported people to manage their health and wellbeing to maximise their independence, choice and control. The service supported people to live healthier lives and where possible, reduced their future needs for care and support.

Staff recognised that patients with complex needs required tailored support to navigate the hospital environment. A specialist Learning Disability and Autism team operated Monday to Friday to support personalised reasonable adjustments for people with sensory or communication needs, enabling them to understand and manage their healthcare, maintain choice and control, and maximise independence during their admission. Staff told us they were easily contacted and responsive when needed. We observed the service used television screens in the waiting room to broadcast community health information. This meant patients had access to services within the hospital to support them, and information was shared for people to independently access health advice if they wanted to.

The emergency department (ED) used other specialist teams to focus on the root causes of ill health, such as alcohol and drug dependency. An alcohol liaison team screened patients aged over 18 years and referred them to community partners as necessary. These interventions connected patients with local pharmacies and support groups, giving them a clear pathway to

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recover from addiction and helping to prevent future emergency admissions.

Staff worked with external partners to support the most vulnerable members of the community, including those experiencing homelessness. They collaborated with a local ambulance service and social workers to help and support patients who attended the ED frequently for the same reasons (such as for drug and/or alcohol addiction). Staff told us about their 'High Impact User' group and how they initiated care plans based on information from multiple services. This joined-up work helped to ensure that patients in these circumstances did not leave the hospital returning to unsafe conditions, helping to promote long-term health.

Monitoring and improving outcomes

Score

2. Evidence shows some shortfalls in the standard of care

Description: We routinely monitor people's care and treatment to continuously improve it and to ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.

Quality Statement Score: 2

We scored the service as 2. The evidence showed some shortfalls. The service did not always routinely monitor people's care and treatment to continuously improve it. They did not always ensure that outcomes were positive and consistent, or that they met both clinical expectations and the expectations of people themselves.

The trust managed patient flow with mixed success, as high bed occupancy within the hospital often affected how quickly patients received care and treatment. Data from August 2025 showed the hospital operated at a 93.62% occupancy rate. Staff reported that patients staying longer than 7 days who no longer needed medical care occupied 16.2% of these beds. These waits were particularly acute for patients experiencing mental health crisis, who waited in the department on average 7.4 hours in August 2025. This meant patients faced ongoing delays where outcomes in this area were unchanged.

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However, the trust had lower numbers of patients who reattended the department when compared with the national average. From July 2023 to July 2025, the trust's monthly unplanned reattendance rate was between 5.5% and 6.8%. This was the number of attendances recorded as reattending for an unplanned follow up for the same or related clinical condition at this department. This was consistently lower than the national (which was between 8.5% and 9.4%) and regional average (which was between 7.9% and 8.9%). One indicator of patients being given the right care first time was in the number of patients reattending the service within 7 days. This meant patients were discharged when their condition was stable, their diagnosis was likely accurate, and their treatment plan was effective.

The service took active steps to improve performance and protect vulnerable groups through clinical workstreams. For example, leaders expanded the Same Day Emergency Care (SDEC) service to offer alternatives to admission. In the children's ED, leaders tracked 82 standards set by the Royal College of Paediatrics and Child Health. However, they only fully met 60 of these, with 6 standards not met and 16 only partially met. For older patients, the trust achieved 93% compliance for clinical frailty assessments among patients aged 65 and over. This meant specific risks were identified early and supported people's independence.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

Description: We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Quality Statement Score: 3

We scored the service as 3. The evidence showed a good standard. The service told people about their rights around consent and respected these when delivering person-centred care and treatment.

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Staff ensured patients understood and agreed to their treatment before it began. We heard consent conversations taking place between staff and patients, and all were conducted as they should be. Most staff were aware of legislation when it came to a patient who could not give their consent. Staff knew if the patient was not conscious that they had a duty to act to save their life or provide the right care and treatment. Reasons for the treatment being necessary would be explained to the patient when they regained consciousness and were judged as able to understand.

Staff were aware of their role and responsibilities around patients who did not have the mental capacity to give consent to care and treatment. Most staff knew consent could not be provided by another person unless they had a lasting power of attorney for health and welfare for the patient. In those cases where the patient did not have capacity or an attorney, staff knew they needed a multidisciplinary approach to treating the patient where a decision was taken in the patient's best interests. Most staff were aware of the legal position around consent from children or young people under the age of 18. Staff mostly recognised how a child or young person could give their consent if they were assessed as mature enough to do so regardless of age.

Caring

Rating Requires improvement



This means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. At our last assessment we rated this key question as good. At this assessment the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Kindness, compassion and dignity

Score

2. Evidence shows some shortfalls in the standard of care

Description: We always treat people with kindness, empathy and compassion and we

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respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

Quality Statement Score: 2

We scored the service as 2. The evidence showed some shortfalls. The service did not always respect people's privacy and dignity, and in times of increased demand, it was challenging for staff to consistently deliver compassionate care.

The department did not always ensure the basic privacy and dignity of patients during periods of high pressure. We observed elderly patients on trolleys in the corridor for extended periods of time. In the ambulatory area, we saw staff performing ECGs behind short screens that allowed passers-by to see patients during this time. These shortfalls did not promote the dignity of patients using the service. Overcrowding of the department prevented staff from always being able to deliver compassionate care. This meant they did not always have the time to interact with patients or to update them on the next steps in their journey. We saw patients in the ambulatory area sitting 'shoulder to shoulder' without knowing how long they would wait or what the next step in their journey was.

Poor access to the children's resuscitation room meant children and young people were not treated with dignity when requiring emergency care and treatment.

Almost all the patients we met said staff treated them well. Patients were able to maintain their dignity as much as possible, although this became less easy for them and staff when the department was crowded and patients were being held on corridors. One patient told us, "The staff have been great, although I've been waiting a long time and not really sure what I'm waiting for next." Another patient said, "I can't say it's been a great experience, and in this area (the ambulatory assessment unit of the majors' department) they really do appear to be run off their feet, which affects how kind they are able to be."

However, staff tried their best to maintain a culture of kindness, empathy, and compassion. We observed nurses in the children's area taking extra time to be playful with children and offering tea and biscuits to worried families. Friends and Family Test results, which included feedback from patients, informed that 80% of patients rated the service as "good" or "very good", noting staff were approachable and empathetic.

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Staff worked hard to prioritise dignity in a difficult environment. Reception staff told us they used alert cards to identify patients with autism or dementia early. In one instance, we observed staff protecting the dignity of a patient in mental health crisis by pulling curtains around other patients during a challenging incident.

Treating people as individuals

Score

3. Evidence shows a good standard of care

Description: We treat people as individuals and make sure their care, support and treatment meets their needs and preferences, taking account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Quality Statement Score: 3

We scored the service as 3. The evidence showed a good standard. The service treated people as individuals and made sure people's care, support and treatment met people's needs and preferences. They took account of people's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Staff respected the unique identities and sensory needs of their patients. For instance, clinicians addressed a transgender patient by their preferred name, and the observation area provided fidget items for patients with a learning disability and autistic people. Similarly, a learning disability team assisted patients with complex needs and staff told us they were easily contacted.

During our inspection, we were told staff sometimes used a 'reverse queue' system which meant the most vulnerable patients were identified and moved to a quieter, safer space. However, we did not observe this in practice, and we continued to see vulnerable patients in suboptimal areas. After further discussion with leaders, it was not their intention to provide care in this way but at times of increased demand, it was often difficult. Staff continued to do their best for people, and we observed patients in the corridor being offered hot drinks and

biscuits while they waited.

Staff used tailored approaches to meet the emotional and physical needs of different age groups. We saw staff communicate effectively with children in the children's area, and the service utilised a therapy dog to provide emotional support.

Independence, choice and control

Score

2. Evidence shows some shortfalls in the standard of care

Description: We promote people's independence, so they know their rights and have choice and control over their own care, treatment. and wellbeing.

Quality Statement Score: 2

We scored the service as 2. The evidence showed some shortfalls. The service did not always promote people's independence, so people did not always know their rights and have choice and control over their own care, treatment and wellbeing.

The physical environment of the department often hindered patients' ability to look after themselves. We identified chairs in the waiting room did not have armrests, which made it difficult for frail patients to stand up without help. In the corridors, immobile patients were dependent on staff to move them to a private room if they needed to use the commode or bedpan. These physical constraints did not help to support people's independence.

Systemic pressures and a lack of resources often overrode a patient's control over their personal information. In the ambulatory area, we observed staff handing over patient details in front of others. This meant patients could not control who overheard these conversations including personal information.

The service's approach to discharge did not always support a person's independence once they left the hospital. Instead of printing discharge summaries or providing instruction leaflets for specific medical problems, staff gave verbal advice or signposted patients toward the NHS

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website. This meant patients had less control over their recovery at home if they didn't have a computer or didn't know how to use one.

However, the service instigated a standard process of promoting patient choice by offering flexible assessment options. For example, when the Urgent Treatment Centre became overwhelmed, staff gave patients with non-life-threatening conditions the choice to book a 'hot clinic' appointment for the next day. This allowed patients to return at a time that suited them rather than waiting in a crowded room. By providing this option, staff helped patients to have more independence, choice and control over their care and treatment.

Responding to people's immediate needs

Score

3. Evidence shows a good standard of care

Description: We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.

Quality Statement Score: 3

We scored the service as 3. The evidence showed a good standard. The service listened to and understood people's needs, views and wishes. Staff responded to people's needs in the moment and acted to minimise any discomfort, concern or distress.

The staff mostly listened to and understood patients' needs, views and wishes. Staff usually responded to people's needs in the moment and acted to minimise any discomfort, concern or distress. For example, staff prioritised clinical safety by using structured assessment tools to identify and treat the most unwell patients first. Upon arrival by ambulance, the Pitstop area was used to conduct immediate assessments to support critical decision making. This meant that despite a crowded environment, any life-threatening emergencies were quickly identified and prioritised first.

Staff acted with compassion to maintain the dignity and comfort of patients facing long waits

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or difficult circumstances. For example, during 'comfort rounds', team members moved long-stay patients from trolleys onto hospital beds. Although we observed patients remained on trolleys in the corridor due to capacity, the majority of those in the majors' area had been transitioned to beds. Patients not yet moved confirmed staff were already in the process of arranging their transfer. This was a significant positive finding, as the wider mattresses provided essential support for frail and vulnerable individuals, directly improving pressure area care and overall comfort.

Staff were quick to help whenever a patient used their call bell. During a July 2025 audit relating to the use of call bells, it was found that every patient had their call bell within easy reach. Similarly, on average, staff answered calls in less than 3 minutes in the same audit. We observed patients in majors with their call bells in easy reach, which meant people could summon help when they needed it. We also observed patients in the corridor requesting help from time to time and staff were immediately responsive to their requests.

Staff were able to support patients and relatives in distressing events. They said they were enabled to have time to look after friends and relatives of a patient who had sustained serious or life-threatening injuries. They were able to keep them updated and felt they had the skills to deliver bad news when this was necessary. However, staff told us how this became harder to manage when the department was crowded and there were few available spaces to take friends and relatives aside for more privacy.

Workforce wellbeing and enablement

Score

2. Evidence shows some shortfalls in the standard of care

Description: We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person centred care.

Quality Statement Score: 2

We scored the service as 2. The evidence showed some shortfalls. The service did not

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always promote the wellbeing of their staff. They did not always support or enable staff to deliver person-centred care.

Staff told us that delivering care became increasingly difficult during periods of extreme pressure. Operational demands often meant managers had to cancel their dedicated management days to cover clinical gaps, and nurses regularly missed their breaks during busy shifts. These persistent challenges contributed to higher sickness levels, with many staff citing stress as the primary cause. Ultimately, while support systems were available, they could not fully shield the workforce from the physical and mental exhaustion caused by a crowded and understaffed environment.

Senior staff actively promoted a culture of support, ensuring that team members felt valued and empowered to deliver person-centred care. Doctors felt well-supported by their consultants, while nursing staff described their leaders as experienced and visible on the shop floor. When asked, staff across all levels expressed confidence they would receive help if they were struggling.

Leaders tried their best to make staff feel safe and valued. Nurses told us they felt like a “united team” that “gelled well”, with one noting how colleagues supported them through a difficult time. Emergency department leads also stayed involved by helping with clinical tasks when things got busy. By holding weekly wellbeing meetings and listening sessions, leaders stayed approachable. This meant staff felt comfortable speaking up, ensuring their concerns were heard, which helped to maintain morale even when the workload was heavy.

Some of the wellbeing events and arrangements included ‘Greatex’ prizes (for when a member of staff was praised for something they had achieved); a ‘wellbeing consultant’ offering support and guidance; visits from the ‘pets as therapy’ dog; coffee mornings; cycle club; and a ‘wellbeing huddle’ every Wednesday for 20 minutes. There had also been away days for staff with visiting speakers, including the air ambulance charity team.

Responsive

Rating Requires improvement



This means we looked for evidence that the service met people’s needs. At our last assessment we rated this key question good. At this assessment the rating has changed to requires improvement. This meant people’s needs were not always met.

Person-centred care

Score

3. Evidence shows a good standard of care

Description: We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.

Quality Statement Score: 3

We scored the service as 3. The evidence showed a good standard. The service made sure people were at the centre of their care and treatment choices and they decided, in partnership with people, how to respond to any relevant changes in people's needs.

The service tailored its clinical assessments to the individual lives of its patients. For example, staff asked questions about home lives and personal circumstances, recording this social history in clinical files. We saw this in our review of patient records where individual home circumstances were always recorded. This meant treatment plans could be tailored to individual needs, such as if a person lived alone and required additional support on hospital discharge.

Staff told us they used tools to support patients with specific communication or cognitive needs. The department used 'Hospital Passports' and 'This is me' documents to support patients with dementia, a learning disability and autistic people. Although we could not review these during our inspection, the team explained they proactively requested this information from care or nursing homes to tailor their support to the individual. While the high-pressure environment sometimes limited their ability to complete new paperwork, staff prioritised obtaining existing records to bridge gaps in care.

Care provision, integration and continuity

Score

2. Evidence shows some shortfalls in the standard of care

Description: We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Quality Statement Score: 2

We scored the service as 2. The evidence showed some shortfalls. There were some shortfalls in how the service understood the diverse health and care needs of people and their local communities, so care was not always joined-up, flexible or supportive of choice and continuity.

The service had an above average number of patients leaving the department prior to being seen. Between April and September 2025, the number of patients who left the department before being seen started at 5.27% (456 patients) in April and peaked at 6.42% (568 patients) in July. While this dropped slightly to 4.59% in September, it remained above the national average of 2% to 3%. This meant staff had to spend time tracking down patients after they left, rather than focusing on treating them.

Disconnected computer systems undermined the department's ability to coordinate safe, integrated care. Since the hospital's electronic patient record (EPR) and mental health notes were on separate systems, emergency department (ED) clinicians could not access psychiatric histories. This gap was worsened by restricted service hours, such as the children and adolescent's mental health team's 3pm referral cut-off and the closure of Same Day Emergency Care (SDEC) on weekends. Consequently, the ED often had to act as a safety net for patients who did not require emergency intervention but had no available community or specialist alternative. The impact was a severely overcrowded environment where clinical staff had to manage a high volume of 'stuck' patients, stretching resources thin and compromising the safety and experience of everyone in the department.

Due to a lack of available ward beds, the department faced significant challenges in moving patients to the appropriate wards or social care settings. In late 2025, approximately 9.1% of

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patients remained in the department for over 12 hours. Although this performance was better than the national average (12.5%), these delays specifically affected elderly patients and those experiencing mental health distress. This mismatch between patient needs and hospital capacity meant the service fell short of the national goal to provide integrated, 24/7 mental health support and timely elderly care. The impact was a blocked system where patients had to stay in a loud, high-pressure environment longer than clinically necessary, increasing the risk of distress and physical deconditioning.

Providing information

Score

2. Evidence shows some shortfalls in the standard of care

Description: We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.

Quality Statement Score: 2

We scored the service as 2. The evidence showed some shortfalls. The service did not always supply appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

The department did not always provide clear, automated information about waiting times and processes. Ongoing IT issues meant electronic screens in the waiting room only showed general community health adverts rather than wait times. We observed a receptionist hand-wrote a sign for 2 to 3 hours wait, but it was not clear to everyone in the room. This meant patients could not plan their stay or understand the pressure the department was under.

Patients told us the highest concern for them was being kept updated about what was happening to them. This was particularly with patients who were in waiting areas, as those in bays or treatment areas said staff were doing their best to keep them informed. A key theme in comments from people we spoke with (patients and family) was that they needed more information or at least to be acknowledged, even when there was nothing new to tell them.

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Guidance provided to patients at the end of a visit to the service was inconsistent. For adult patients, staff told us they gave verbal advice or told them to look at the general NHS website. In contrast, the children's department used QR codes to give parents easy access to discharge information. The lack of printed or digital summaries for adults meant patients might struggle to remember key medical advice once they returned home.

Staff said there were various ways in which they could provide information in a way people could understand. This included being able to provide interpretation for patients who did not speak English as a first language. They were also able to obtain support for people who were deaf and used British Sign Language. Teams used picture-based communication sheets to help patients with learning disabilities or language barriers.

Patients told us that although it was not explicitly said, they were confident staff would not share their confidential information with anyone not authorised to see it. Staff confirmed this and said this also included making sure they checked first with patients before giving information to family or friends, in case the patient did not want this information passed on at that time.

Listening to and involving people

Score

3. Evidence shows a good standard of care

Description: We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.

Quality Statement Score: 3

We scored the service as 3. The evidence showed a good standard. The service made it easy for people to share feedback and ideas, or raise complaints about their care, treatment and support. They involved people in decisions about their care and told them what had changed as a result.

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Staff recognised how complaints were opportunities for learning and making things better for patients. They were discussed at governance meetings to look for themes and where improvement could be made. For example, the service acted quickly to improve how they supported neurodiverse patients based on direct feedback. When a formal complaint highlighted a lack of support for autistic patients, they responded by instructing reception staff to offer Autism Alert Cards and reinforced mandatory training for all patient-facing staff. This helped to ensure that staff adjusted their care to meet specific individual needs.

The service valued feedback as a tool for improvement, though it did not always make these processes visible to patients or staff. Staff viewed complaints as opportunities to improve clinical care. For example, they reviewed a case relating to a misdiagnosed injury to focus on root causes and make improvements in their care. Leaders also encouraged staff input through suggestion boxes and 'You said, we did' boards. However, during our visit, the feedback board was empty and patient resources, such as chaperone signage and patient feedback forms were stored out of sight. While the department used feedback to improve safety and clinical standards, the lack of visible information made it harder for patients to know how to share their experiences or understand their rights.

Equity in access

Score

1. Evidence shows significant shortfalls in the standard of care

Description: We make sure that everyone can access the care, support and treatment they need when they need it.

Quality Statement Score: 1

We scored the service as 1. The evidence showed significant shortfalls. The service did not make sure that people could access the care, support and treatment they needed when they needed it.

The service struggled to provide timely care because the hospital consistently operated at full

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capacity, leading to severe overcrowding. On the 21 October 2025, which marked the first day of the inspection, a red flag was submitted regarding a critical incident. A red flag acts as early warning signal that a situation is developing which could lead to harm if not quickly addressed. This had resulted in a call for ward-based or specialty medical staff to prioritise seeing patients in the emergency department (ED) to make a clear decision about their onward care. Elective surgery was stood down in some circumstances. Wards were required to expedite discharges as early as possible and senior doctors supported decisions. The local system partners, on tactical calls, were asked to support the trust with prioritising discharges of patients and alternatives to admission. Leaders told us the hospital often ran at full capacity, meaning patients got stuck in the ED with nowhere to go. This was on their risk register and graded at the highest level of risk with a recognition of all the risk factors for patients.

The crowding and delays to ambulance handovers meant staff had no choice but to treat patients in corridors and other unsuitable areas. Patients also stayed for many hours and sometimes days in beds in busy areas. This was specifically for patients with mental ill health. Some majors' patients were being cared for in the Urgent Treatment Centre (UTC) overnight as the majors' area was also full. On the day before our visit, patients had stayed overnight in the Same Day Emergency Care (SDEC) area, which was not designed for patients to be accommodated overnight.

Patients often remained in ambulances because crews could not hand them over and return to the needs of the community quickly. To address this, there had been the introduction of the 45-minute handover standard operating procedure with the ambulance trust. This meant that any patient waiting with a crew for 45 minutes was automatically handed over to staff in the department. On the first day of our visit, the impact of this was evident with 13 patients remaining in the corridor at once, and trolleys blocking fire doors and emergency exits. Staff said patients were often held in the Pitstop rapid assessment and triage area, in the UTC, or in waiting areas, which increased the risk of harm to the patient as this was not an optimal place of safety.

There was action taken to divert patients to other services if they did not require urgent or emergency care, although the process was confusing and did not always manage patients' expectations. National guidelines recommend triaging patients within 15 minutes of arrival, yet the trust averaged less than 60% compliance over the last year. On the first day of our visit, there was a period of confusion among staff where no one had been assigned to triage. When a

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member of staff did pick up the role, the longest wait for patients was 1 hour and 6 minutes and there were 11 patients waiting.

Staff said there was a process for other staff being brought to assist with triage when the waiting times grew, but one of the senior members of staff on duty admitted this was rarely adhered to and should the need for additional triage be recognised, it was often not supported.

The streaming process existed to direct walk-in patients to GPs or pharmacists, it was confusing. Patients were often moved to secondary waiting areas before being properly assessed, making it unclear when or how their clinical priority was decided. These delays and gaps in the assessment process meant the department did not have a reliable safety net. This increased the risk that a patient's condition could worsen and go unnoticed.

There was no overnight service for patients needing treatment for minor injuries and minor illnesses as the service closed from 10pm to 8am. However, patients were still able to walk in as the waiting area was also the entrance for walk-in patients for the ED. Any patients who did arrive but did not need urgent or emergency care were streamed and either asked to make a GP appointment; go to their local pharmacy; given an appointment to come back to the service the next morning; or diverted if they were seriously unwell to the ED.

Adjacent services had been established to help reduce direct demand for urgent and emergency care. The hospital trust operated a medical and surgical same-day emergency care service (SDEC), along with a frailty acute same-day service which helped with the pressure on the ED.

A shortage of available ward beds prevented the department from admitting or discharging patients within required timeframes. The national goal was to treat, admit, or discharge 78% of patients within 4 hours. However, in the 2 weeks before our visit, only 18% to 39% of the most unwell patients met this standard. This was also reflected in a longer-term trend between October 2024 and September 2025, where the department averaged 59%, which was below the local and national averages for England (72%). While the service performed better than the national average for 12-hour waits, we still found patients waiting in chairs for over 16 hours due to communication errors. In July 2025, the proportion of patients who left the department (including those who left prior to assessment and those who left after assessment but before treatment was completed) peaked at 6.4%.

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While the department showed significant year-on-year improvement and outperformed both local and national averages, extended waits remained a concern for some patients. Between October 2024 and September 2025, an average of 4.5% of patients waited more than 12 hours following a decision to admit. This was better than the England average of 11.3% for the same period. However, despite a steady reduction in these waits since early 2025, recent data indicated that numbers were beginning to rise again, mirroring a broader regional and national trend. During our inspection, we observed the human impact of these delays: one patient in the ambulatory care assessment unit had been waiting in a chair for over 16 hours due to a reported “miscommunication,” while another had been seated for 12 hours awaiting a medical assessment. Additionally, the longest wait for a patient yet to be assigned for an onward review was recorded at over 8 hours.

Ambulance handover delays and overcrowding prevented patients from accessing timely care, resulting in many people leaving without treatment. In the 10-month period from 1 October 2024 to 31 July 2025, 41% of patient handovers were delayed by more than 60 minutes. This was against an England average of 10.8%. During our visit, we observed elderly patients waiting in corridors for extended periods, including an 86-year-old who had been there for 7 hours, and an 80-year-old waiting for 6 hours. These wait times created an inequity in access, as the department’s most vulnerable patients had to wait in unsuitable, public areas.

Equity in experiences and outcomes

Score

3. Evidence shows a good standard of care

Description: We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Quality Statement Score: 3

We scored the service as 3. The evidence showed a good standard. Staff and leaders actively listened to information about people who are most likely to experience inequality

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in experience or outcomes and tailored their care, support and treatment in response to this.

The trust had a co-produced 'Vulnerable People Strategy' to help ensure care meets the diverse and individual needs of people who may be vulnerable for a wide range of reasons, including but not limited to disability and neurodivergence. Evidence showed the service used tools like hospital passports and dementia safety matrices to provide person-centred care, and we were told the service had sensory items like fidget toys and iPads. Data received from the trust further informed their use of a network of 'champions'. It stated the hospital had over 140 Learning Disability and Autism Champions, 100 Dementia Champions, and 60 Deaf Awareness Champions. They also introduced Makaton training at the beginning of 2025 which has resulted in 41 staff members, including nurses to domestic staff, to be able to communicate with non-verbal patients. Although we did not have the opportunity to see this in practice during our visit, staff told us they would escalate this need to their nurse in charge or matron.

The department was working to balance high patient demand across all ages, with opportunities to further strengthen the support for children and young people. Staff from the paediatric unit told us they were regularly moved to adult areas during busy periods. We were told staffing levels in the children's area sometimes adjusted to a single nurse to meet this demand, which impacted on the speed of triage for children with minor injuries. This approach helped manage patient flow during these times, but it highlighted the impact of reduced staffing levels across the entire department.

Planning for the future

Score

3. Evidence shows a good standard of care

Description: We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.

Quality Statement Score: 3

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We scored the service as 3. The evidence showed a good standard. People were supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.

The department improved future planning by integrating specialist teams and involving families in the decision-making process. When patients could not speak for themselves, staff made documented efforts to engage with relatives and carers to understand the patient's values. These proactive reviews caught vulnerable patients who might otherwise have been missed in the busy ED environment. By involving families and specialist nurses, the department ensured that even in high-pressure situations, the care provided remained person-centred and legally compliant with the Mental Capacity Act.

We saw records to alert staff to the wishes of a patient around resuscitation or ongoing care or intervention. Staff were aware of the patient's background and alert to their needs as early as triage, or records being updated in more detailed discussions with the patient and their family. This meant staff had immediate information about a person's resuscitation status and ensured that medical interventions aligned with patients' wishes.

However, data received from the trust indicated shortfalls with ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) documentation. The ReSPECT Documentation Audit tracked performance from June 2025 to March 2026 and achieved an overall compliance of 65.7%. To address the audit failings, the ED Matron joined the Deteriorating Patient Working Group in late 2025 to launch an improvement plan. When records were available, staff provided medical interventions that matched the patient's preferences, ensuring dignified care. The ongoing collaboration between the Resus team and the ED Matron also led to new, practical changes such as identifying better locations to print and display ReSPECT information to ensure these documents remained visible despite high patient turnover.

Well-led

Rating Requires improvement



This means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At our last assessment we rated this key question as requires improvement. At this assessment

the rating has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

The service was in breach of regulation 17 for good governance.

Shared direction and culture

Score

3. Evidence shows a good standard of care

Description: We have a shared vision, strategy and culture that is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding and meeting the needs of people and our communities.

Quality Statement Score: 3

We scored the service as 3. The evidence showed a good standard. The service had a shared vision, strategy, and culture. This was based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and their communities.

Within the emergency department (ED), a strong culture of teamwork was evident; staff described a supportive environment and a clear, shared vision of the high-quality care they wanted to deliver. However, maintaining a focus on service improvement during periods of extreme pressure was challenging. Extreme operational and financial pressures hindered the service's ability to evolve. Staff within the ED described a state of constant "firefighting" that left no room for meaningful development. These intense conditions led many employees reporting that clinical progress felt like an "impossible goal." Furthermore, senior leaders told us they lacked direct control over their own budgets due to a 'triple lock' framework, which restricted spending during the ongoing financial crisis. A triple lock in this context is a strict financial recovery process. It means external services have taken over the management of budgets in order to meet targets.

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Despite these struggles, leaders fostered a collaborative culture by involving staff and patients in the trust's long-term planning. The trust implemented improvement huddles and performance review meetings to help ensure the lived experience of frontline workers directly shaped executive priorities. Leaders also invited patient representatives to board meetings and utilised Friends and Family Test feedback to keep the trust's direction grounded in real-world patient needs. By integrating these diverse perspectives, the service aimed to ensure its strategic goals remained relevant and inclusive.

The trust further strengthened its direction by aligning with external partners to manage regional patient surges. Leaders held joint improvement meetings with the local ambulance service to review data and streamline handover processes. These collaborative efforts successfully reduced friction between the different services and created shared goals for the entire region. Consequently, the trust improved its ability to move patients from ambulances into the hospital more efficiently, protecting both patient safety and system capacity.

Capable, compassionate and inclusive leaders

Score

2. Evidence shows some shortfalls in the standard of care

Description: We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively and do so with integrity, openness and honesty.

Quality Statement Score: 2

We scored the service as 2. The evidence showed some shortfalls. Although leaders understood the context in which the service delivered care, treatment and support, consistent ongoing pressures did not always enable leaders to take a proactive approach to issues and risks.

During our inspection, we observed that leaders had a good understanding of the service's

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shortfalls. They demonstrated a genuine commitment to improvement, engaging in open and honest conversations with us regarding current struggles and future goals. However, systemic pressures often tested leaders' capacity to provide safe and responsive care. They faced daily challenges including high nursing vacancies, a lack of doctors, and a hospital at full capacity. While leaders remained visible and understood these issues, the constant pressure often limited their ability to provide consistent oversight to effectively manage these challenges.

Leaders focused on reacting to problems as they happened rather than preventing them, which allowed known safety risks to persist. Audits indicated ongoing problems, yet these did not always lead to improving trends over time. Key safety measures continued to fall below acceptable standards, for instance, staff were not up to date with their mandatory training, individual ligature risk assessments for patients in mental health distress were not standardised despite an increased cohort in this area and frail patients were situated next to vulnerable patients experiencing mental health problems. Poor infection control, as well as patient dignity concerns all impacted on patient safety and experience within the service, and because leaders did not act quickly and decisively on these concerns, avoidable risks remained ongoing.

However, leaders told us they maintained oversight of these challenges through regular quality walk-arounds and executive involvement in critical incident meetings. These forums allowed senior leaders to request external support and ensured that risks were recognised at both the department and board levels. By maintaining these reporting lines, the trust ensured that the emergency department's struggles remained a central focus for the leadership team.

Emergency department (ED) leaders fostered an open and supportive culture for staff, though a disconnect remained between frontline staff and executive response. To support a strained workforce, ED leaders created a speaking up culture where staff felt safe to be honest. They also held listening events and ensured staff went home on time. However, some senior staff felt their specific concerns about overcrowding were not always acknowledged, leading to frustration. While executive leaders were aware of these risks, they had not effectively shared their response plans with the team.

Freedom to speak up

Score

3. Evidence shows a good standard of care

Description: We create a positive culture where people feel that they can speak up and that their voice will be heard.

Quality Statement Score: 3

We scored the service as 3. The evidence showed a good standard. The service fostered a positive culture where people felt they could speak up and their voice would be heard.

Leaders had built a positive culture where most staff felt they could speak up and their voice would be heard. Most staff we met said they felt able to speak up if they needed to and they felt they would be listened to. Those we asked knew about the role of the Freedom to Speak Up Guardian and their team. Some staff said they would approach the guardian if they needed to, but others said they would be more likely to approach their own manager first or a trusted colleague.

Some staff said they did not feel anything changed when they spoke up. They spoke about concerns around safe levels of staffing at times, or specific concerns about their area of work. Some felt speaking up about this did not make a difference.

Workforce equality, diversity and inclusion

Score

3. Evidence shows a good standard of care

Description: We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.

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Quality Statement Score: 3

We scored the service as 3. The evidence showed a good standard. The service valued diversity in their workforce. They work towards an inclusive and fair culture by improving equality and equity for people who work for them.

The service had a commitment to equality, diversity, and inclusion through the You Matter Strategy and the 2025 refresh of the RUH People Plan. These frameworks directly addressed systemic gaps identified in the trust's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data. To foster a sense of belonging, the executive team formally recognised and funded 6 primary staff networks, including the REACH Network for ethnic minority colleagues and the Enable Network for disabled and neurodiverse staff. Leaders granted employees dedicated time during work hours to attend monthly meetings, ensuring that lived experiences directly influenced the trust's diversity agenda and internal policies.

To promote professional growth, the trust launched the Routes to Success positive action programme, which supported Band 5 nursing and midwifery staff from underrepresented groups in progressing to senior leadership roles. This was complemented by a trust-wide network of Inclusion Champions embedded within individual teams to provide localised advice on best practices. Specialised support groups also emerged to address specific health and wellbeing needs, such as the Menopause Support Group and the Neurodivergence Peer Support Group, creating informal spaces for staff to share advice and seek peer-led solutions.

The organisation also prioritised speaking up by investing in the Report and Support platform, which allowed staff to escalate concerns about bullying or harassment more easily than traditional routes. This sat alongside a new Violence Prevention and Reduction Policy designed to empower employees to challenge discrimination or abuse from the public. Between 2023 and 2025, the trust met specific breakthrough objectives that focused on reducing manager-led discrimination against staff with disabilities and those from diverse racial backgrounds. Progress remained under constant scrutiny, with monitoring occurring during monthly Divisional Performance Review Meetings to ensure these initiatives translated into measurable improvements in staff morale and clinical effectiveness.

Governance, management and sustainability

Score

1. Evidence shows significant shortfalls in the standard of care

Description: We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Quality Statement Score: 1

We scored the service as 1. The evidence showed significant shortfalls. The service did not have clear responsibilities, roles, systems of accountability and good governance. They did not act on the best information about risk, performance and outcomes, or share this securely with others when appropriate.

The trust operated within a highly pressured environment where their governance framework struggled to effectively resolve long-standing staffing shortages and rising patient demand. While leaders recognised these risks and invested significant resources into temporary staffing, a lack of consistent clinical oversight and updated emergency planning made it difficult to maintain good standards of care. Despite the best efforts of a dedicated workforce, these challenges created a cycle of operational strain that impacted both patient safety and staff wellbeing.

The service faced long-standing difficulties in securing enough staff. Staffing risks remained on the department's risk register as a 'major' concern since 2020. Despite this risk being known to leaders, the department continued to operate with only one registrar at night because locum shifts often went unfilled. Similarly, increased nursing and healthcare support worker vacancies had not been reduced and did not meet the trust target, and staff sickness continued to increase. Managers struggled to maintain safe staffing levels, resulting in a reliance on a depleted workforce that could not meet national operational standards.

Due to failure to meet certain national standards, the trust was referred to a performance

Urgent and emergency services

management system used by NHS England to provide extra support to help them meet national standards. Actions for improvement were being managed through the Urgent and Emergency Care Delivery Group improvement programme, aiming to ensure better alignment with national expectations. This meant any investment of over £100,000 had to be authorised by the Integrated Care Board and NHS England. Data received from the trust indicated they had spent £2.47 million on temporary staffing in the 2024/25 financial year, including £1.16 million in nursing and £532,000 in medical staffing. High vacancy rates remained ongoing as the nursing establishment was increased and the trust was actively on a recruitment drive. Furthermore, high sickness rates accounted for a portion of the £2.47 million spent on temporary staffing.

The service failed to maintain a comprehensive overview of patient safety, leading to significant gaps in quality assurance. Although leaders held governance meetings every 2 months, these did not provide the leadership with overall effective assurance in several key performance and quality audit areas. For example, there were no audits carried out in certain key performance areas to determine where there were areas of concern and how these were going to be addressed. This included an audit of times to carry out an electrocardiogram (ECG) against the 15-minute guidance. Senior staff said they recognised there were gaps in the audit of sepsis management. Patients' pain was not audited. This lack of oversight meant there was an ongoing risk that any declining standards would go unnoticed and unaddressed. This directly compromised patient safety and prevented the trust from meeting the Royal College of Emergency Medicine (RCEM) standards for over a long period.

Leaders did not manage critical departmental risks effectively, particularly the safety of the environment. We observed breaches in information governance with patient records left visible on unattended computers and test results scattered on public counters. Our review of the risk register further identified ongoing problems within the service, such as CCTV blind spots, and medicine drug cupboards with broken locks (although we did not observe this on our inspection).

The department lacked a clear and up to date framework for managing large-scale emergencies, leaving the service vulnerable to sudden surges in demand. While the specific emergency department major incident plan had not been reviewed since 2017, the trust stated they would utilise the Trust Incident Response Framework. Senior nursing staff, however, expressed a lack of awareness regarding how to access or deploy major incident equipment.

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Furthermore, the department had not conducted any ED-specific emergency exercises over the last 4 years, meaning staff had not practiced the coordination required for large-scale emergency situations. This lack of preparation created a significant risk that, in the event of a declared major incident, the team would be unable to respond with the necessary speed and organisation, potentially compromising patient safety during a crisis.

Partnerships and communities

Score

2. Evidence shows some shortfalls in the standard of care

Description: We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Quality Statement Score: 2

We scored the service as 2. The evidence showed some shortfalls. The service did not always understand their duty to collaborate and work in partnership, so services work seamlessly for people. They did not always share information and learning with partners or collaborate for improvement.

The partnership working with the mental health trust required far more cooperation and responsiveness than was happening in practice. It was in this clinical specialty where many patients remained in the department for unacceptable lengths of time. There were regular calls which included the integrated care system team to review the needs of patients, but this remained an area of concern for safety and wellbeing of the patients and staff.

Representatives from the local NHS ambulance service said they had a good working relationship with the emergency department leadership team and the trust in general. There had been close working over some of the most challenging times for urgent and emergency care. The ambulance service provided a hospital ambulance liaison officer (known as a HALO) to provide a link between both services. This was acknowledged to work well and be of noted

value to both organisations.

Staff shared information and learning with partners and collaborated for improvement. Key organisations included the local NHS ambulance service and the local NHS mental health trust. They also included the integrated care system for the region and other system partners who had links with other health and social care services.

Learning, improvement and innovation

Score

2. Evidence shows some shortfalls in the standard of care

Description: We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Quality Statement Score: 2

We scored the service as 2. The evidence showed some shortfalls. The service did not always focus on continuous learning, innovation and improvement across the organisation and local system. They did not always encourage creative ways of delivering equality of experience, outcome and quality of life for people. They did not always actively contribute to safe, effective practice and research.

There was a plan for the service to focus on continuous learning, innovation, and improvement. However, because of shortages of staff, and crowding in the service, staff did not always have creative ways of delivering equality of experience, outcome, and quality of life for patients. Despite obvious skills, experience and clinical knowledge, staff could not always contribute to development of practice and research actively.

There was continuous development available for staff around day-to-day clinical practice. The service had a team of clinical educators across various grades and clinical specialities. Their

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role was to support with education for staff, including development and advancement, and to help through this with staff retention.

There were opportunities for research which was overseen by an ED Consultant and ED Consultant Nurse. One study currently being undertaken was a review of the rapid assessment and triage process by the ED Consultant Nurse.

Staff and leaders were encouraged to learn about new and innovative approaches that evidence showed could improve the way their service delivered care. However, staff commented how the pressures on the department from managing so many patients did not leave them always enough time to explore other innovative or emerging approaches to care and treatment.

Royal United Hospital Bath

Action plan requests

Regulation 17: Good governance

Service

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Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

The emergency department did not provide sufficient evidence of how it assessed, monitored, and improved the quality and safety of the service provided in the carrying on of the regulated activity. It did not provide evidence of how it assessed, monitored, and mitigated the risks to the health, safety, and welfare of service users. The leadership team did not present a clear and well-understood overview of quality and safety which included some of the vital key metrics for determining assurance.

Regulation 12: Safe care and treatment

Service

Urgent and emergency services

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

The emergency department was not ensuring care and treatment was provided in a safe way for service users. Due to crowding in the department from a lack of available hospital ward-based beds or

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waiting for specialty review to determine onward care, people were having to wait for unacceptable periods of time in a department not designed for this purpose, or on the back of an ambulance waiting for handover. This included and specifically affected patients who had mental health needs.

Regulation 18: Staffing

Service

Urgent and emergency services

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

The emergency department did not have enough suitably qualified, competent, skilled, and experienced persons deployed. There were high levels of nursing vacancies, which would reduce through new starters, and the department did not meet the recommended level of consultant cover for an emergency department and had unsatisfactory and unsafe numbers of resident doctors as senior decision makers overnight.

Report to:	Public Board of Directors	Agenda item No:	14
Date of Meeting:	3 June 2026		

Title of Report:	Maternity and Neonatal Safety Report Quarter 3 2025/26
Board Sponsor:	Antonia Lynch, Chief Nursing Officer
Author(s):	Zita Martinez, Director of Midwifery and Neonates Jodie Clement, Quality and Patient Safety lead for Maternity and Neonates
Appendices	Appendix 1: Q3 TC/ATAIN report

1. Executive Summary of the Report
The Quarter 3 (2025/26) Maternity and Neonatal Safety Report provides assurance to the Board of Directors regarding the quality, safety, and performance of perinatal services at the RUH. The report highlights continued compliance with national safety standards, and targeted improvement work aligned with the Three-Year Delivery Plan, the Maternity Incentive Scheme (MIS), and the Saving Babies' Lives Care Bundle v3.2. Perinatal Mortality: Stillbirth and Neonatal mortality rates remain below national averages; however, the stillbirth rate increased slightly in 2025 (2.6/1000 vs 2.4/1000 in 2024). A thematic review of stillbirths from 2024–2025 is underway to identify contributory themes and drive system improvements. Six perinatal mortality cases met the Perinatal Mortality Review Tool (PMRT) criteria during Q3, with the service maintaining 100% compliance with all PMRT process measures. National pathology delays continue to impact the timeliness of postmortem results, affecting both families and review completion; this has been added to the risk register and escalated regionally (Risk 3251). Safety Surveillance & Investigations: Two Maternity and Newborn Safety Investigations (MNSI) were completed in Q3, with one ongoing investigation. Two new referrals were made in Q3. Key learning themes include neonatal hypoglycaemia risk assessment, safe skin-to-skin documentation, and fetal monitoring guidance. One Patient Safety Incident Investigation (PSII) was completed, with improvements implemented in neonatal triage pathways leading to reductions in readmissions to the Neonatal Unit demonstrated through Avoiding Term Admissions Into Neonatal Unites (ATAIN) audit outcomes. Three new local learning responses commenced under the Patient Safety Incident Response Framework (PSIRF), focusing on maternal deterioration, neonatal hypoglycaemia, and digital integration of ultrasound pathways. Saving Babies 'Lives & Maternity Incentive Scheme Compliance: As of Q3, the service remained on track for full compliance with the 10 Maternity Incentive Scheme (MIS) Safety Actions for Year 7 by March 2026. Implementation of SBL v3.2 is 96% compliant in Q3, with targeted work underway to increase ultrasound capacity and strengthen Peri-Prem processes. The service has subsequently submitted full compliance with all 10 Safety Actions. Equity, Quality & Patient Experience: Enhanced surveillance of ethnicity and deprivation data in PMRT continues. Q3 analysis shows a disproportionate representation of Black women noted, however due to the small dataset, this may present a skewed result and should be interpreted with caution. To ensure early identification of any correlations, informing focus for improvement actions, continuous monitoring of ethnicity and Index of Multiple Deprivation (IMD) within PMRT is in place. Equity improvement projects are progressing, including culturally tailored continuity of care models, improved language access, and enhanced mechanisms for hearing lesser-heard voices.

Patient experience continues to show sustained themes around immediate postnatal care; leadership strengthening on Mary Ward and medicines-related quality improvement (QI) work have begun to improve these concerns. Compliments highlight consistent compassion and kindness across services.

Workforce & Culture:

Staffing stability remains positive, with improved recruitment, sickness reduction, and 100% retention of newly qualified midwives since 2023. The Perinatal Culture & Leadership Programme continues to drive improvements in communication, teamwork, and postnatal ward culture, supported by four trained culture coaches. Training compliance remains strong across PROMPT, fetal monitoring, neonatal resuscitation, and adult basic life support (ABLS), with improvements attributed to redesigned training delivery models.

Risk Management:

Two new risks were added in Q3:

- Digital ultrasound data interoperability issues
- Perinatal pathology delays affecting bereavement care and learning.

All risks >12 continue to be monitored closely through Divisional governance and Perinatal Quality Oversight Model (PQSOM) structures.

2. Recommendations (Note, Approve, Discuss)

Discuss

3. Legal / Regulatory Implications

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

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

In Q3 two new risk assessments were presented and approved for the risk register:

Risk No	Domain of Risk	The Risk	
3202	Digital	There is a risk Maternity Ultrasound imaging and clinical data may not be reliably shared across the various digital systems impacting upon adequate care planning and provisions	6
3251	Patient Safety and Quality	There is a risk to quality of care and compounded harm to bereaved families due to perinatal pathology workforce gaps	12

Table 1: New risk, Q3 2025/26

Current open risks scoring >12 in Maternity and Neonates Q3 2025/6 scoring:

Risk No	Domain of Risk	The Risk	
3182	Patient Safety and Quality	There is a risk to neonatal care provision due to service cot capacity pressures impacted by reduced cot capacity within level three tertiary neonatal units	16
3103	Patient Safety & Quality	There is a risk women categorized as amber of green do not receive a medical review in line with RCOG Triage guidance (2023)	15
3013	Patient Safety & Quality	There is a risk that USS service, provided jointly by maternity and radiology, does not have enough	12

		capacity	
2950	Patient Safety & Quality	There is a risk that due to the current compliance of percentage of staff QIS trained in the LNU below BAPM standards, the quality of care being delivered to the babies at risk of being compromised	12
2785	Patient Safety & Quality	There is a risk that the current pharmacist cover for the Neonatal Unit does not meet clinical needs or BAPM standards	12

Table 2: Ongoing risks scoring >12 Q3 2025/26

All risks are managed as per the Trust Risk Management Policy.

5. Resources Implications (Financial / staffing)

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

6. Equality and Diversity

Equality and Diversity legislation is an integral component to registration.

7. References to previous reports

Previous monthly Perinatal Quality Surveillance reporting Q3, and 4 Maternity and Neonatal Safety Reports – Quality Governance Committee & Board of Directors

8. Publication

Public.

Report Overview

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance oversight model*' (December 2025). The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) Board and the Board of Directors of present or emerging safety concerns within Maternity and Neonatal services. The information within the report reflects actions and progress in line with the three-year delivery plan (3YDP) for Maternity and Neonatal Services of 2023. It also outlines the current position of compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) including Saving Babies Lives Care Bundle V3.2 (SBL).

1.0 Perinatal mortality and morbidity Q3

The following graphs demonstrate RUH performance against the national ambition to reduce stillbirths in the UK by 50% from the 2010 rate by 2025, and the RUH local ambition for continual progression in reducing perinatal mortality.

From May 2025 the national averages have been adjusted to reflect the latest publication of the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries UK (MBRRACE-UK). MBRRACE-UK collects data on perinatal deaths, defined as stillbirths from 22 weeks' gestation and neonatal deaths up to 28 days of age, excluding terminations. Due to differing definitions (stillbirths recorded from 24 weeks, perinatal deaths from 22 weeks), reported rates may vary.

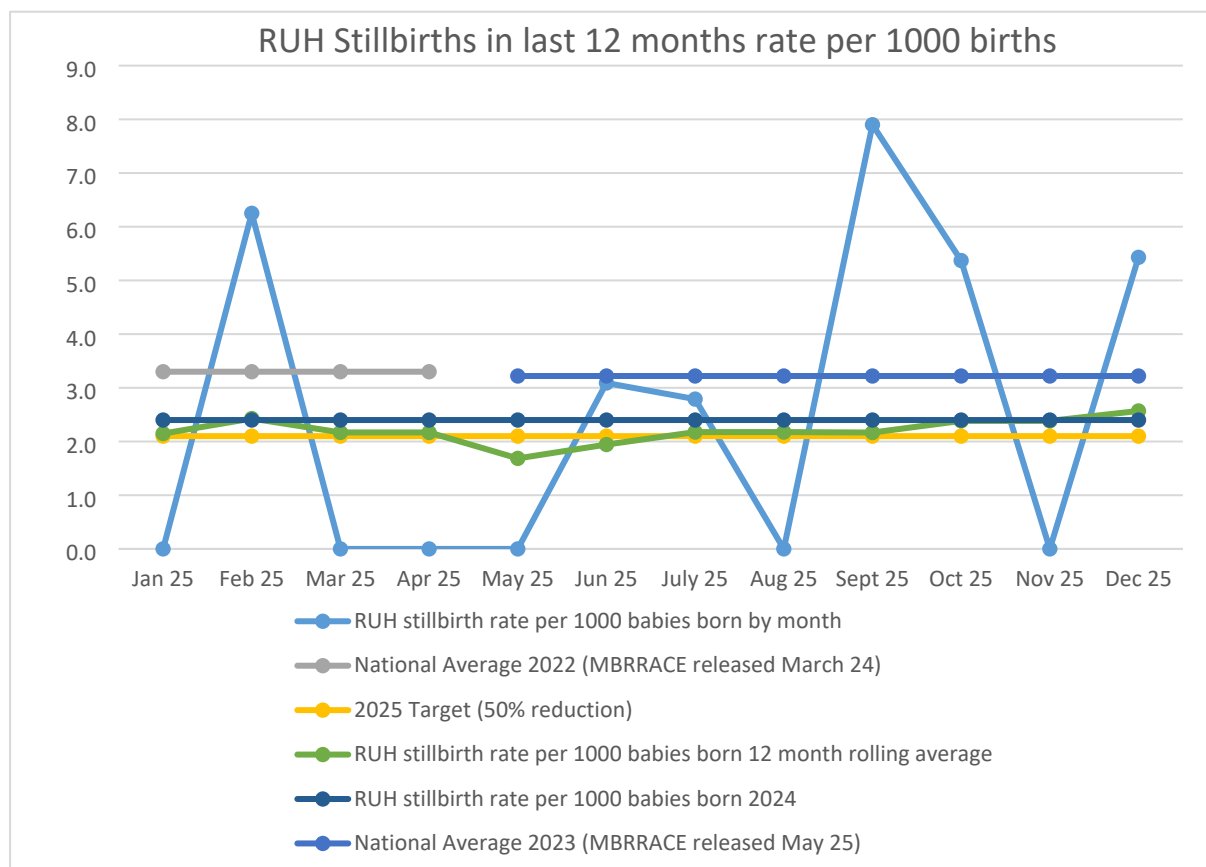


Figure 1: RUH NHS Trust stillbirth rate per 1000 births over last 12 months

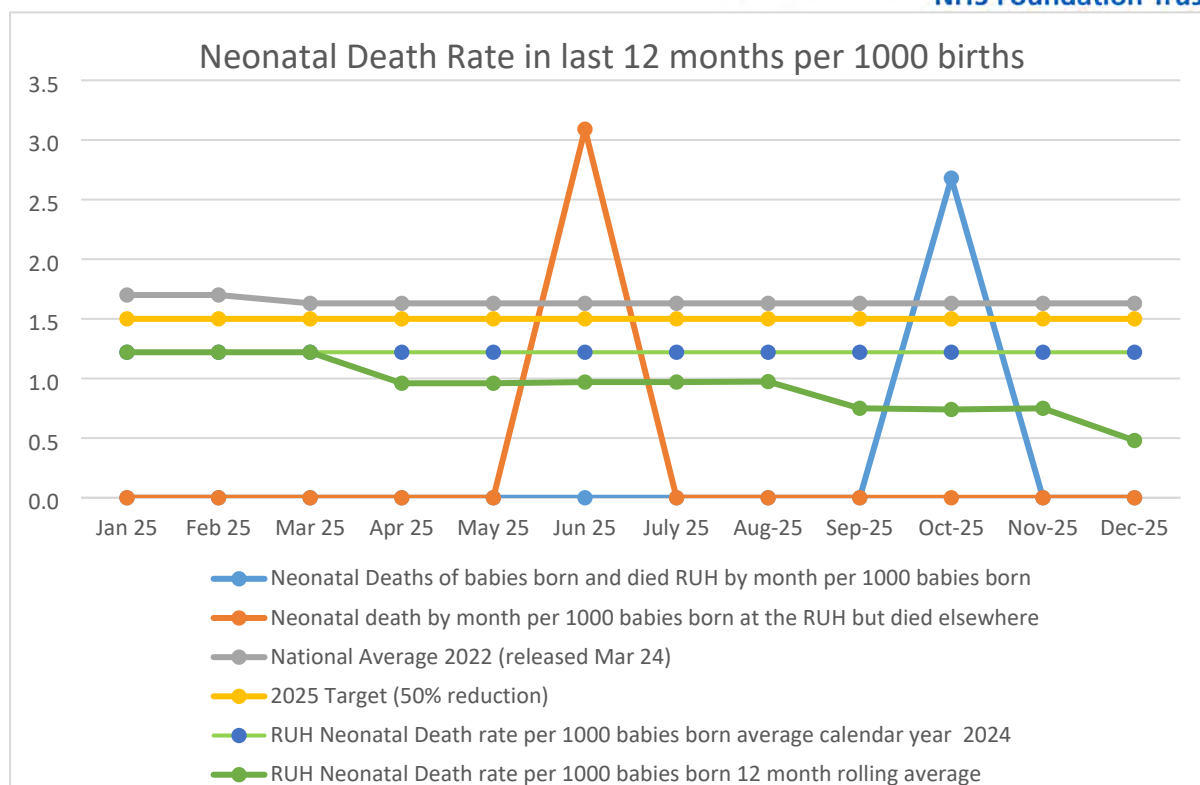


Figure 2: RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months

Trusts are provided with initial MBRRACE-UK perinatal mortality rate per 1000 births; results are subsequently stabilised and adjusted to reflect if the RUH statistics were representative of the national socioeconomic demographics. Therefore, the MBRRACE-UK crude, and stabilised and adjusted rates of perinatal mortality for the RUH will be different.

MBRRACE-UK collates the data for those babies who were born at the RUH and subsequently died elsewhere. This report has separated these values to ensure alignment of internal mortality data figures ahead of reported and adjusted MBRRACE-UK figures (Figures 1 and 2).

The RUH annual calendar year stillbirth rate for 2025 was 2.6 per 1000 births. This remains below the national average, although is an increase from the 2024 rate of 2.4 per 1000 births. This exceeds the national ambition of a 50% reduction to 2.4 per 1000 births in 2025 and equates to a crude increase of 1 stillbirth from 2024 – 2025.

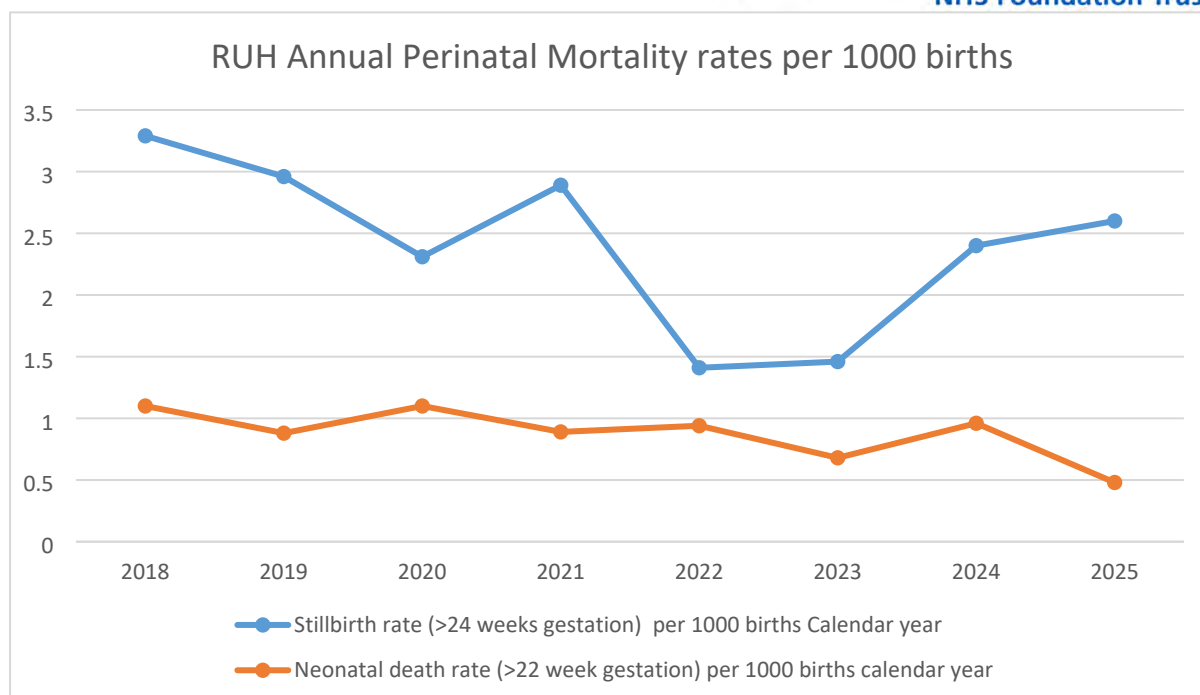


Figure 3: RUH annual Perinatal mortality rate per 1000 births by year

During quarter 4 the service will be conducting a thematic review of stillbirths in 2024 and 2025 in recognition of an increased rate comparative to 2022 and 2023, seeking identification of commonality and system improvements to safeguard against stillbirth.

2.0 Perinatal Mortality Review Tool (PMRT)

There were 4 antenatal stillbirths, 1 late miscarriage, and 1 early neonatal death of a baby born with congenital anomalies during Q3 eligible for PMRT reporting (Table 1).

2025/26 (excluding terminations for abnormalities)	Q3 25/26	Annual total 25/26 (fiscal)	Annual total 2025 (calendar year)
Stillbirths (>37 weeks)	2	4	5
Stillbirths(>24weeks-36+6weeks)	2	5	6
Late miscarriage (22+weeks-23+6weeks)	1	1	1
Neonatal death at the RUH	1	1	1
Neonatal death elsewhere following birth at the RUH	0	1	1
Total	6	12	14

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

During Q3 it was identified that there was a duplicate reporting of 1 stillbirth during Q4 of 24/25. 1 term stillbirth was reported during February and March of 2025 via the Perinatal Quality Support and Oversight Model (PQSOM). This has been verified and cross referenced with the maternity bereavement team, quality and safety team, MBRRACE reporting system and Datix, therefore the values in Table 3 may differ from previous quality reports.

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

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

Table 4 identifies the service's current PMRT process performance metrics against MIS standards, demonstrating continued compliance, reflective of well embedded and embraced processes in place to deliver the PMRT across perinatal services.

PMRT PROCESS MEASURES

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Q3 25/26	Annual 25/26	MIS Standard
Notification of all perinatal deaths eligible to notified to MBRRACE-UK to take place within seven working days	100%	100%	100%
A PMRT review must be commenced within two months following the death of a baby	100%	100%	95%
An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	100%	100%	50%
A PMRT report must be published following the MDT review within six months of the death of a baby's death	100%	75%	75%
All parents will have been informed that a review of their baby's death is taking place and Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have	100%	100%	95%
Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024. (See technical notes 19 to 20)	100%	100%	100%

Table 4: PMRT Process Measures Quarter 3 25/26

The family remain at the focus of the PMRT, all families are offered support through a single point of contact during the review process to provide regular updates of PMRT progression.

The service is aware of the workforce gaps in perinatal pathology services impacting upon delays to pathology results. This continues to significantly impact the timeliness of postmortem examinations following neonatal deaths and stillbirths. The delays not only affect the completion of the Perinatal Mortality Review tool (PMRT) process, but has a profound emotional impact on bereaved families, who often face extended periods of uncertainty while awaiting answers about their baby's death. The inability to provide timely postmortems results can impact families' ability to process grief, delay closure, and in some cases, affect future pregnancy planning. It also limits the maternity service's ability to efficiently identify areas of

learning and improvements in care, supporting continuous improvement in service provision.

Efforts to mitigate these delays locally are ongoing: however, the issue remains a national workforce challenge requiring strategic attention to ensure families receive compassionate, timely, and informative care during the most difficult of circumstances. A risk assessment has been completed during Q3 and is risk 3251 on the service's risk register.

Families may choose to receive draft reports pending further investigation results detailing review findings to date, others may choose to await final PMRT completion to receive PMRT outcomes. The service delays are currently impacting 8 families. In recognition of the delays, to ensure patient confidentiality, respect and safeguard family choice pertaining to the sharing of PMRT outcomes this report will no longer share provisional gradings of care. This is in recognition that this report is within the public domain. Once PMRT gradings are finalised and have been shared with the families, as per their wishes, they will be reported under section D.

Actions and learning opportunities were identified as follows.

Issue/area for improvement	Review Response/Action plan	Action target date
1. Escalation and actions for mitigation regarding regional delays to perinatal pathology services	Risk assessment to be undertaken and identified on service risk register outlining the actions to be taken to mitigate and safeguard against poor patient experience for families within perinatal bereavement services	Complete

Table 5: Q3 2025/26 PMRT completed reviews improvement plan

Q3 2025/26 PMRT REVIEWS EQUALITY, DIVERSITY AND INCLUSION

Ongoing disparities in perinatal outcomes across the UK highlight the urgent need to prioritise equality, diversity and inclusion within maternity services. MBRRACE-UK continues to show significant ethnic and socioeconomic gaps in stillbirth and neonatal mortality rates, with babies from Black and Asian backgrounds and those born into the most deprived communities experiencing disproportionately poorer outcomes.

PMRT cases Q3 25/26 by Maternal Ethnicity

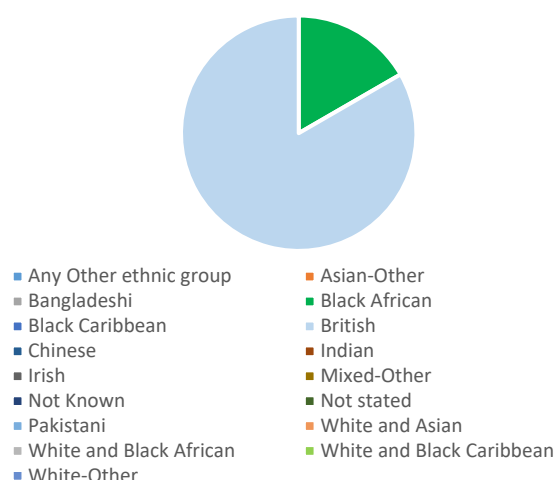


Figure 4: PMRT birth data Q3 25/26 by maternal ethnicity

Births in Quarter 3 25/26 by Maternal Ethnicity

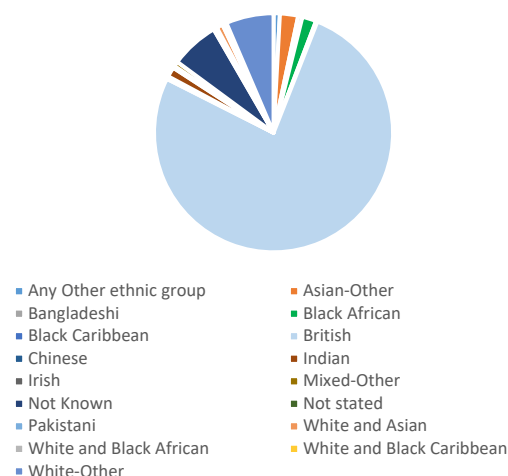


Figure 5: All births Q3 25/26 by maternal ethnicity

During Q3 17% of PMRT cases related to individuals who self-identified as Black African comparative to a background demographic of 1.8% of all maternities for the same period. While this appears disproportionate, it is important to interpret with caution. The PMRT dataset involves a small case number, and as such, year to year and quarter to quarter variation can appear more pronounced and may not reflect a sustained trend.

To strengthen reliability, we will report proportionality for ethnicity and IMD annually within the Q3 quality report, providing a full calendar year of data aligned to the MBRRACE-UK reporting cycle. Real-time recording of IMD and ethnicity during PMRT reviews will continue to ensure early sight of any emerging patterns that may warrant further exploration. This approach enables us to identify potential inequalities at the earliest opportunity, while avoiding over-interpretation of small-number variation, and supports our ongoing commitment to reducing health inequalities in maternity and neonatal outcomes.

When reviewing 2025 calendar year data for ethnicity of births and PMRT the overall proportion of PMRT cases attributed to births to white women/birthing people was proportionate to the background representation of white births within the service, with 85% of births and 86% of PMRT cases.

The largest disproportion is seen within black and/or black British women with 2% of births during 2025 and 7% of PMRT cases (n=1). The service commenced enhanced community midwifery care in September 2025 for all women who self-identify as black or brown in recognition of the national health inequalities gap and outcomes.

2025 PMRT births by Ethnicity

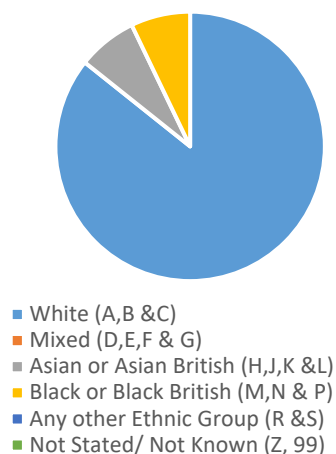


Figure 6: PMRT birth data Q3 25/26 by maternal ethnicity

2025 Births by Ethnicity

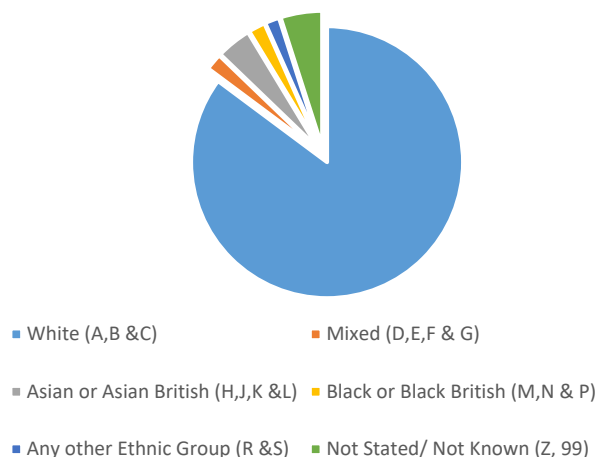


Figure 7: All births Q3 25/26 by maternal ethnicity

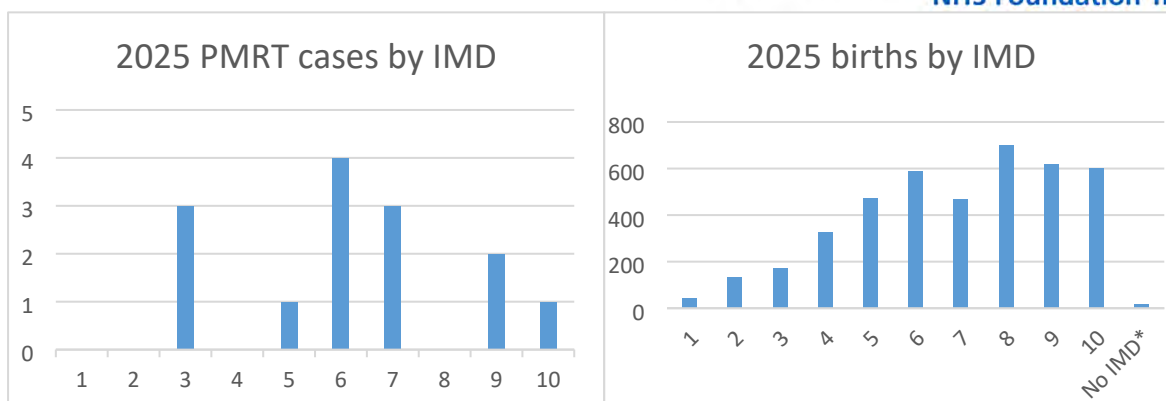


Figure 8: PMRT birth data 2025 by IMD

Figure 9: All births during 2025 by IMD

Q3 2025/26 PMRT INITIAL REVIEW LEARNING OPPORTUNITIES

Systematic learning identified during Q3 highlighted risks associated with Anti-D (an injection given to prevent complications from Rhesus incompatibility) processes. This was a recurrent theme across low and no harm incidents and was a contributory factor in one PMRT-reviewed case. Delays or omissions in Anti-D administration present a potential patient safety risk, with implications for future pregnancies if sensitisation occurs.

System controls and assurance are supported through incident reporting and PMRT review processes to identify themes and contributory factors. Oversight is provided via the Maternity and Neonatal Medicines Safety Group, alongside established protocols for Anti-D administration and identification of sensitising events.

Review of incidents and cases identified a number of system gaps, including ineffective communication pathways between the blood transfusion laboratory and community maternity teams, limited visibility of daily workload allocation, particularly across community settings, challenges for junior staff managing complex and cross-site workloads, and variation in staff knowledge regarding timely Anti-D administration and sensitising events.

An action plan has been developed and is being actively monitored through the Maternity and Neonatal Medicines Safety Group. Key actions include strengthening communication pathways between laboratory and community teams, introducing revised processes for daily work allocation to improve workload oversight, providing enhanced supervision and support for junior staff, and delivering targeted education to improve understanding of Anti-D requirements and clinical indications.

Ongoing assurance will be provided through continued monitoring of incident trends to assess the impact of interventions, audit of Anti-D compliance and timeliness, and routine reporting of progress and residual risk through governance structures, with escalation of any continued risk via the Quality Committee.

2.1 SAVING BABIES LIVES CARE BUNDLE 3.2

The Saving Babies Lives Care Bundle v3.2 (SBL) provides evidence-based best practice standards to achieve the national ambition to halve the rate of perinatal mortality by 2025 through innovation and quality improvement in key areas in maternity care. As part of the

three-year delivery plan, providers are responsible for fully implementing all interventions of the care bundle. All PMRT cases, inclusive of family feedback of care, are benchmarked against each element of SBL to further focus potential areas of local system and process improvement requirements (Table 6).

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

Table 6: Q3 2025/26 PMRT care concerns triangulated against SBL elements

During Q3 there were two points of care provision identified though PMRT which presented opportunities for learning under the SBL domains of fetal growth surveillance and raising awareness of reduced fetal movements.

Element 2 – Fetal Growth surveillance.

There is strong evidence linking undiagnosed fetal growth restriction (FGR) to stillbirth, making effective antenatal detection critical to risk reduction. In this case, a missed opportunity was identified to refer for a growth ultrasound following presentation with reduced fetal movements and a reduction in symphysis fundal height. No evidence of referral or scan was found in the clinical record.

Although the baby's birthweight two weeks later was not indicative of FGR, perinatal pathology results are awaited to determine any contributory role. This case highlights the importance of consistent recognition, escalation and documentation of growth concerns, with ongoing assurance to be provided through audit and governance oversight.

Element 3 - Raising awareness of reduced fetal movements.

Family feedback identified that the mother recalled being verbally advised that it was normal for fetal movements to 'slow down' in late pregnancy. This highlights a potential inconsistency

in the communication of clinical guidance, as reduced fetal movements should always prompt assessment. The case reinforces the importance of clear, consistent messaging to women and families, alongside staff adherence to established guidance. Ongoing assurance will be strengthened through education, reinforcement of national guidance, and review of how information is communicated and documented.

Q2 2025/26 LEARNING FROM COMPLETED PMRT REVIEWS

No PMRT reports were completed in Q3, due to the outstanding post-mortem results delaying finalisation of reports.

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

Table 7: PMRT grading of care key

Child Death Overview Panel (CDOP)

There was 1 early neonatal death at the RUH during Q3 (Table 1). The Child Death Overview Panel (CDOP) process is in progress alongside the PMRT review of care.

3.0 Maternity and Neonatal Safety Investigations (formerly the Healthcare Safety Investigation Branch) and Maternity Patient Safety Incident Investigations

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

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

There were two completed reports in Q3 (Table 8). There are 1 ongoing MNSI review (Table 9). Two referrals were made and accepted in Q3 (Table 10). Initial findings from multi-professional safety reviews (MPSR) identified learning around neonatal hypoglycaemia risk assessment and care pathways. A local learning response under PSIRF is in progress in view of the learning available to the service alongside the MNSI review of care.

1 of the above cases meets criteria for Early Notification Scheme, a referral to NHS-Resolution has been made with family consent.

Reference	Event Summary	Investigation Status	External Notifications	Duty Of Candour	Key Learning Identified
MI-042892	Neonatal transfer to tertiary unit	Investigation progressing at family's	MNSI	Yes	Information sharing with parent on safe sleeping and feeding

	for therapeutic cooling. MRI post cooling was normal.	request			advice immediately post birth Ticket raised with System C for amendment to badger.net to facilitate documentation of 'safe skin to skin' after birth in line with BAPM and MNSI National learning report
MI-042893	Neonatal transfer to tertiary unit for therapeutic cooling. MRI post-cooling was normal.	Investigation progressing at family & Trust's request	MNSI	Yes	Current guidance discrepancies within national and local guidance (NICE, 2025) regarding management of 1 deceleration during Intermittent auscultation particularly in a community birth setting Email of escalation and clarification sent to NICE- local guidance and education programme to be amended following confirmation of evidence based best practice from NICE

Table 8: Completed MNSI investigations Q3 25/26

Reference	Event Summary	Investigation Status	External Notifications	Duty Of Candour	Key Learning Identified
MI-047238	Intrapartum intrauterine death	Accepted	MNSI MBRRACE	Yes	

Table 9: Ongoing MNSI Referrals 25/26

Reference	Event Summary	Investigation Status	External Notifications	Duty Of Candour	Key Learning Identified
MI-049980	Neonatal re-admission on day 5 of life with hypoglycaemia. Subsequent	MNSI review in progress Local	MNSI NHS-R ENS	Commenced - in progress	Risk assessment, screening and care pathways pertaining to

	Magnetic Resonance Imagery (MRI) changes.	learning response in progress			the management of hypoglycaemia
MI-0050463	Neonatal transfer to tertiary unit for therapeutic cooling. MRI post-cooling was abnormal.	Investigation progressing	MNSI NHS-R ENS	Commenced – in progress	

Table 10: New MNSI Referrals Q3 25/26

3.1 Coroner Regulation 28

Nil.

3.2 Maternity Patient Safety Incident Investigations (PSII)

One Patient Safety Incident Investigation (PSII) reached completion in Q3 and no new PSII's were declared.

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

Table 11. Maternity and Neonatal Patient Safety Incident Investigations Q3 25/26

Amendments have been made to the maternity telephone triage services to ensure neonatal concerns are referred into medical care pathways not Maternity to ensure appropriate care location, assessment and ongoing care planning. Audit of Avoiding Term Admissions Into the Neonatal Unit (ATAIN- Appendix 2), identifies that the changes implemented have been effective and embedded with a reduction in community readmissions into the Neonatal Unit.

3.3 Maternity PSIRF Learning Responses

During Q3 the service commenced 3 new Trust learning responses under the PSIRF framework.

Reference	Event Summary	External Notifications	Duty Of Candour	Key Learning Identified
Datix 146425	Maternal Admission to ICU on day postnatal with Invasive Group A Strep Sepsis	nil	Commenced by Obstetric Consultant	Collaborative care pathways with Emergency Department. Use of Maternity Early Warning Scores within the ED. Identification of the deteriorating patient.
Datix 146963	Neonatal re-admission on day 5 of life with hypoglycaemia. Subsequent Magnetic Resonance Imagery (MRI) changes.	MNSI	Commenced by Neonatal Consultant	Risk assessment, screening and care pathways pertaining to the management of hypoglycaemia. Accurate documentation of Neonatal observations. Digital/paper interfaces.
Datix 143919	Baby born in unexpected poor condition with undiagnosed fetal growth restriction.	Discussed with NHS ENS & MNSI	Commenced by Obstetric Consultant	Digital integration of Ultrasound and EPR systems. Transcription risk with current USS and EPR systems.

Table 11: New local PSIRF Learning responses commenced Q3 25/26

2 learning responses are ongoing during Q3. 1 regarding a retained vaginal swab following perineal suturing and 1 following notification of an indirect late maternal death by suicide.

Reference	Event Summary	External Notifications	Duty Of Candour	Progress update/ Key Learning Identified
Datix 144851	Retained Foreign Object	Learn from Patient Safety Events (LFPSE) CQC	Commenced by Obstetric Consultant	Response in draft, for sharing with the family following trust-wide sign off. Learning from this review will be shared within the Q4 report
Datix 145104	Late indirect maternal death by suicide	MBRRACE-UK	-	Care review following South West Maternal Medicine Maternal Death Standard Operating Procedure. An initial panel meeting was held in December 25 with plans to reconvene in Q4 for shared learning from primary, and social care partners. No immediate learning was identified for Maternity services following initial review.

Table 12: Ongoing local PSIRF Learning responses commenced Q3 25/26

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3.4 Trust Claims Scorecard – Obstetrics

The Trust's latest scorecard correlates open and closed claims managed by the Trust's legal team for care provided between April 2015 and March 2025. Obstetric-related claims represent approximately 17% of the total number of claims, yet account for around 80% of the overall financial value. This reflects the high-value nature of obstetric claims rather than a high frequency of incidents.

For context, the NHS Resolution Annual Report and Accounts 2024/25 highlights that obstetrics represents 11% of clinical claims by volume but 53% by financial value nationally. While the Trust's profile is higher than national averages, this pattern is consistent with the complexity and severity associated with obstetric claims across the NHS.

This is further demonstrated by the variation between injury types by volume and by financial value, where the most common causes of claims do not correspond to the highest levels of financial damages. This indicates that a small number of high-severity cases drive the majority of costs, rather than a widespread pattern of incident frequency.

Top 5 injuries by volume for Obstetrics

					% of Specialty	
	Injury	Volume	Value	Ave Claim Value	Volume	Value
1	Unnecessary Pain	9	1,046,326	116,258	18%	1%
2	Psychiatric/Psychological Dmge	9	779,581	86,620	18%	1%
3	Adtnl/unnecessary Operation(s)	6	427,163	71,194	12%	0%
4	Stillborn	3	205,149	68,383	6%	0%
5	Fatality	3	504,775	168,258	6%	0%
Total Top 5 injuries by Volume for Obstetrics		30	2,962,994	98,766	60%	2%

Table 13: Top 5 injuries by volume for Obstetric legal claims April 2015-Mar 2025

Top 5 injuries by value for Obstetrics

					% of Specialty	
	Injury	Volume	Value	Ave Claim Value	Volume	Value
1	Cerebral Palsy	3	60,118,541	20,039,514	6%	47%
2	Brain Damage	3	44,780,000	14,926,667	6%	35%
3	Hypoxia	2	12,919,089	6,459,544	4%	10%
4	Meningitis	1	2,975,306	2,975,306	2%	2%
5	Erb's Palsy	2	2,215,103	1,107,552	4%	2%
Total Top 5 injuries by Value for Obstetrics		11	123,008,039	11,182,549	22%	96%

Table 14: Top 5 injuries by value for Obstetric legal claims April 2015-Mar 2025

The service is actively implementing measures to reduce both the likelihood and impact of obstetric claims, including:

- **Enhanced Clinical Governance:** Strengthening incident review processes by continuing to embed Patient Safety Incident Response Framework (PSIRF), monitoring of clinical outcome indicators, learning from both national and local themes.
- **Data-Driven Insights:** Using claims and outcome data to identify trends and recurring themes where care has not achieved the standard expected, ensuring that quality improvement initiatives are targeted and evidence-based.

- **Implementation of the Saving Babies Lives (SBL) Version 3.2 care bundle.** The service continues to show progression to full implementation of the SBL care bundle aiming to reduce stillbirth and neonatal death within the UK by 50%.
- **Training and Innovation:** The service is actively engaging with Health Innovation West of England's Avoiding Brain Injury in Childbirth (ABC) programme with the RUH Fetal Wellbeing Lead Midwife commencing a secondment within the ABC programme as a clinical advisor.
- **Early Resolution and Engagement:** Working closely with NHS Resolution to promote early engagement and resolution strategies, reducing litigation costs.

These actions aim to improve patient outcomes, reduce risk exposure, and align the Trust more closely with national benchmarks over time.

3.5 Learning and improvement from PMRT, family feedback, MNSI & claims

Triangulation of feedback and insights has identified several priority themes, including:

- Improved postnatal experience for women and families – addressed through the Perinatal Culture and Leadership Programme (PCLP)
- Bladder care
- Informed consent to support shared decision-making
- Effective intermittent auscultation fetal monitoring
- Guideline management
- Medicines management

Bladder care, informed consent, and effective intermittent auscultation were identified as priorities in 2024/25 following the Insights Report. These continue to progress through ongoing quality improvement projects monitored via governance. Refer to Section 9.1 for further detail.

A quality improvement project is also underway in response to continued variation in risk assessment and prescribing of Low Molecular Weight Heparin (LMWH). This work applies Human Factors and Ergonomics methodologies, with updates reported through the Perinatal Medicines Safety Committee and into the Medicines Assurance Committee.

Clinical guideline oversight is monitored monthly. Delays in central validation have been identified as the main barrier to increasing the proportion of in-date guidelines. This has been escalated to the departmental leadership team. A new process introduced in Q3 now provides improved monitoring, traction, and timely progression of Baseline Assessment Tools (BATs) through governance.

In response to staff feedback, the perinatal service has strengthened internal communication channels. A monthly newsletter now includes updates from specialist services, with a standing item from the Perinatal Quality and Safety Team highlighting 'Safety Hot Spots'. These Hot Spots are derived from triangulated learning, such as low/no-harm incidents, audit findings, and family feedback.

Safety insights are shared widely through the RUH Maternity Microsoft Teams page, QR-coded posters linking to full case reviews, and quality and safety whiteboards in clinical areas displaying the Safety Hot Spot of the month. Local learning is also embedded within the mandatory training programme in line with the Core Competency Framework Version 2 (CcFv2).

4.0 Three Year Maternity and Neonatal Services (3YDP)

The Trust continues to work toward compliance with the 3YDP. The Perinatal Pelvic Health Service is well embedded, and recruitment and retention continue to be in a positive position.

Key workforce improvements have led to a reduction in sickness absence rates in both maternity and neonatal services and 100% retention of newly qualified midwives since 2023.

A strong focus has been maintained on building a positive culture of safety, enhancing co-production with service users, and improving staff and family engagement.

Re-accreditation for UNICEF BFI for both Maternity and Neonates is due during 2026. Should the service achieved level 3 accreditation this will inform a decision to pursue Gold accreditation within the following year.

The Perinatal Service remains committed to delivering safe, personalised, compassionate and equitable maternity and neonatal services, with ongoing governance oversight to monitor progress, ensure continuous improvement, and respond to national expectations.

5.0 Training compliance for all staff groups in maternity related to the core competency framework

The report provides evidence of training compliance, including a response to year 7 of MIS, Safety Action 8. The Core Competency Framework version 2.2 sets out clear expectations for all Trusts, aiming to address known variation in training and competency assessment for maternity staffing across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service. Compliance with attendance and demonstrated competence for fetal monitoring, neonatal resuscitation, and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) across all staffing groups (Figure 10).

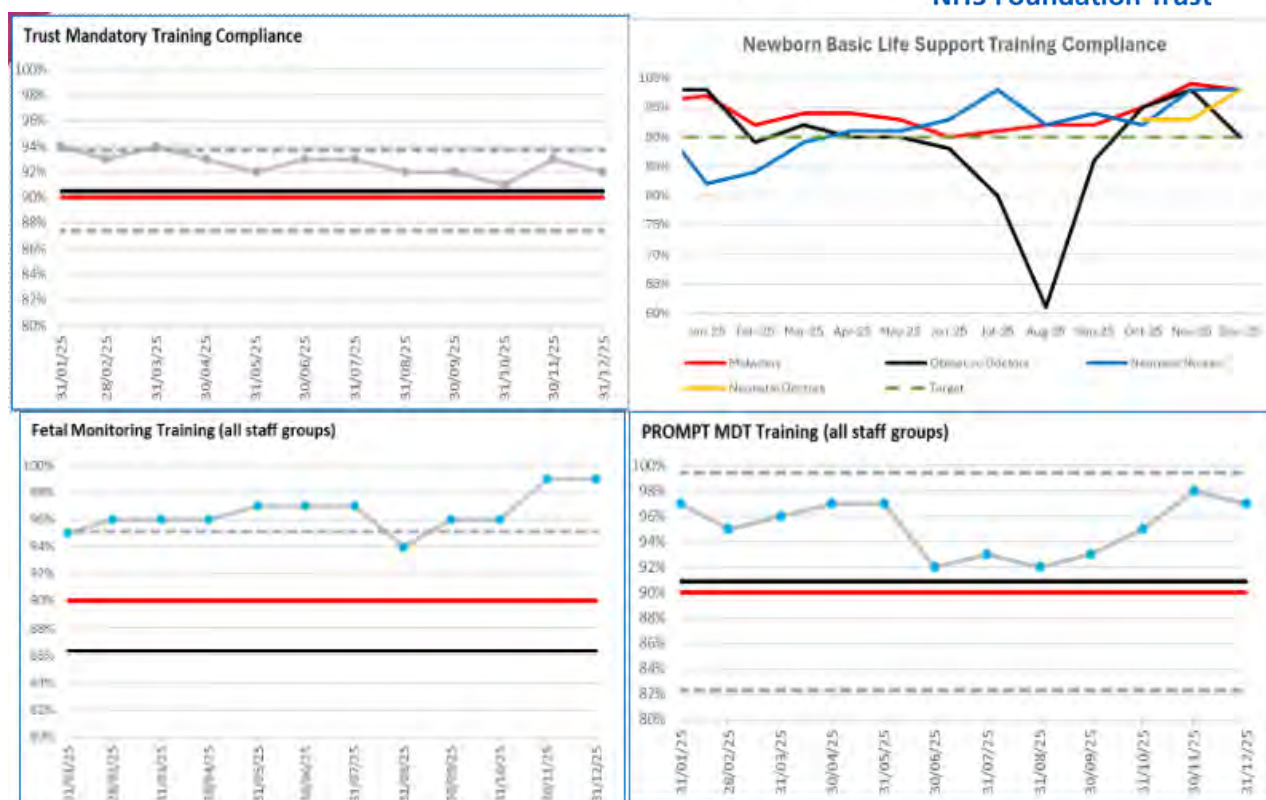


Figure 10: Maternity Training Statistical Process Charts for PROMPT, Fetal Monitoring, Mandatory Training compliance and Adult Basic Life Support compliance Q3 25/26

Specific training standards for all staffing identified within the Saving Babies Lives version 3.2 are externally assessed by the Integrated Care Board (ICB) Local Maternity and Neonatal System (LMNS) for both content and compliance.

Following incorporation of Adult Basic Life support onto the Maternity PROMPT mandatory study day increased compliance has been identified with maintained compliance to 90%.

The next step is to replicate this approach within neonatal services, with ABLS being incorporated into the neonatal mandatory study day programme for 2026.

6.0 Board Level Safety Champions

The Maternity and Neonatal Safety Champions continue to be active and visible in their role, ensuring staff voices across maternity and neonatal services are heard. All staff are invited to attend monthly listening events and are encouraged to engage with the Safety Champions during walkabouts with the Chief Nursing Officer, the Non-Executive Director for Maternity and Neonatal Services, and the Obstetric, Neonatal and Maternity Safety Champions.

Themes raised with the Safety Champions during Q3 included:

- Workforce pressures within the Neonatal service, linked to Level 3 tertiary cot closures (see Risk 3182).
- The impact of staff redeployment during periods of acute service escalation, particularly on community birth teams.

- Changes to employment pathways for newly qualified midwives, specifically the inability to offer automatic employment to RUH trained students, reflecting a shift from the previous three years when this was supported during a period of high vacancy in 2022.
- Positive feedback regarding improvements to staff rest areas following refurbishment.

Themes, commonalities and resulting actions are monitored through the Maternity and Neonatal Safety Champions meetings. These insights are triangulated with wider feedback captured in the Maternity and Neonatal Insights Report to inform and prioritise continuous improvement work across the service.

7.0 NHS Resolution Maternity Incentive Scheme update Q3 2025/26

The Clinical Negligence Scheme for Trusts (CNST) released the Maternity (and perinatal) Incentive Scheme Year 7 on 2 April 2025. Updates on progress and monitoring towards achievement of the 10 Safety Actions outlined is completed and shared within Maternity and Neonatal Speciality Governance meeting and Board Level Safety Champions monthly.

Each of the 10 Safety Actions has a senior perinatal leader sponsor with oversight of the compliance requirements and regular meetings with the patient safety lead to identify and act on any concerns. Compliance in Q3 remains on target to declare full compliance within Q4.

Maternity Incentive Scheme Y6 - Safety Action Detail		Current Position Q3 25/26	Anticipated submission position March 26
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?		
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		
3	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?		
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?		
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users		
8	Can you evidence the 3 elements of local training plans and 'in-house', one day multi professional training?		
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?		
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB)(known as Maternity and Newborn Safety Investigations Special Health authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?		

Table 15: Q3 2025/26 Mis year 7 Red Amber Green (RAG) rated compliance

7.1 Safety Action 6 - Saving Babies Lives Care Bundle V3.2

Implementation of the Saving Babies' Lives (SBL) Care Bundle Version 3.2 remains an ongoing programme of continuous improvement. The service is compliant when assessed using the NHSE SBL Implementation Tool, and at least quarterly improvement discussions have taken place with the ICB. Compliance in Q3 was 96%, following an anticipated reduction to 84% in Q2 associated with the transition to BadgerNet.

Current areas of focus for continued improvement include:

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- Provision of Uterine Artery Dopplers for pregnancies at high risk of early-onset fetal growth restriction.
- Ultrasound (USS) capacity, specifically ensuring next-working-day scanning for individuals presenting with reduced fetal movements.
- Operational support for the Peri-Prem working group, enabling progress on quality improvement actions alongside core clinical responsibilities.

USS demand versus capacity is recognised on the service risk register. A joint action plan between maternity and radiology is in place to mitigate risk and safeguard against harm, with progress monitored through established governance structures.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	90%	Fully implemented	100%
Element 2	Fetal growth restriction	Partially implemented	90%	Partially implemented	95%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	80%
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	88%
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%
All Elements	TOTAL	Partially implemented	96%	Partially implemented	93%

Table 16: RUH Maternity position for implementation of Saving Babies Lives Care Bundle v3.2 Q3 25/26

8.0 Safe Maternity and Neonatal Staffing

Perinatal nursing and midwifery staffing metrics are monitored and reported against service key performance indicator targets monthly through governance within the Perinatal Quality Support and Oversight Model (PQSOM). A bi-annual deep dive into the service workforce is conducted outlining areas of operational focus and improvement for the following 6 months recognising the systematic impact staffing has on care quality and outcomes.

9.0 Complaints, compliments, Patient Support and Complaints Team (PSCT)

	Oct	Nov	Dec
Number of Patient Support and Complaints contacts	16	19	13
Number of formal complaints	2	4	2

Table 17: Complaints and compliments Q3 25/26

Compliments continue to be received across all areas of maternity and neonatal care. A consistent theme is the kindness and compassionate care provided to women, birthing people and their families.

During Q3, eight formal complaints were received. All complaints, Patient Support and Complaints Team (PSCT) contacts, and informal feedback are reviewed for themes and trends

through the monthly Maternity and Neonatal Insights and Quality Improvement Group.

Postnatal Care (Inpatient): Improvement in immediate postnatal inpatient care remains an area of focus, as this continues to feature within patient concerns and complaints.

Postnatal Discharge:

Following a successful pilot, the service has now substantively implemented 2 whole time equivalent (WTE) Band 7 midwives on Mary Ward, ensuring daily Band 7 leadership. Historically, discharge processes were a recurring complaint theme. The introduction of a dedicated 'operational flow' role alongside Mary Ward leadership has provided:

- Clear prioritisation of planned discharges
- Improved oversight of bed status
- Earlier escalation where required
- More available time for staff to support women and birthing people requiring inpatient care.

No discharge-related complaints were received in Q3, indicating positive impact from these changes.

Postnatal Inpatient Analgesia:

Timing and responsiveness of postnatal analgesia remains a theme within Q3 complaints. A Quality Improvement project, aligned to the Quality Service Improvement and Redesign (QSIR) methodology, is underway led by the Insights and Improvement Lead Midwife. This work aims to enhance the efficiency and reliability of postnatal medicines management on Mary Ward, with progress monitored through the Perinatal Medicines Safety Group.

Intravenous Iron Infusions: Two PSCT contacts in Q3 related to skin staining following intravenous iron infusions: In response, the service is developing:

- A new information leaflet
- A consent form for women receiving intravenous iron

These will ensure that individuals are fully informed about the risk of extravasation and skin staining prior to consenting to treatment.

9.1 Service 'insights' safety priorities

All service feedback 'insights' received 'in month' are reviewed for thematic assessment of trends or commonalities seeking identification of areas for improvement. Any identified 'in month' themes or trends requiring action are shared via the Perinatal Quality Support and Oversight Model (PQSOM) shared with board level Safety Champions and Trust Quality and Safety Group.

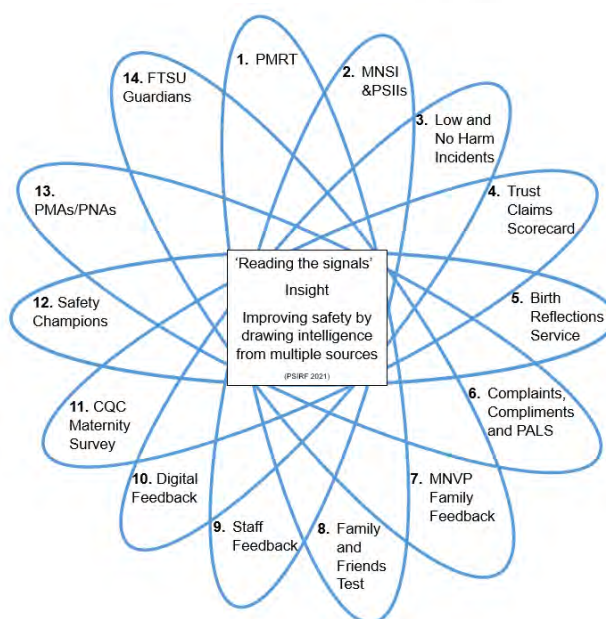


Figure 11: Sources of service 'Insight' analysed monthly via the Maternity and Neonatal Triangulation of feedback group.

The 2023/24 Insights report provided comprehensive themes and actions for improvement drawing from triangulated feedback with the recommendations below aligning with national priorities and the 3YDP. After careful consideration the Insights report will move to 2 yearly to allow for implementing and embedding the priorities identified in 2023/24 allowing for resources to be directed toward sustainable change. Regular updates will continue to be provided through governance.

1. Fetal Monitoring – Intermittent Auscultation

A review and update of relevant clinical guidelines was completed in Q3 to ensure alignment with current best practice. In addition, the service is actively participating in the national quality improvement initiative *Listen2Baby*, with the Fetal Monitoring Lead Midwife contributing to this work. The recommended package of care is due to be launched in May 2026. The Fetal Monitoring Lead Midwife has been successful in securing a position within the Midwifery faculty for the Avoiding Brain Injury in Childbirth (ABC) programme being led by Health Innovation West of England (HIWE) and therefore will be at the forefront of best practice initiatives to drive local improvements in fetal monitoring both cardiotocography (CTG) and intermittent auscultation (IA).

The Fetal Monitoring Lead Midwife is working in collaboration with the Labour Ward Co-ordinators to develop patient information leaflets on fetal monitoring in labour. These leaflets will be signposted to service users during birth-preferences discussions, in the antenatal period to support collaborative communication and strengthen informed consent and decision-making processes. Provision of high-quality information during the antenatal period is particularly important to support effective and efficient labour care discussions, where factors such as pain can affect information processing and the ability to make fully informed decisions. Progress will be monitored through Specialty and Divisional Governance structures, as well as the Perinatal Review Meeting (PRM), with regular updates provided. Audit activity related to this work has been on hold during the launch of BadgerNet but will resume in February 2026.

2. Information provision to ensure Informed Consent

The quality improvement project to improve information for families in the antenatal period continues an information leaflet is in draft aimed at improving informed consent conversations about potential modes of birth recommendations. It has been coproduced with the maternity and neonatal voices partnership (MNVP). Virtual tours are now available to service users and include links to additional resources to promote informed decision making about place of birth and birth choices.

Following the publication of the Coronal Inquest into the deaths of Jennifer and Agnes Cahil within the national public domain, a service benchmarking exercise has been completed by the community midwifery Matron and Lead Obstetric consultant for the birth choices clinic. Actions towards assurance of service delivery against the areas of concern raised will be monitored through governance. A monthly update on the community and home birth service provision will form part of the PQSOM with a quarterly update within this report from Q4.

3. Improving patient experience in the immediate postnatal care provision

The RUH joined the Perinatal Culture and Leadership Programme (PCLP) in Autumn 2023 and with support from the quadrumvirate and perinatal culture coaches produced an improvement plan following culture conversations with a wide range of staff who work in the inpatient areas (Section 12.0). Six themes were identified and actions derived from further conversations which are monitored through governance. Staff survey results identified a desire for enhanced leadership on Mary Ward to support efficiency, flow and staff wellbeing, following a period of trial in a pilot programme, and positive staff feedback the service substantively recruited into 2 additional Midwifery Sisters on Mary Ward during Q3.

10.0 Risk Register

There were two new risks added in Q3, all risks and emerging risks are monitored through Maternity and Neonatal Specialty Governance

Risk No	Domain of Risk	The Risk	
3202	Digital	There is a risk Maternity Ultrasound imaging and clinical data may not be reliably shared across the various digital systems impacting upon adequate care planning and provisions	6
3251	Patient Safety and Quality	There is a risk to quality of care and compounded harm to bereaved families due to perinatal pathology workforce gaps	12

Table 18: New risk for the Maternity and Neonatal risk register Q3 2025/26

During Q3 no risks were closed, risk is monitored by the Quality and Patient Safety lead midwife in conjunction with the service quadrumvirate. All risks rating >12 are reported monthly via Speciality and Divisional governance to the Management Executive Committee, to ensure appropriate actions are taken in accordance with the Trust Risk Management Framework.

Risk No	Domain of Risk	The Risk	
3182	Patient Safety and Quality	There is a risk to neonatal care provision due to service cot capacity pressures impacted by reduced cot capacity within level three tertiary neonatal units	16
3103	Patient Safety &	There is a risk women categorized as amber of green	15

	Quality	do not receive a medical review in line with RCOG Triage guidance (2023)	
3013	Patient Safety & Quality	There is a risk that USS service, provided jointly by maternity and radiology, does not have enough capacity	12
2785	Patient Safety & Quality	There is a risk that the current pharmacist cover for the Neonatal Unit does not meet clinical needs or BAPM standards	12

Table 19: Maternity and Neonatal Risk Register rating >12

Moderate and low risks are monitored as per Trust Risk Management policy.

11.0 Avoiding Admission into the Neonatal Unit (ATAIN) & Transitional Care

The Q3 Transitional Care (TC) and ATAIN report demonstrates a reduction in avoidable term admissions to the Neonatal Unit, with two cases identified in Q3 compared to five in Q2. Review of these cases did not identify a single consistent theme; however, recurring areas for improvement include fetal monitoring, CTG interpretation and management of the neonatal hypoglycaemia pathway.

Actions to support risk mitigation and service improvement are monitored through specialty governance structures, with learning shared locally and regionally to support wider system improvement in reducing avoidable neonatal admissions.

The TC service maintained strong performance, operating 99% of the time, with 95% of shifts meeting the recommended staffing model. Activity increased during Q3, with 39% of shifts caring for more than four babies on the pathway (compared to 26% in Q2), requiring additional neonatal staffing to maintain safe care.

Due to sustained high acuity, further impacted by system pressures including reduced tertiary cot capacity (Risk 3182), 14% of shifts exceeded the recommended 1:4 nurse-to-baby ratio. No harm has been identified in association with these episodes.

12.0 Perinatal Culture and Leadership Programme

The Perinatal Culture and Leadership Programme (PCLP) aim to support perinatal Quadrumvirate (Quad) teams to create and craft positive safety cultures within perinatal services. The programme design was in direct response to nationally derived intelligence regarding the intrinsic relationship between a positive workplace culture and continuous quality improvement. The RUH service has 4 trained culture coaches with ongoing planning and training of further culture coaches.

The focus of the PCLP is expected to evolve in line with emerging national and local priorities for 2026. Key areas of emphasis will include Avoiding Brain Injuries in Childbirth (ABC), postnatal care, and escalation processes, all of which are grounded in the ongoing development of a safe and positive organisational culture.

Progress continues in strengthening MSW recruitment and retention. Additional culture conversations are planned to inform a comprehensive MSW workforce planning and retention strategy, ensuring long-term sustainability and consistency within the team.

The inpatient ward remains a priority area. The forthcoming national guidance, improving

postnatal care: a toolkit for Integrated Care Boards, partners and providers, will be reviewed and benchmarked against current practice. Findings will inform a refreshed improvement plan, with progress monitored and reported quarterly through the Maternity and Neonatal Safety Group.

13.0 Equity and Equality

The RUH Maternity Equity and Equality Group relaunched in November 2024 to align with the BSW Equity and Equality plan and evolving national guidance including the Department of Health's Core20plus5 Framework and the Three-Year Delivery Plan priorities. Core membership includes clinical leads across all departments and the MNVP. The groups improvement plan continues to focus on four strategic priorities:

- Improving data quality and responsiveness
- Enhancing language and communication
- Expanding access to physical and digital care
- Promoting staff equity.

The improvement plan is being actively monitored through governance structures and focuses on tangible outcomes and impact. Improvement projects in Q3 included:

- Ongoing review of model of care implemented in Q2 to support antenatal and postnatal care case loading for women racialised as Black or brown, in line with progress towards Core20plus5 framework maternity goal.
- Exploration of opportunities to gain feedback to understand experiences of lesser heard voices in collaboration with MNVP.
- Late Booker review analysed to understand themes and opportunities to improve access to care.
- Trial commenced of a Maternity specific Learning Disabilities passport and 'Your choices' whiteboards in all birthing areas for enhancing and communicating personalised care preferences.
- Launch of language access to care passport, co-produced with the MNVP, aimed at removing barriers to accessing urgent maternity care for families with English as an additional language.

Continued collaboration across teams and with service users remains central to achieving meaningful equity in maternity and neonatal care. Q4 priorities include rebuilding of health inequalities dashboard, as metrics have been impacted by BadgerNet transition; progressing implementation of feedback mechanisms for understanding experiences of lesser heard voices and opportunities to promote and support equity for perinatal staff.

14.0 Maternity Triage

The national review of maternity services undertaken by the Care Quality Commission (CQC) in 2022 highlighted significant variation in maternity triage provision across the country, noting the absence of national standards or targets. In 2023, the Royal College of Obstetricians and Gynaecologists (RCOG) published its *Good Practice Paper on Maternity Triage*, setting out recommended operational structures and pathways to support safe, timely care for pregnant and newly postnatal women and people outside of scheduled appointments.

In response, the RUH began implementation of the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), a Trust-wide quality improvement programme requiring investment

Author: Jodie Clement, Quality Improvement and Patient Safety Lead Midwife	Date: 29 May 2026
Approved by: Toni Lynch, Chief Nursing Officer	Version:1
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in both estates and staffing. This work culminated in the opening of a dedicated Maternity Triage Unit in May 2024.

The service continues to monitor call-waiting times and call abandonment, telephone assessment quality, in-person triage activity and BSOTS compliance, alongside feedback from staff and families, through established governance processes.

The focus in Q3 was on strengthening data quality following the transition to BadgerNet, with particular work to improve the recording of medical review waiting times. Although data capture has improved, further refinement is planned for Q4 as national BadgerNet updates in November affected consistency. Greater visibility of medical review times will support future service planning and help address areas of non-compliance with RCOG (2023) guidance, which advises the presence of a resident F1/F2 doctor within maternity triage.

15.0 Recommendations

The Board of Directors is asked to discuss and approve the content of the report.

16.0 Appendices

Appendix 1 Transitional Care Pathway and ATAIN Audit Q2 2025/26

Author: Jodie Clement, Quality Improvement and Patient Safety Lead Midwife	Date: 29 May 2026
Approved by: Toni Lynch, Chief Nursing Officer	Version:1
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Clinical Audit Report

Transitional Care Pathway and ATAIN Audit Q3 2025/2026

Speciality: RUH Local Neonatal Unit

Division: Family & Specialist Services Division

Project team			
Kirstie Flood	Title/grade:	Lead Nurse	Data period: Q3 October 2025-December 2025
Sarah Goodwin	Title/grade:	Neonatal Governance Lead Nurse	Report completion: January 2026

Transitional Care Pathway and ATAIN Audit Q3 2025/26

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Appendix 1: Detailed analysis of babies requiring TCP

Appendix 2: Detailed analysis of term babies admitted to the neonatal unit

Executive Summary

This report summarises the findings of the Q3 2025/26 audit of the Transitional Care Pathway (TCP) and the Avoiding Term Admissions Into Neonatal Units (ATAIN) programme at the Royal United Hospitals Bath NHS Foundation Trust. Covering the period October to December 2025, it demonstrates continued progress in reducing avoidable term admissions, minimising mother–baby separation and improving neonatal outcomes.

Key Achievements

Key achievements during Q3 demonstrate continued strong performance of the Transitional Care Pathway. Compliance with NEWTT2 documentation and escalation protocols remained at 100%, and the service operated 99% of the time, with 95% of shifts meeting the established staffing model.

Utilisation of the pathway has continued to improve, with 49% of babies receiving all their care on TCP and a further 9% receiving part of their care on the pathway, representing an upward trend from previous quarters. This reflects effective pathway use in supporting mother–baby proximity and reducing Neonatal Unit admissions.

Parental feedback remained positive, highlighting compassionate, supportive care and reinforcing the value of the service in delivering family-centred care.

Key Challenges and Strategic Priorities

During Q3, the Transitional Care Pathway experienced challenges due to sustained neonatal acuity and workforce pressures, as outlined in the Bi-annual Staffing Report. This resulted in 14% of shifts exceeding the recommended 1:4 nurse-to-baby ratio. Pressures were further compounded by reduced cot capacity within local tertiary neonatal units, increasing overall service acuity. This risk is recorded on the risk register (Risk 3182).

In response, a business case is being progressed to expand TCP capacity to eight cots, aligned with GIRFT recommendations. The conversion of Room G into a four-bedded parent–baby residential bay has further supported capacity, is well utilised, and has received positive parental feedback.

Two avoidable term admissions were identified in Q3, representing a reduction from five in Q2. Review of these cases continues to inform targeted areas for improvement, including fetal monitoring, cardiotocography (CTG) interpretation, and the neonatal hypoglycaemia pathway. Quality improvement initiatives are progressing, including the CPAP on Skin Early Intervention (COSEI) pilot, a thematic review of pneumothorax cases, and enhanced validation of ATAIN data to support service development and equitable care delivery.

Overall, this report provides assurance of continued progress in delivering safe, effective and family-centred neonatal care. The findings and actions support compliance with the Maternity Incentive Scheme (Year 7, Safety Action 3) and contribute to wider system objectives across the LMNS and ICB.

Background

The ATAIN (Avoiding Term Admissions Into Neonatal Units) programme is a national patient safety initiative aimed at reducing unnecessary admissions of term babies to neonatal units. Its primary focus is to prevent avoidable separation of mothers and babies, recognising the

critical importance of early bonding for both physiological stability and long-term health outcomes.

Evidence shows that early separation can negatively impact maternal mental health, breastfeeding success, and infant development.

At RUH, ongoing monitoring of neonatal admissions and modifiable factors supports continuous service evaluation and improvement. This audit contributes to the Trust's compliance with the Maternity Incentive Scheme (Year 7, Safety Action 3) and reflects the work of the ATAIN working group in driving quality and safety in maternity and neonatal care.

Objectives

- To assess compliance with the pathways of care into Transitional Care which have been jointly approved by maternity and neonatal teams focusing on minimising the separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in Transitional Care.
- To monitor that the pathway of care into Transitional Care has been fully implemented and is audited quarterly. Audit findings are shared with the Neonatal Safety Champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care Board (ICB) quality surveillance meeting each quarter.
- To evaluate the number of admissions into the Neonatal Unit that would have met TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues.
- To evaluate the number of babies that were admitted to or remained on Local Neonatal Units (LNU) because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there, 34+0 - 36+6.
- To provide a data record of existing transitional care activity, (regardless of place - which could be a Transitional Care postnatal ward, virtual outreach pathway etc.). The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery, nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.
- To analyse staff/parent data captured via a questionnaire around satisfaction, quality and safety of care.
- Outline the key findings and improvements identified by the ATAIN working group's activity on a quarterly basis for sharing within Maternity and Neonatal Governance structures and the Board Level Safety Champions.
- To provide evidence and assurance of progression with the action plan for sharing with the neonatal Maternity Safety Champion, and Board Level Champions, LMNS and ICB quality surveillance meeting each quarter.
- To provide an audit trail of evidence that reviews of all term babies transferred or admitted to the LNU, irrespective of their length of stay.

The ATAIN working group is responsible for completing a thematic review of the primary reasons for all admissions, with a focus on the leading cause/ reason(s) for admission through a deep dive to determine relevant areas of improvement to be addressed. This is in line with the working group's terms of reference.

Key Findings

Standard	Compliance October 2025	Compliance November 2025	Compliance December 2025	This Quarters total (Q3)	Year total to date 2025/2026

Audit findings shared with neonatal safety champion	Complete	Complete	Complete	N/A	N/A
The % of babies who received all their care on the TCP pathway	49%	52%	47%	97 babies 49% average of all admissions	289 babies 49% average of all admissions
The % of babies who received care on the TCP for part of their admission	10%	13%	7%	19 babies 9% average of all admissions	84 babies 14% average of all admissions
The number of admissions to the neonatal unit that met TC criteria but unable to receive care on TC ward due to mat/neo capacity or staffing issues	0	0	0	0	2
% of shifts TCP nurse provided as per TCP staffing model	100%	92%	92%	Average 95%	Average 97%
% of shifts TCP nurse: baby ratio was above 1:4 as per recommendation.	10%	17%	16%	Average 14%	Average 15%
% of days >4 babies cared for on TCP	26%	50%	42%	Average 39%	Average 45%
TCP open	100%	100%	99%	Average 99%	Average 99.5%
Number of babies transferred to neonatal unit from TCP for higher level of care	4	0	2	2	13
The percentage of term transfers or admissions reviewed by the ATAIN working party irrespective	100%	100%	100%	100%	100%

of their length of stay.					
The number of avoidable term admissions 37+0 weeks gestation and above admitted to the neonatal unit	1	0	1	2	7
The number of term babies transferred or admitted to the neonatal unit from other areas – for example Emergency Department, Children's ward.	1	3	0	4	8

Table 1: ATAIN audit findings

Clinical Audit Report

Project title

Transitional Care and ATAIN Audit Q3 2025 October - December 2025

Division

Family & Specialist Services Division

Specialty

Local Neonatal Unit

Disciplines involved

Neonatal Nurse Consultant, Neonatal Senior Sister

Obstetric Consultant, Patient Safety Midwives

ATAIN working group

Project leads

Kirstie Flood Lead Nurse

Sarah Goodwin Neonatal Governance Lead Nurse

Standards

Maternity Incentive Scheme – Year 7. Safety Action 3.

Sample

- All admissions to LNU and TCP from 01/10/2025-31/12/2025 to determine if the correct location of care was achieved.
- All babies born at 37+0 weeks gestation and above from 01/10/2025-31/12/2025 who were admitted to the LNU.

Data source

BadgerNet, LNU and TCP admission book and individual medical notes.

Audit type

Retrospective and live data collection.

Transitional Care Audit Findings Q3.

Staffing Overview:

In Q3, the Transitional Care Pathway remained highly operational, with 99% availability and 95% of shifts meeting the recommended staffing model. However, sustained neonatal acuity reduced staffing flexibility, with 14% of shifts exceeding the recommended 1:4 nurse-to-baby ratio.

Activity increased during the quarter, with an average of 39% of shifts caring for more than four babies on TCP, compared to 26% in Q2. This reflects rising demand alongside continued system pressures, including reduced cot availability within local tertiary neonatal units. This has been recognised as a risk on the risk register (Risk 3182).

Despite these pressures, no missed opportunities for TCP care were identified, and no babies remained on the neonatal unit solely due to nasogastric feeding requirements, providing assurance that patient flow and care decisions remain appropriate.

The staff feedback questionnaire remains open to support ongoing service evaluation and continuous improvement.

Admission Summary

The leading causes of admission to the Transitional Care Pathway in Q3 remained consistent: 24% required intravenous antibiotics, 28% required 'Kaiser' observations for suspected sepsis, and 13% were babies below the 2nd centile. The Perinatal Culture & Leadership programme continues to support positive collaboration between maternity and neonatal

teams, with ongoing efforts to expand TCP cot provision, which will require further workforce investment.

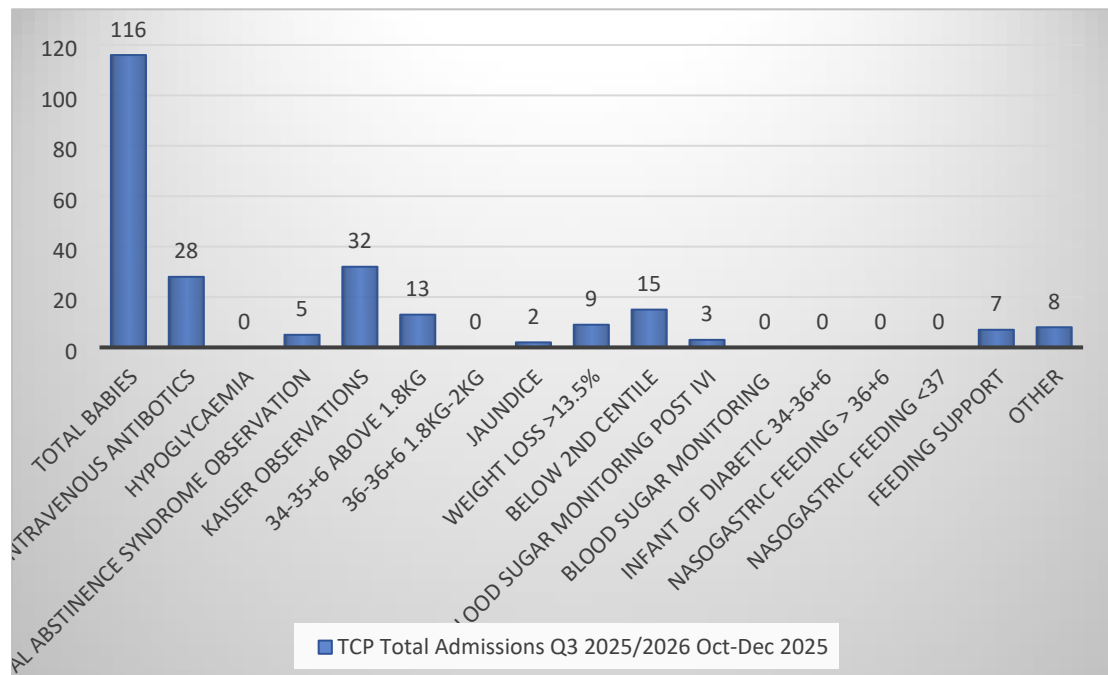


Figure 1: values of admissions to the RUH Transitional Care Pathway (TCP) by causation Q3 2025-2026

Babies transferred to neonatal unit from TCP for higher level of care

During Q3, six babies were transferred from the Transitional Care Pathway to the Neonatal Unit for escalation of care. All babies were appropriately identified and managed, with timely escalation in line with clinical need.

This demonstrates continued strong performance, with 100% compliance in NEWTT2 documentation and escalation protocols, providing assurance of effective clinical governance and staff capability.

Parental TCP feedback and Impact on Service Improvement

No parental feedback was captured for TCP during Q3 due to a technical issue with the feedback platform, where the existing SurveyMonkey tool was no longer supported and the QR code had not been updated.

This issue has now been resolved, with a new feedback process implemented via the MST platform. Updated QR codes, staff communications, and revised patient information materials have been introduced to support improved feedback capture. Ongoing monitoring will provide assurance that patient experience feedback is consistently captured and used to inform service improvement.

ATAIN Audit Findings Q3

In Q3, two avoidable term admissions to the Local Neonatal Unit (LNU) were identified through ATAIN multidisciplinary review. These cases involved a range of contributing factors, including CTG interpretation and aspects of care within the hypoglycaemia pathway. While no single consistent theme was identified, recurring areas for improvement include fetal monitoring, escalation and CTG interpretation.

These cases have informed targeted learning and system improvement. This includes the development of a multidisciplinary training programme focused on human factors, escalation, intrauterine resuscitation and fetal physiology, aligned to national recommendations from the Ockenden and East Kent reviews. This work is supporting updates to local fetal monitoring guidance and escalation processes.

Learning is embedded through governance structures, safety forums and training programmes, ensuring that improvement actions are implemented, monitored and shared across the maternity and neonatal teams. Overall, this provides assurance that avoidable admissions are subject to robust review, that learning is effectively translated into practice, and that ongoing actions are in place to strengthen clinical decision-making and reduce future risk.

Admissions to the neonatal unit from other areas in the hospital

In Q3, four term babies were admitted to the Neonatal Unit from other areas within RUH, including the Emergency Department and Children's Ward. All admissions were reviewed and appropriate.

Term Admissions to the Neonatal Unit – Q3 Analysis

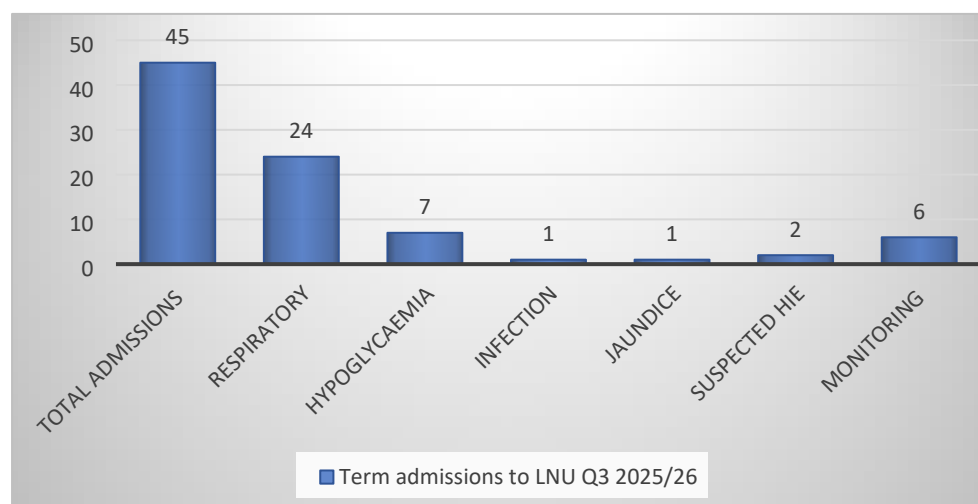


Figure 2: Values of Term admissions to the Neonatal Unit RUH by causation Q3 2025-2026

The leading cause of term admissions to the Local Neonatal Unit in Q3 was respiratory symptoms, consistent with national trends. Multidisciplinary review found no concerns or common issues in respiratory management, and all admissions were deemed clinically appropriate.

Since the introduction of routine pulse oximetry screening in January 2025, 17 babies, of which 3 were in Q3, have been admitted following failed screens, requiring monitoring, respiratory

support, or medical care. While this has contributed to an increase in ATAIN rates, it reflects the success of early detection and timely intervention. These outcomes have been positively received and were presented at both the LMNS and BAPM Annual Conference as evidence of the screening programme's impact on improving neonatal safety and care quality.

Q3 saw a rise in admissions with a diagnosis of hypoglycaemia to 7 compared to 3 in Q2. In response, there has been a review of all cases and a Learning Action Group implemented to identify and action workstreams to improve hypoglycaemia screening and management.

Quality Improvement Projects

Progression of the continuous positive airway pressure (CPAP) on Skin Early Intervention (COSEI) project continues, supporting efforts to reduce parent–infant separation for term babies with transient tachypnoea of the newborn. To date, three babies have received this intervention; two required onward admission for continued respiratory support following the initial 90-minute treatment. Delivery of this pathway is dependent on appropriate ANNP and nursing workforce, as it requires 1:1 care on the birthing suite. Ongoing simulation training is supporting staff capability and confidence in delivering this model of care.

A quality improvement project reviewing all cases of pneumothorax over the past 2.5 years has been completed. This thematic review examines antenatal, intrapartum and postnatal factors to identify opportunities for improvement. Findings will inform targeted actions, with measurable improvements monitored through ongoing audit. This work has been shared with the LMNS and South West Operational Delivery Network (SWODN) to support wider learning.

Ongoing Improvement Workstreams

Work continues to review the inclusion of 37+ week readmissions in ATAIN data, with benchmarking against the Southwest Neonatal Network to ensure consistency and equity. New guidelines for the care of community infants under three months requiring paediatric intensive care have been published and are being audited for compliance, alongside NEO-129.

A Collaborative Transitional Care Special Interest Group (TC SIG) has been established to drive service improvement and cultural alignment between maternity and neonatal teams. In response to parental feedback, an action plan is being developed to improve the environment on Mary Ward.

Quarterly audits of newborn observation records using the NEWTT2 tool continue to provide assurance, with Q3 showing full compliance. Learning from ATAIN MDT reviews is triangulated with other feedback sources and shared across the MatNeo team to inform ongoing quality improvement.

Standard 10 sets of records with baby observations	Q1 2025-2026	Q2 2025-2026	Q3 2025-2026
The NEWTT2 chart should be fully completed With core observation	90%	100%	100%
Correct time interval in between observations	100%	100%	100%
The total NEWTT 2 score should be calculated and correct	90%	100%	100%

Escalation is compliant with the NEWTT2 escalation pathway	60%	100%	100%
If score above 0 has the response been documented in the baby notes	80%	100%	100%
Is the chart labelled	n/a	n/a	100%

Figure 3. Audit results of NEWTT2 compliance Q2 2025-2026

Report to:	Public Board of Directors	Agenda item:	15
Date of Meeting:	3 June 2026		

Title of Report:	Bi-annual Midwifery, Neonatal Nursing and Medical Staffing Report
Status:	For approval
Board Sponsor:	Antonia Lynch, Chief Nursing Officer
Author:	Zita Martinez, Director of Midwifery and Neonates Jodie da Rosa, Head of Midwifery and Neonates
Appendices	None

1.	Executive Summary of the Report
This bi-annual report provides assurance that maternity and neonatal services maintained safe care between July and December 2025, with strong performance in key safety-critical areas. The service consistently delivered one-to-one intrapartum care and maintained full consultant obstetric and anaesthetic presence in line with national standards. Labour ward coordinator supernumerary status was sustained, with one brief five-minute exception that did not impact safety or oversight. Neonatal nursing achieved full Qualified in Specialty (QIS) compliance throughout the period. Daily multidisciplinary safety huddles and the national maternity situation report have strengthened real-time oversight of activity, acuity and staffing. Alongside these assurances, workforce pressures remain evident. Midwifery staffing is fully funded to the BirthRate Plus establishment; however, headroom remains below recommended levels, and inpatient ward staffing has not consistently met acuity requirements. Neonatal nursing continues to experience sustained pressure from vacancies, sickness and regional cot closures, requiring temporary mitigations. The neonatal medical workforce continues to meet the 2018 British Association of Perinatal Medicine (BAPM) framework. However, implementation of the 2025 Medical Workforce Standards is expected to highlight an emerging risk in relation to Tier 2 medical cover. A full benchmarking exercise will be completed in Q4 2025/26, with any required actions and investment identified and progressed through governance and workforce planning processes to ensure a safe and sustainable medical model. Gaps remain in neonatal allied health professional, psychology and pharmacy provision, and work is ongoing to strengthen these areas in line with national recommendations and regional benchmarks. Transitional Care demand continues to exceed the current four-cot model, with plans underway to expand capacity in line with Get It Right First Time (GIRFT) recommendations and further support family-centred care. Final staffing requirements for maternity and neonatal services will be confirmed in Q1 2026/27 following completion of the BirthRate Plus and Neonatal Establishment Reviews. These outputs will inform the 2026/27 business planning cycle.	

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2.	Recommendations (Note, Approve, Discuss)
	Note
3.	Legal / Regulatory Implications
	It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Trust to support Birthrate Plus® report 2023 and meet BAPM Neonatal staffing standards. Maternity Incentive Scheme Year 7 standards.
4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
	3182 – Risk of increased neonatal cot capacity = 16 Patient Safety and Quality 3101 – Non-compliance RCOG Maternity Triage Medical Review = 15 Patient Safety and Quality 2785 – Non-compliance of pharmacist cover BAPM = 12 Patient Safety and Quality 3171 – Non-compliance Allied Health Professionals BAPM= 8 Patient Safety and Quality
5.	Resources Implications (Financial / staffing)
	Nil at this juncture.
6.	Equality and Diversity
	Equality and Diversity legislation is an integral component to registration.
7.	References to previous reports/Next steps
	Routine Bi-annual Trust Board reporting. Previous bi-annual Maternity and Neonatal Workforce paper shared on 5 November 2025.
8.	Freedom of Information
	Public
9.	Sustainability
	N/A
10.	Digital
	N/A

BI-ANNUAL MATERNITY AND NEONATAL STAFFING REPORT

1.0 Background

This bi-annual report provides the Trust Board with an overview of maternity and neonatal staffing between July and December 2025, and how the Trust continues to meet its statutory duties under the Health and Social Care Act 2008 and NHS England's National Quality Board expectations. It outlines the approach to ensuring safe and sustainable staffing through recognised tools, professional judgement and real-time operational oversight.

The report is aligned to national standards and guidance, including NICE NG4, the Maternity Incentive Scheme (MIS), the Maternity and Neonatal Three-year Delivery Plan, BAPM neonatal workforce standards, Royal College of Obstetricians and Gynaecologists (RCOG) acute care guidance and the Anaesthesia Clinical Services Accreditation scheme.

In April 2025, a vacancy factor was applied across all Trust budgets as part of organisational financial recovery measures. At that time, the Executive Team confirmed that this would not restrict recruitment within maternity and neonatal services. This ensured that workforce growth within perinatal services could continue, recognising the critical importance of maintaining safe staffing levels and high-quality care.

2.0 Executive Summary

This bi-annual report provides assurance that maternity and neonatal services delivered safe and effective care between July and December 2025, with strong performance across key safety-critical areas. The service consistently achieved one-to-one intrapartum care and maintained full consultant obstetric and anaesthetic presence in line with national standards. Labour ward coordinator supernumerary status was sustained, with one brief and isolated exception that did not impact safety or oversight. Neonatal nursing maintained compliance with Qualified in Specialty requirements throughout the period. Daily multidisciplinary safety huddles and the national maternity situation report have strengthened real-time oversight of activity, acuity and staffing.

Alongside this strong performance, sustained workforce pressures are evident. Midwifery staffing remains fully funded to the BirthRate Plus establishment; however, headroom is below recommended levels, and inpatient ward staffing has not consistently met acuity requirements. Neonatal nursing continues to experience pressure from vacancies, sickness and regional cot capacity constraints, requiring ongoing temporary mitigations to maintain safe care.

The neonatal medical workforce continues to meet the 2018 BAPM framework. However, implementation of the 2025 Medical Workforce Standards is expected to highlight an emerging risk in relation to Tier 2 medical cover. A full benchmarking exercise will be completed in Quarter 4 of 2025/26, with any required actions and investment identified and progressed through established governance and workforce planning processes.

There are recognised gaps in neonatal allied health professional, psychology and pharmacy provision, with work ongoing to strengthen these areas in line with national expectations. Transitional Care demand continues to exceed the current four-cot model, with plans

Author: Jodie da Rosa Head of Midwifery and Neonates, Zita Martinez, Director of Midwifery Document Approved by: Toni Lynch, Chief Nursing Officer	Date: May 2026 Version: 1.0
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underway to expand capacity in line with GIRFT recommendations and support improved patient flow and family-centred care.

Final staffing requirements for maternity and neonatal services will be confirmed in Quarter 1 2026/27 following completion of the BirthRate Plus and Neonatal Establishment Reviews. These outputs will inform the 2026/27 business planning cycle and support delivery of a safe, sustainable workforce model aligned to national standards.

3.0 Maternity Workforce Overview

The service is fully funded to the establishment recommended by BirthRate+, which aligns with the midwifery safe staffing recommendations from Ockenden 2022. The BirthRate+ funded establishment is 191.83 Whole Time Equivalent (WTE).

BirthRate+ is the only nationally recognised tool for determining safe midwifery staffing levels. A BirthRate+ assessment should be undertaken every three years to ensure the establishment reflects changes in activity, acuity and service configuration. The next assessment will begin in January 2026, with the final report expected in May 2026.

The service currently operates with a headroom allocation of 24 percent. A system wide review across BSW in 2022 concluded that a minimum headroom of 28 percent is required to meet mandatory perinatal training and maintain safety. The current headroom is therefore insufficient, resulting in unavoidable additional costs, including increased reliance on bank staffing to maintain safe clinical cover. Updated headroom requirements and associated financial impacts will be reflected in the forthcoming BirthRate+ report.

In addition to clinical midwifery workforce requirements, national recommendations, including those from the Ockenden Review, the Maternity Incentive Scheme (MIS), and the three-year Maternity and Neonatal Delivery Plan must be factored into BSW ICB workforce planning. These national standards drive expectations for safer staffing, enhanced governance and strengthened multidisciplinary working. The service continues to assess future workforce needs and secure sustainable funding to ensure safer, more personalised and equitable care.

3.1 Recruitment and retention

The maternity workforce remained stable throughout the reporting period, with the pipeline demonstrating predictable patterns in maternity leave, secondments and substantive vacancies. Maternity leave showed normal month-to-month variation, with secondments remaining stable in early summer before reducing from September.

Substantive vacancies also showed gradual improvement over the period, with the highest levels seen in the autumn as newly qualified midwives entered their supernumerary phase. The Budget versus Actuals position was negative throughout, indicating a continued reliance on temporary staffing; however, this reflects the planned approach to holding vacancies for midwifery students and is expected to reduce in quarter four of 2025–2026 as these staff fully enter the roster. Overall, the pipeline remained within anticipated parameters, and movements across leave, secondments and vacancies were managed within existing workforce processes without impacting the ability to maintain safe staffing.

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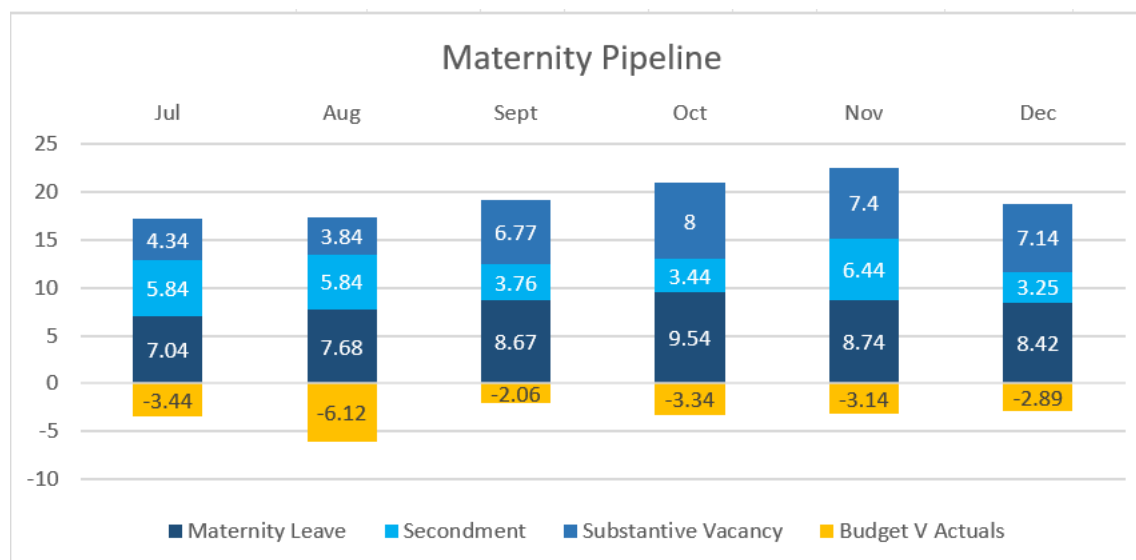


Figure 1: Midwifery pipeline

3.2 Attendance Management

Maternity sickness rates remained broadly stable across the reporting period, with a seasonal rise in December, and the twelve-month rolling rate remained below the Trust target at 3.39 percent. The main contributor to days lost continues to be anxiety, stress and related conditions, reflecting wider Trust and NHS trends.

Attendance is managed consistently in line with Trust policy, with all episodes certified and each staff member receiving a return-to-work health and wellbeing review. Longterm sickness continues to be jointly overseen by Human Resources (HR) and Occupational Health. To strengthen assurance, the service has introduced sickness management surgeries that provide line managers with structured guidance and practical tools developed in partnership with HR. This approach supports early intervention, consistent decision making and compassionate staff support. The service will continue to monitor trends and collaborate with HR to ensure attendance is managed consistently and compassionately, supporting staff wellbeing and sustaining reliable staffing levels for safe service delivery.

3.3 Operational Oversight, Escalation and Mitigation

Operational oversight across maternity and neonatal services strengthened significantly during the reporting period. Following NHS England's mandate on 15 December 2025 to introduce a daily maternity SITREP in place of the previous twice weekly submission, the Perinatal service established a daily 10:00 multidisciplinary Safety Huddle. This forum brings together real-time information on acuity, activity, staffing, capacity and flow, enabling timely and proactive decision making. The daily huddle has also enhanced coordination between maternity and neonatal services, supporting early recognition of operational pressures and providing a reliable mechanism for mutual aid.

Escalation and mitigation processes continued to operate effectively. The senior operational leadership team reviewed the Maternity Operational Pressures Escalation Level Framework each day, applying mitigations where activity or acuity exceeded planned staffing. Where midwifery staffing did not meet acuity, the service implemented several established

measures, including redeployment of specialist midwives into clinical roles, review of elective activity, senior midwives working clinically, maintenance of one-to-one care through staff redeployments to support the Bath Birth Centre. Support from the on-call midwifery manager was requested when required, and close collaboration with neighbouring maternity services supported shared capacity during peak pressure. Improvements in shift fill and the consistent application of escalation processes have meant that use of on call staff is now extremely limited and routine reporting of on call activity is no longer required. Reporting will resume if activity increases or further assurance is needed.

Red flag events continued to function as an important early indicator of staffing pressure and were captured using the BirthRate Plus acuity tool, which provides oversight of both clinical activity and data reliability. During the six-month reporting period (Table 1), red flag events related to delays in time critical tasks, including commencing induction of labour, administering analgesia and undertaking essential care activities. These events occurred primarily on Mary Ward and were closely associated with periods of sustained high activity and gaps in key support roles. Activity levels affected the labour ward coordinator's ability to remain fully supernumerary on one occasion. Despite this, intrapartum safety was maintained through effective dynamic redeployment, continuous senior clinical oversight and real time escalation processes. No patient safety incidents were attributed to any of the red flag events recorded in this period.

Overall, the pattern of red flag activity highlights a consistent operational theme. Delays arose at times when clinical demand exceeded available capacity, particularly in areas where support role staffing was reduced. This reinforces the need to stabilise workforce levels, strengthen the role of support staff within the clinical model and ensure that escalation processes continue to be applied swiftly and consistently.

Where delays in induction of labour were identified, the service has initiated a structured quality improvement programme to address flow and reduce bottlenecks, supported by strengthened data capture and governance oversight. Further mitigation has also been introduced on Mary Ward, including a pilot enabling women recovering from elective caesarean birth to self-administer analgesia. Early feedback from this pilot has been positive, demonstrating quicker access to pain relief and a reduction in routine demand on clinical staff. A full evaluation will be completed in quarter four of 2025/26 to inform potential wider implementation.

	July 25	August 25	September 25	October 25	November 25	December 25
NICE Red Flags	13	7	8	6	2	3

Table 1: NICE Red Flags

3.4 Midwife to Birth Ratio and BirthRate Plus Acuity

The midwife to birth ratio is monitored monthly using the BirthRate Plus methodology, with the Trust working to a target of one midwife to twenty-four births introduced in July 2023 following the RUH BirthRate Plus report. Ratios remained above this target during the reporting period; however, performance showed clear improvement compared with the previous period.

The variance can be attributed to two factors: the intentional holding of vacancies over the summer to prepare for incoming newly qualified midwives, and the sustained period of high activity and acuity experienced from September through November.

Although the new midwifery cohort commenced in October, they required a supernumerary period throughout October and November, meaning the full benefits of their posts were not realised until December. Bank staff are used to support safe staffing during periods of pressure, ensuring continuity of care while substantive workforce capacity stabilises. Based on increasing clinical complexity and evolving service needs, it is expected that the midwife to birth ratio will be reviewed again in 2026 as part of ongoing workforce planning.

Midwife to birth ratio	Target	July 25	August 25	September 25	October 25	November 25	December 25
Substantive only	1.24	1.27	1.27	1.28	1.30	1.30	1.26
Including bank	1.24	1.25	1.26	1.26	1.28	1.28	1.25

Table 2: MW:Birth ratio

Supernumerary status for the labour ward coordinator (LWC) continued to be maintained in line with Maternity Incentive Scheme Safety Action 5, which requires that the coordinator remains free from routine clinical duties to oversee safety and all birth activity. Monthly internal reviews demonstrated full compliance throughout the six-month period, with one brief and fully explained exception in August. In that instance, the labour ward coordinator briefly initiated fetal heart monitoring for approximately five minutes to ensure safe and timely care before another midwife was redeployed to complete the task. At all times, the coordinator retained full oversight of the labour ward, remained immediately available, and safety was not compromised.

Month	Days per month	Shifts per month	Compliance
July 25	31	62	100%
August 25	31	62	99.4%
September 25	30	60	100%
October 25	31	62	100%
November 25	30	60	100%
December 25	31	62	100%

Table 3: Supernumerary status LWC

Alongside this, the service continued to deliver one-to-one midwifery care for all women in established labour, maintaining one hundred percent compliance across the six-month period. This provides strong assurance that intrapartum safety requirements were met consistently and reflects the effectiveness of real-time oversight and escalation processes.

	July 25	August 25	September 25	October 25	November 25	December 25
1:1 care in established labour	100%	100%	100%	100%	100%	100%

Table 4: 1:1 care in established labour

Inpatient ward acuity on Mary Ward remained affected by the need to prioritise one-to-one intrapartum care on the Bath Birth Centre, which is required under national safety standards. This necessary prioritisation, combined with higher sickness levels and vacancies in maternity support worker, ward clerk and housekeeping roles, reduced the care hours available for inpatient activity and required clinical staff to undertake additional administrative duties. The inpatient ward-based acuity tool, which is completed prospectively for the next six hours, showed that staffing did not meet acuity across a significant proportion of shifts, ranging from 89% in July to between 29% and 51% from September to December. The confidence factor remained above 60% throughout, providing assurance that the data is reliable.

Analysis of Mary Ward acuity (Table 5) shows that the care hours needed to provide high quality care regularly exceed the staffing hours available, resulting in reduced capacity to deliver holistic and timely support. To understand the impact on safety and experience, a detailed deep dive will be undertaken as part of the forthcoming BirthRate Plus reassessment. In parallel, targeted culture improvement work will continue on Mary Ward until the reassessment is complete and its recommendations can be implemented.

	July 25	August 25	September 25	October 25	November 25	December 25
% Staff meets acuity Mary Ward (inpatient area)	89%	60 %	29%	31%	47%	51%
Confidence factor >60%	82 %	88%	87%	81%	90%	83%

Table 5: Mary Ward Acuity

4.0 Specialist Midwives

Birthrate Plus recommends 18.37 WTE specialist midwives, inclusive of management posts and the non-clinical elements required for these roles. The service currently has 18.17 WTE specialist midwives in post, including those in management positions who can be deployed flexibly during periods of escalation to maintain safe staffing. Several of these posts are externally funded; however, they remain essential to meeting national requirements, including Ockenden, the Maternity Incentive Scheme (MIS) and the three-year Maternity and Neonatal Delivery Plan.

Work is progressing across the BSW system to ensure the long-term sustainability of these roles. This includes ongoing discussions regarding:

- Future funding models to secure specialist capacity
- Aligning care pathways across organisations to deliver more consistent, personalised and equitable care

- Identifying efficiencies and shared approaches to strengthen clinical governance and improve outcomes.

Collectively, this work provides assurance that the specialist midwifery workforce is being strategically managed to support safety, quality and service transformation across the system.

5.0 Medical Workforce – Obstetric

The service has not employed any locum obstetric staff during the reporting period, with all shifts covered by substantive obstetricians in line with Maternity Incentive Scheme (MIS) Year 7 requirements. Consultant presence fully met RCOG guidelines (Table 6), with no episodes of non-attendance when clinically indicated (Table 7).

	July 25	August 25	September 25	October 25	November 25	December 25
Hours of consultant presence	98	98	98	98	98	98

Table 6: Consultant presence in hours

	July 25	August 25	September 25	October 25	November 25	December 25
Consultant non-attendance when clinically indicated	0	0	0	0	0	0

Table 7: Consultant non-attendance when clinically indicated

A survey exploring compliance with RCOG compensatory rest recommendations highlighted variable staff experience. While many reported feeling supported, several noted inconsistencies in access to compensatory rest, escalation routes and peer cover. Despite this, most staff felt safe to return to duties following an on-call shift. Targeted actions are underway, including enhanced one to one engagement, a buddy support system and strengthened job planning to protect SPA time for key quality improvement roles.

The service remains non-compliant with the RCOG *Good Practice Paper: Maternity Triage* requirement for timely access to senior medical review, as defined by BSOTS (Birmingham Symptom specific Obstetric Triage System) symptom specific algorithms that determine both the urgency and seniority of clinical assessment required for each presentation. Current medical workforce models mean that the service cannot reliably meet these expectations, particularly for women triaged to the yellow or green pathways. For these lower acuity groups, the principal impact is on patient experience, with waiting times for medical review often exceeding the recommended timeframe. This has not translated into clinical safety concerns.

No patient safety incidents have been attributed to delays within the triage pathway. Oversight remains robust, with call handling performance, clinical risk assessments, BSOTS compliance and feedback from families and staff routinely monitored through established governance structures. To strengthen assurance, work is underway to better understand the effect of prolonged waits on patient experience, supported by enhanced electronic data capture within the triage environment.

To improve compliance with national standards, the service is actively exploring the introduction of Advanced Midwifery Practitioner roles as a sustainable workforce solution that would increase clinical cover, enhance responsiveness and reduce delays for women requiring non-urgent review.

5.1 Medical Workforce – Anaesthetic

Table 8 provides clear evidence of a dedicated obstetric rota that includes resident anaesthetic staff alongside a named consultant, ensuring clear escalation pathways to a dedicated consultant anaesthetist whenever required. The rota demonstrates full compliance with the Anaesthetic Clinical Services Accreditation (ACSA) Standard 1.7.2.2.1, which specifies the requirement for appropriately staffed and supervised obstetric anaesthetic services. This level of provision meets the minimum requirement set out within the Maternity Incentive Scheme (MIS) for Year 7, providing assurance of safe and consistent anaesthetic cover for the obstetric unit.

	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25
Resident doctor rostered	100%	100%	100%	100%	100%	100%
Consultant Rostered	100%	100%	100%	100%	100%	100%

Table 8: ACSA Standards

6.0 Neonatal Nursing Workforce Overview

The Neonatal Nursing Workforce Tool (2020), adapted from the Clinical Reference Group Workforce Calculator (Dinning Tool, 2013), provides a consistent method for calculating nursing establishment requirements and is designed for use in direct patient care within the LNU only. NHSE (2016) recommends a 25% uplift for headroom; however, the current budget includes 23% percent, creating a shortfall.

During this reporting period, the Neonatal Service experienced significant challenges in maintaining safe staffing levels. Pressures were primarily driven by higher than usual vacancy rates, short term sickness absence and temporary neonatal cot closures at the Level 3 Tertiary Neonatal Unit at North Bristol Trust. These factors increased acuity within the service and extended lengths of stay, further intensifying demand on the workforce. Activity and acuity remained consistently high throughout Quarter 3 2025/2026, this is reflected in the Risk Register entry 3182.

To maintain safe staffing levels, the service implemented a range of mitigating actions. Specialist roles such as infant feeding and education leads were deployed into clinical rotas to support shift fill. Non-essential training was paused or adapted, with teams using creative approaches to deliver essential training requirements while maximising clinical capacity. The service also received substantial support from paediatric staff redeployed into neonatal care, alongside bank utilisation. It is noted, however, that the bank pool is small and predominantly made up of substantive neonatal nurses, creating potential pressure on staff wellbeing.

To provide further stability, the service submitted a proposal for an additional 3WTE through a long line agency arrangement. This option offered a lower cost than equivalent bank usage and provided predictable cover. The proposal was supported by the Trust Executive Team and approved at the Management Executive Committee in October. The temporary uplift remained in place until the end of December, aligning with the planned reopening of cots at the tertiary centre, new starters completing their supernumerary period and a strong recruitment pipeline into January 2026.

In addition, the service is scheduled to undergo a formal establishment review led by the South-West Operational Delivery Network (ODN). It is anticipated that this review may identify gaps in the current establishment and could result in the requirement for additional WTE and associated investment to ensure staffing levels remain resilient. Any recommendations arising from the review will be progressed through the Trust's standard business planning and financial governance processes.

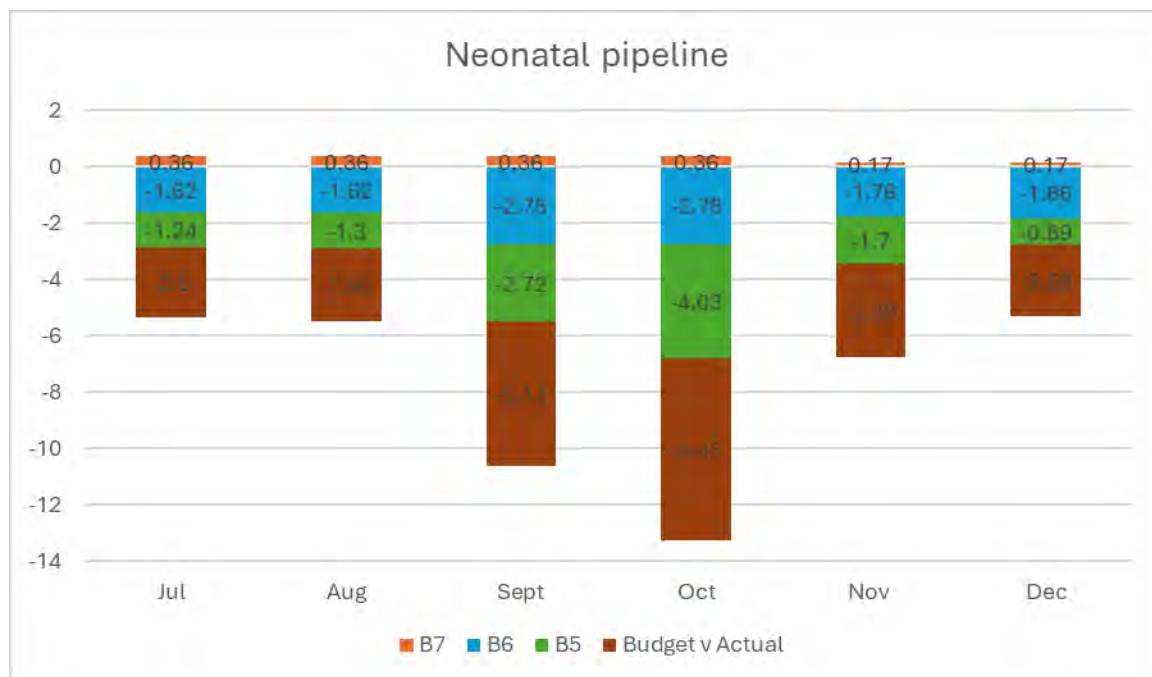


Figure 2: Neonatal nursing pipeline

7.0 Qualified in Speciality (QIS)

The British Association of Perinatal Medicine (BAPM) recommends that all babies receiving intensive (ICU) or high dependency (HDU) care are cared for by a nurse who is Qualified in Specialty (QIS). QIS training is a post registration education and competency framework that equips neonatal nurses with the specialist knowledge and skills required to deliver safe and effective neonatal critical care. While it is best practice for babies receiving special care to be looked after by a QIS trained nurse, national standards can be met where they are appropriately supervised by a QIS trained colleague. The national BAPM requirement for Local Neonatal Units is that at least 70 percent of the patient facing nursing workforce is QIS qualified.

During this reporting period, the service is pleased to confirm full compliance with the BAPM QIS standard, with overall QIS staffing consistently above the 70 percent threshold. As a result, the requirement to maintain and report against an improvement action plan is no longer applicable for the purposes of the Maternity Incentive Scheme (Safety Action 4). QIS compliance data continues to be monitored routinely through maternity and neonatal specialty governance and reported via the Perinatal Quality Surveillance Tool.

	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25
QIS Compliance %	65	65	70.8	70.8	70.8	70.8

Table 9: QIS compliance

Although the service is now compliant, skill mix remains an operational challenge, particularly during periods of high acuity or short notice workforce disruption. To maintain safe skill mix across all shifts, the service prioritises QIS cover in daily rostering and real time shift management. Senior Sisters oversee shift allocation to ensure that ITU and HDU cots are consistently staffed by QIS trained nurses, with supervisory and coordinating roles also fulfilled by QIS trained staff in line with national standards. Where short term sickness or surges in acuity occur, shift swaps and redeployments are managed proactively to maintain QIS cover in areas of greatest clinical risk.

All registered nurses continue to complete the Southwest Neonatal Foundation Programme and local competency frameworks, ensuring a strong baseline of knowledge and enabling non-QIS staff to be effectively supported while gaining experience in higher acuity care. The service also maintains a strong and sustainable pipeline into QIS training, supported through the Southwest ODN programmes and ongoing continual professional development (CPD) investment secured through Trust wide funding processes.

The service will continue to monitor compliance, skill mix and acuity levels closely and will report any significant changes through established governance structures.

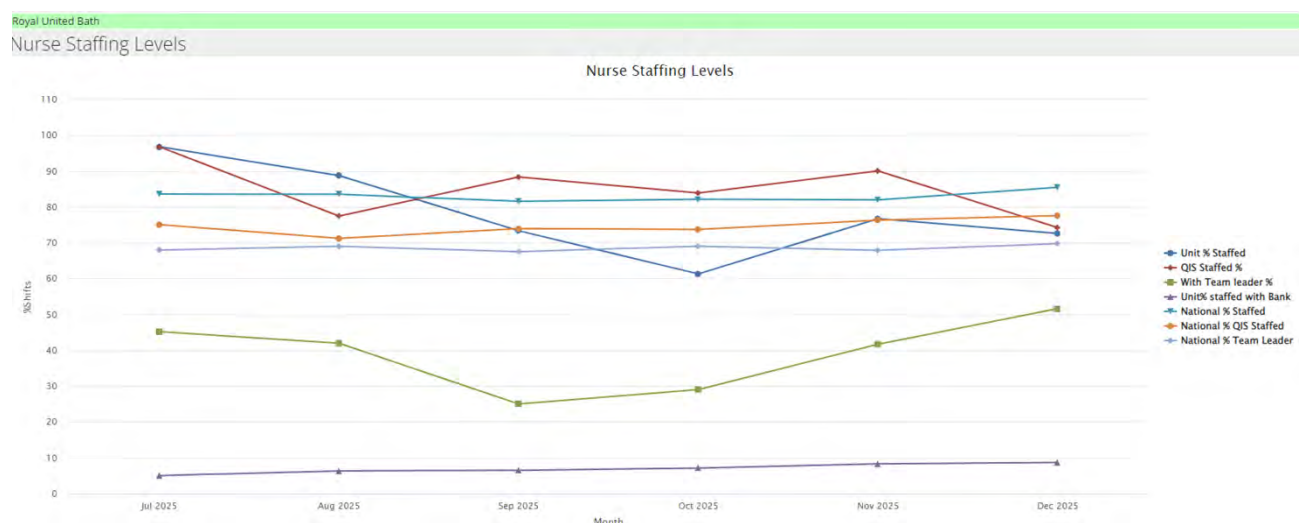


Figure 3: QIS shift fill rates

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7.1 Attendance Management

Neonatal attendance reflected similar patterns to maternity and was managed through the same Trust processes, with HR and Occupational Health oversight.

7.2 Transitional Care

In line with BAPM (2017) guidance, all Local Neonatal Units (LNUs) are required to provide a Transitional Care (TC) service. The Trust currently operates a 4 bed TC provision, staffed from the LNU patient facing budget, with 100 percent of shifts covered by a neonatal nurse or nursing associate. The service aims to maintain a 1:4 nurse to patient ratio in accordance with BAPM standards.

During 2025, safe staffing levels for the existing 4 bed provision were maintained through the inpatient establishment, supported by continuous monitoring of capacity and demand. The recent GIRFT review recommends expanding TC capacity to at least 8 beds based on the Trusts birth rate and activity levels. Operational practice already reflects this need, with the service frequently caring for more than four babies within the TC pathway. In Quarter 3, 39 percent of shifts involved caring for more than four babies, and 14 percent of these shifts did not meet the recommended staffing ratios. All eligible babies received appropriate transitional care during this period.

Where staffing levels fall below recommended ratios, robust escalation processes are in place. These include redeployment of neonatal nurses from within the LNU where clinically appropriate, support from specialist roles such as Advanced Neonatal Nurse Practitioners and Clinical Nurse Specialists, and additional input from midwives, maternity support workers (MSWs) and paediatric colleagues. This multidisciplinary approach ensures safe care; however, it is recognised that these pressures increase workload across the perinatal workforce, and the impact on staff wellbeing is monitored and escalated through established governance processes.

A review of current staffing is underway to assess the feasibility of increasing TC cot provision in line with GIRFT recommendations and anticipated activity. Expansion of the TC service is a key priority for 2026, supporting safer, more responsive family centred care and improved flow across maternity and neonatal services. Work is progressing on a perinatal workforce model to strengthen TC delivery on the postnatal ward, including upskilling maternity support workers and exploring the development of a dedicated TC team. Quarterly reports continue to be submitted to the Trust Board, and ongoing activity, acuity and capacity data collection will inform the recommended expansion model and future investment requirements.

7.3 Neonatal Community Outreach

The Neonatal Community Outreach service currently operates with 1.8 WTE nurses, providing a six-day service in line with GIRFT (2022) recommendations. This remains below the BAPM Neonatal Outreach Framework, which recommends 1 WTE per 800 births plus a

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lead nurse. With an annual birth rate of around 4,500, a benchmarked establishment would be approximately 6.6 WTE to deliver a full seven-day model.

The service has broadened its offer to include Home Tube Feeding, which has delivered clear quality benefits, including earlier discharge, improved parental experience and enhanced breastfeeding rates. Over six months, five babies were supported through this pathway, enabling safe care at home and positive feedback from families.

Further development will explore expansion of outreach pathways in line with BAPM standards, such as home antibiotics and home phototherapy, which would provide additional clinical and operational benefits.

In line with NHSE recommendations, Transitional Care and Community Outreach functions should be separated from the inpatient neonatal budget. This work is progressing through the SW ODN Establishment Review and business planning processes.

8.0 Neonatal Medical Staffing

The BAPM Medical Workforce Standards for Local Neonatal Units (October 2025) replaced the 2018 Framework for Practice and introduce a more detailed and prescriptive approach to medical and Advanced Neonatal Nurse Practitioner (ANNP) staffing. These updates reflect modern models of neonatal care, where responsibilities may be undertaken by medical staff or appropriately trained ANNPs.

The updated 2025 BAPM framework outlines enhanced requirements for Tier 1, Tier 2 and Tier 3 staffing, with a strong emphasis on:

- Dedicated, on-unit clinical presence
- Clear separation from routine paediatric commitments
- Consistent consultant leadership through structured rota models
- Recognition of ANNPs as core members of the neonatal medical workforce.

These standards represent a significant evolution from the 2018 framework. The service will undertake a full benchmarking exercise against the new national requirements in Quarter 4 of 2025/26. Findings and any associated mobilisation or investment requirements will be reported following completion of that work. At this stage, benchmarking is not yet complete, and therefore no compliance position is assigned against the 2025 framework within this reporting period.

For this reporting cycle, the service continues to report performance against the 2018 BAPM Framework, in accordance with MIS Year 7 reporting requirements. As reflected in the previous reporting period, the service remains compliant with all 2018 BAPM medical staffing standards, demonstrated in Table 10. The service has an established ANNP workforce operating across both Tier 1 and Tier 2 levels. ANNPs provide advanced clinical

decision making, procedural skill, continuity of care and family centred expertise, forming a fundamental component of the medical staffing model.

BAPM Standard	RUH
Tier 1 separate rota compliance 24/7	Compliant
Tier 2 separate rota compliance 12h per day	Compliant
Tier 2 compliance: significant geographical separation between neonatal and paediatric units	N/A
Tier 3 daytime compliance	Compliant
Tier 3 compliance on-call rota	Compliant

Table 10: BAPM 2018 Medical Workforce compliance

9.0 Allied Health Professionals (AHP) Psychology and Pharmacy Provision

Neonatal services rely on Allied Health Professionals (AHPs) to support safe, high-quality care and to optimise the short and long term neurodevelopmental and mental health outcomes of infants. This multidisciplinary requirement is endorsed by the Neonatal Critical Care Review (2019).

Each AHP discipline has national staffing recommendations and competency frameworks (BAPM, 2022), including cot-based standards and 0.15 WTE per discipline for neurodevelopmental follow up. At the RUH, these clinics are delivered by physiotherapy and occupational therapy, with referrals to other AHPs as needed.

There is a shortfall in AHP staffing against BAPM standards, recorded on the risk register and monitored through neonatal governance. Although Ockenden funding supported some recruitment, current provision remains below the recommended BAPM level. This means AHP input is prioritised for infants at highest risk, such as those born before 32 weeks gestation. Specialist MDT groups, including Family Integrated Care and Nutrition, have been established to promote consistent best practice despite these constraints. The BAPM Outreach Framework also specifies additional psychological support, including a Band 8a psychologist and Band 5 assistant, which sits outside the inpatient total.

Increasing service demand, particularly when cot occupancy exceeds the 80 percent commissioned level, has intensified existing workforce pressures. High acuity during Quarter 3 required AHP staff to work beyond substantive hours to maintain safe care for the most vulnerable infants. In response, the service has strengthened job planning and clinical prioritisation frameworks and is exploring remuneration processes for situations where higher acuity requires increased staffing.

Pharmacy provision was not included in Ockenden funding, and current capacity remains below the Neonatal and Paediatric Pharmacists Group (NPPG) standards aligned to BAPM

guidance. These recommend defined pharmacist WTE per Intensive Care, High Dependency and Special Care cots to ensure safe and effective medicines management. Incident reporting has identified recurrent medication related safety issues linked to insufficient pharmacy capacity, including expired medicines, delays in supply and challenges during repatriation that required more invasive administration routes. Limited staffing has also affected the services ability to maintain clinical guidelines, deliver staff training and develop drug monographs.

Given national maternity and neonatal safety investigations, including the forthcoming Thirlwell Inquiry, pharmacy support has been identified as a priority safety risk and is recorded on the Trust Risk Register (Risk 2785). Within this reporting period, there has been positive recruitment within the pharmacy specialty, which has enabled interim support to the neonatal pharmacy team and provided some short-term mitigation while longer-term workforce planning continues

National standards for SCBUs, LNUs and Medical NICUs					
	OT	Physio	Dietitian	S&LT*	Clinical Psychologist
IT cot	0.05	0.05	0.1	0.05	0.055
HD cot	0.05	0.05	0.05	0.05	0.055
SC cot	0.05	0.05	0.033	0.05	0.055
TC cot	0.02	0.05	0.033	0.02	0.055
1/2-day clinic	0.15	0.15	0.15	0.15	

Table 11: National standards for AHP WTE provision (BAPM 2022)

AHP	Current provision (WTE)	Deficit against BAPM (WTE)
Physio	0.2	1.15
OT	0.35	0.93
SALT	0.2	1.08
Dietician	0.2	1.09
Psychologist	0.3	0.86
Pharmacist	0.08	1.24 *(3.24)

Table 12: AHP WTE comparison

10.0 Specialist roles

BAPM service specifications state that additional provision should be implemented for staff delivering quality, management and other non-direct patient facing roles, which sit outside

the ratios used for direct patient care. Every provider of neonatal care should ensure that non direct patient facing roles include a designated lead nurse, clinical nurse educator, supernumerary shift coordinator, discharge planning or outreach coordinator, bereavement lead, patient safety and governance nursing lead and infant feeding lead, in addition to the other roles outlined in the Toolkit for High Quality Neonatal Services (2009).

The service currently maintains four dedicated specialist roles: 0.4 WTE Neonatal Education and Quality Lead, 0.4 WTE Safety Governance Lead and 0.5 WTE Family Integrated Care Lead. Remaining specialist functions, as recommended by BAPM, are assigned to individuals within the clinical nursing establishment. These roles are subject to redeployment during periods of staffing escalation, which may impact the continuity and delivery of specialist led initiatives.

11.0 Recommendations

The Trust Board is asked to note that the latest, evidence based, establishment requirements for maternity and neonatal services will not be available until the Maternity BirthRate Plus and Neonatal Establishment Reviews are completed, with findings expected in Quarter 1 of 2026/2027. These outcomes will inform the 2026/2027 business planning cycle, ensuring that any required investment, headroom adjustments and workforce expansion can be appropriately supported.

The benchmarking exercise against the updated BAPM medical workforce standards is also in progress and is expected to identify gaps within the current neonatal medical staffing model. The Trust Board is asked to note this position and to agree that the findings, once available, will inform future workforce planning and be taken forward through the Trust's established approval processes. The Board is further asked to maintain oversight of workforce risks relating to AHP, psychology and pharmacy provision, Transitional Care capacity and Neonatal Outreach, all of which will require future investment to meet national standards and sustain high-quality perinatal care.

12.0 Conclusion

Maternity services are a high-risk specialism; the impact of poor care can be life changing for women and their families. Investment in safe maternity staffing not only safeguards the provision of high-quality care and best outcomes but also mitigates the reputational and litigious risk for the organisation.

Neonatal services offer the best start in life to babies who have care needs which will have a lifelong impact if not provided in line with national standards. Having a baby in neonatal care has a significant impact to parental mental health which is long standing if they do not receive the care and support as per national requirements.

The Trust Board is asked to discuss the report and note the position of staffing in maternity and neonatal services.

Report to:	Public Board of Directors	Agenda item:	16.1
Date of Meeting:	3 June 2026		

Title of Report:	Freedom to Speak Up (FTSU) Q4 2025/26 Report
Status:	For Information, Discussion and Assurance
Board Sponsor:	Kheelna Bavalia, Interim Chief Medical Officer
Author:	Parmi Perera, Freedom to Speak Up Guardian for RUH
Appendices	None

1. Executive Summary of the Report

This report provides assurance on the effectiveness of Freedom to Speak Up arrangements at RUH for the reporting period, including access, themes, learning, and alignment with national and Group requirements.

FTSU arrangements operated effectively during the period, with continued staff access, appropriate escalation, and executive oversight.

The Board can take assurance that FTSU remains a credible, accessible, and independent route for staff voice.

2. Recommendations (Note, Approve, Discuss)

The Board is asked to note the contents of the report, which is provided for information, discussion and take assurance that FTSU arrangements are effective and support the forward actions identified.

3. Legal / Regulatory Implications

Following the [Dash review](#) of patient safety across the health and care landscape, the government has agreed that the National Guardian's Office will close at the end of June 2026.

From 1 July 2026, NHS England will deliver some activities previously undertaken by the National Guardian's Office, and healthcare organisations will take on greater responsibility and accountability for embedding effective Freedom to Speak Up arrangements.

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

Principal risk:

- There is a risk that staff feel unable to speak up, limiting organisational learning and potentially impacting patient safety.

Current assurance level:

- Current controls provide reasonable assurance, supported by case escalation, leadership engagement, and triangulation with workforce and safety intelligence.

Planned strengthening:

- Clarified reporting routes and strengthened monitoring of detriment and feedback.

5. Resources Implications (Financial / staffing)

N/A

6. Equality and Diversity

FTSUG quarterly triangulates with RUH HR Director, Workforce lead and EDI colleagues to discuss and share insights of FTSU data.

7. References to previous reports/Next steps

Previous report to Public Board was FTSU Q2 report.

As per previous board recommendations, FTSU has engaged with HR, Culture Team and Workforce and requested a triangulation committee, this will be followed up with RUH HR Director.

8. Freedom of Information

Public

9. Sustainability

N/A

10. Digital

N/A

RUH FTSU Q4 and 2025-2026 Annual Report

1. Purpose

The purpose of this report is to provide MEC and Board with an overview of themes, breakdown of concerns per staff groups and divisions and the demographics of staff accessing the FTSU service. It will provide an opportunity to discuss areas that need a more focused and deliberate approach, seek assurance that progress is made within the Trust in relation to the National FTSU agenda. It will also highlight concerns related to quality/safety and the staff experience and provide insight to support proactive planning.

2. Background

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC's report "[The Freedom to Speak Up](#)" (2015).

These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

The office leads, trains and supports a network of Freedom to Speak Up Guardians in England and conducts speaking up reviews to identify learning and support improvement of the speaking up culture of the healthcare sector.

There are over 1,200 guardians in NHS and independent sector organisations, national bodies and elsewhere that ensure workers can speak up about any issues impacting on their ability to do their job. The National Guardian's Office also provides challenge and learning to the healthcare system as part of its remit.

3. Updates regarding FTSU

3.1 Updates from the National Guardian's Office (NGO) and NHS England

From 1 July 2026, following a recommendation in July 2025 by the [Dash review](#) of patient safety across health and care, NHS England will deliver some activities previously undertaken by the National Guardian's Office (NGO). Trusts, primary care organisations, integrated care boards (ICBs) and independent providers will be taking on greater responsibility and accountability for embedding effective Freedom to Speak Up arrangements.

Key Points:

NHS England will:

- support existing guardian networks and individual guardians, including managing general enquiries through the national contact centre and escalating specialist queries to the NHS England Freedom to Speak Up team
- provide and maintain the platform for free online guardian foundation training

- collect Freedom to Speak Up data nationally and use both qualitative and quantitative insights to strengthen system learning. Insight will be shared routinely with guardian networks
- review national Freedom to Speak Up policy and guidance across all sectors, starting with primary care organisations

NHS healthcare providers and commissioners will:

- have sole responsibility for ensuring that information about how to contact their Freedom to Speak Up guardian is kept accurate, made publicly available and is accessible
- routinely submit their Freedom to Speak Up data through NHS England's national data collection system (for 2026/27, this will be trusts and ICBs only)
- ensure that any guardian they appoint completes the mandatory guardian foundation training before starting their role and support their continuing professional development
- ensure appropriate psychological support is available for their guardians once the nationally sourced independent Employee Assistance Programme ends on 31 December 2026

3.2 South West Regional and BSW FTSU Updates

FTSUG continues to participate in regular regional meetings and workshops, including sessions focused on FTSUG wellbeing. FTSUG also meets monthly with the BSW Group FTSUG to support alignment, shared learning, and professional peer support.

3.3 Local FTSU Updates

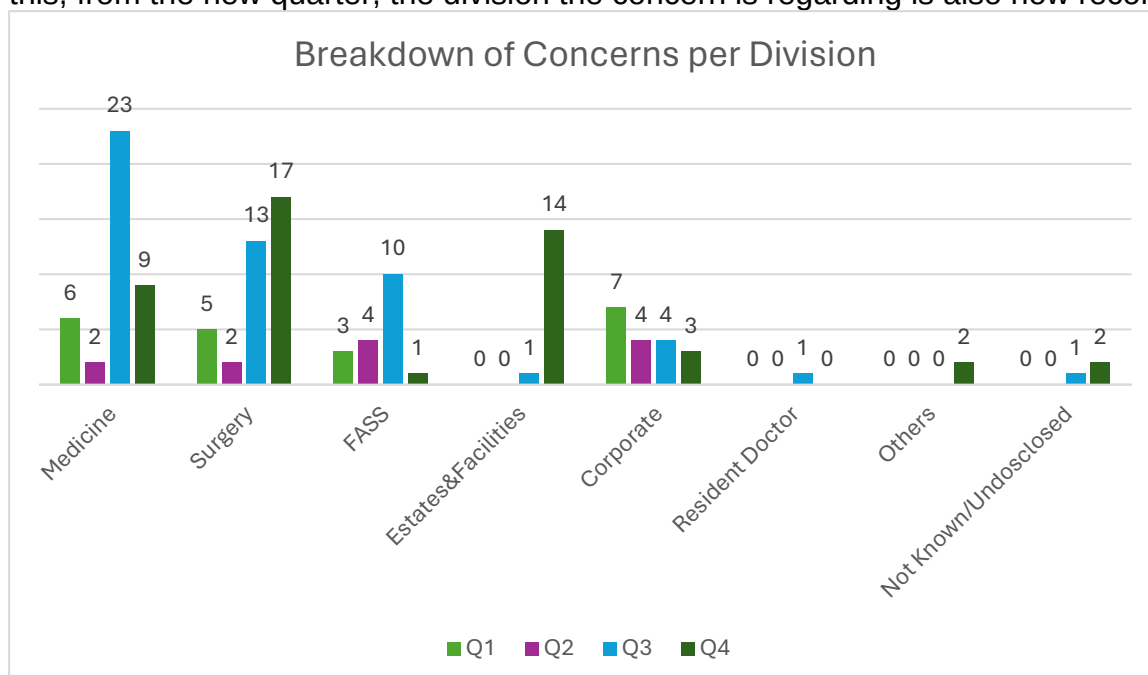
- Q4 data was reported to NGO
- FTSUG continues to engage with executive, divisional and other leaders (Patient Safety, Safeguarding, Quality Assurance and Staff Governors) to share FTSU data to discuss emerging trends and improvement opportunities.
- FTSU continues to raise awareness and engage with staff with the aid of a communication plan.
- FTSUG continues to attend Trust, local inductions and will attend team meetings where appropriate. In addition, FTSUG will do walk-arounds visiting various wards/departments and run awareness stalls.
- FTSU Champion network is kept updated and expanded with further recruitments.

4. Summary of Q4 (January-April 2026)

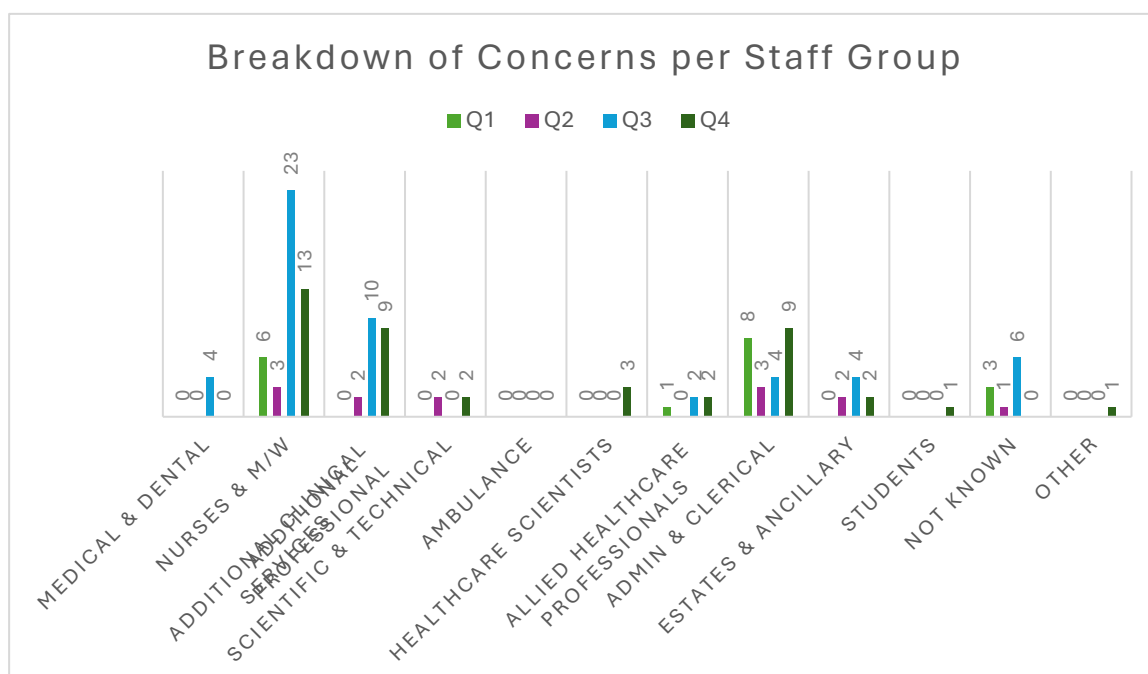
4.1 Breakdown of concerns per division

For reporting purposes, the division recorded reflects the division in which the member of staff raising the concern is substantively employed. As a result, this may not always

correspond to the division to which the concern itself relates. To get better clarity around this, from the new quarter, the division the concern is regarding is also now recorded.

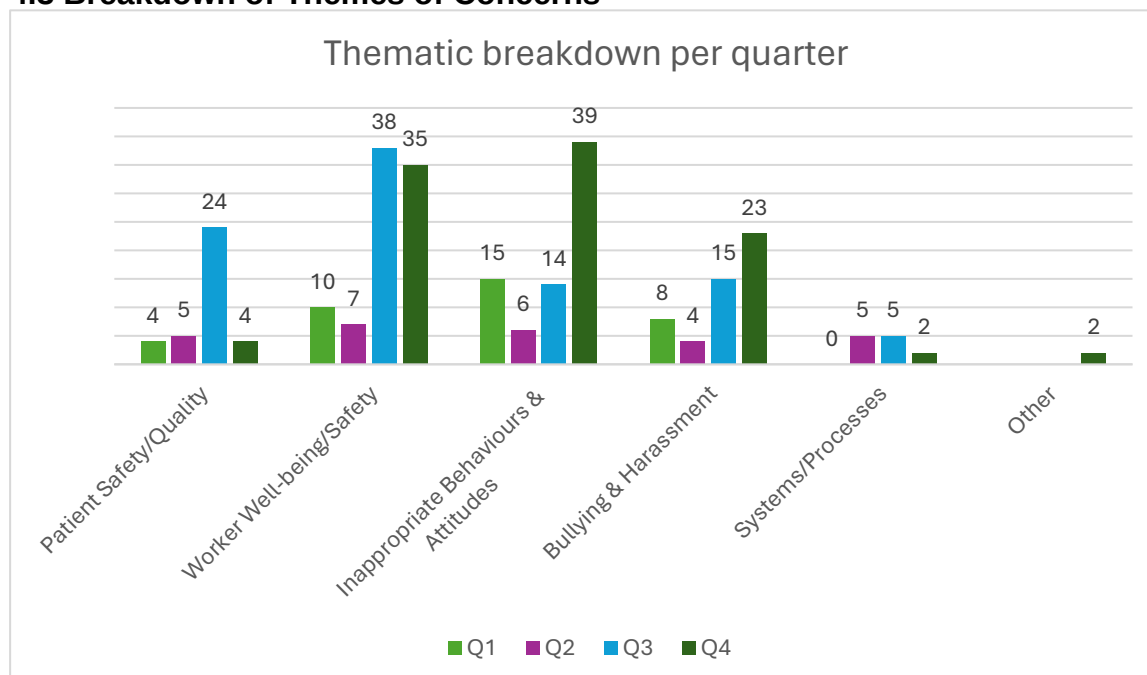


4.2 Breakdown of Concerns per staff group



There are plans to collaborate with GMC to initiate a plan similar to previous years to increase awareness of 'raising concerns/speaking up' amongst 'Medical and Dental' staff groups. FTSUG continues to provide FTSU induction to students through the Preceptorship team to overcome any gaps/disempowerment amongst this group.

4.3 Breakdown of Themes of Concerns



Please find below a further breakdown of each theme:

Patient Safety/Quality	- Indirect impact due to equipment failures/not up to standards - Incompetency in staff, negative attitude to errors - Outpatient staff shortages to handle calls from patients
Worker Well-being/Quality	- Conflict amongst staff - Concerns being dismissed/not taken seriously - Inappropriate behaviours and attitudes - Poor/broken down relationships with management - Unfair allocations of annual leave
Inappropriate behaviours and attitudes	- Negative feedback/criticisms delivered in inappropriate manners/times - Potential breach in confidentiality - Micro-management, poor management - Lack of support for career progression - Discriminatory attitudes - Behaviours/attitudes going against trust values

Systems/Processes	• Policy needing improvement • Potential information governance issues related to communication methods
Other	• Incomprehensive anonymous reports

Please note each concern may relate to 1 or more themes.

Please note that the number of cases recorded under “Bullying and Harassment” may not always equate to formal complaints progressed through HR processes.

4.4 Cases raised ‘Anonymously’

13 cases were raised ‘anonymously’ with FTSU, out of which 9 were raised through ‘Report and Support’ platform with no contact details provided. These ‘completely anonymous’ concerns have limitations in obtaining more information, checking in for resolution and identifying detriment and validating concerns. However, themes of these concerns are still escalated to relevant leaders/managers and action/learning is still captured.

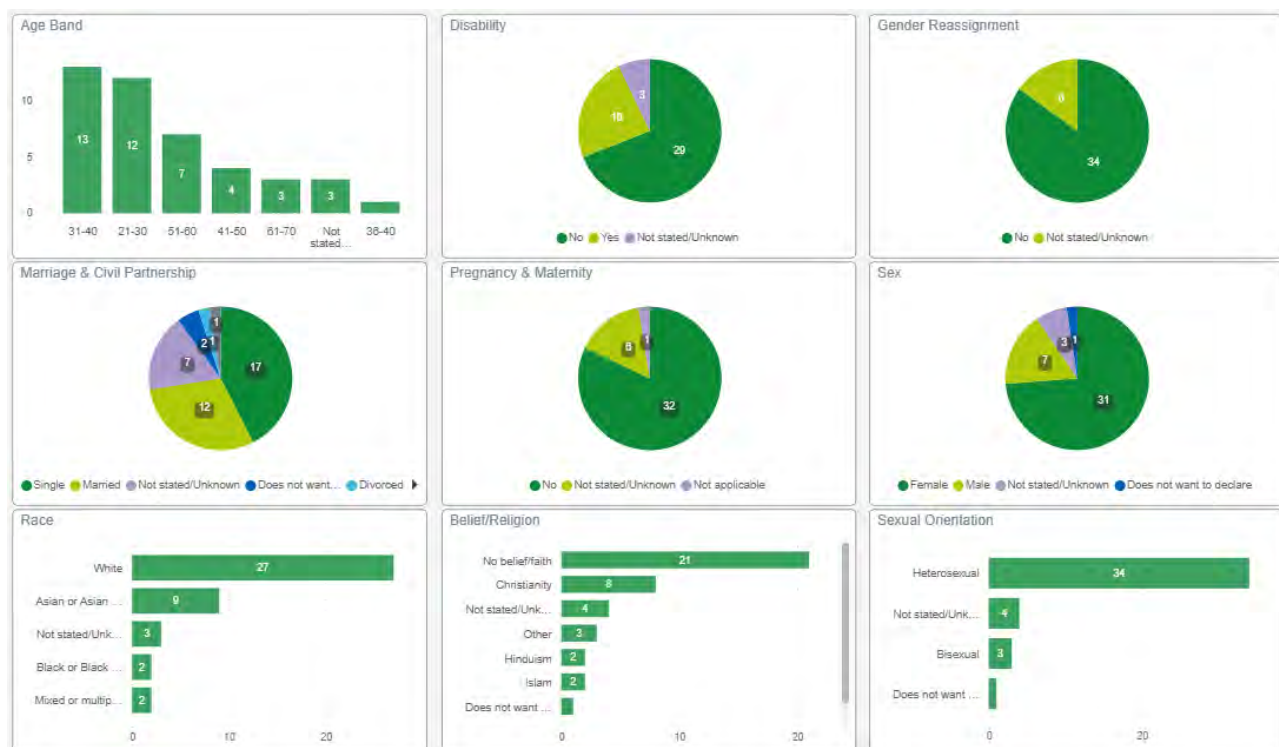
The ‘Report and Support’ platform will not be renewed in October 2026. Alternative routes for raising completely anonymous concerns (if need arises) will be communicated in advance of this date.

4.5 Cases involving alleged detriment

3 cases of staff stating they are facing detriment because of speaking up. When the concern is escalated, this aspect is also discussed to address the issue within team/department. These cases are discussed and brought to the attention of the NED and Executive lead for FTSU.

Staff are also encouraged to get back in touch with FTSU even after the case is closed, if they are facing detriment as this will identify poor culture around ‘raising concerns/speaking up’.

4.6 Breakdown of Protected Characteristics of staff who raised concerns



If staff state their concerns are due to their protected characteristic and there are elements of discrimination, they are signposted to 'People Hub' and Unions as they may wish to follow a formal route.

5. LearnTogether Compliance

There are 3 modules for FTSU (Speak Up, Listen Up and Follow Up). Only the 'Speak Up' module is compulsory for all staff and the compliance is as below:

- Indicative compliance: 96.32%
- In date completion rate: 93.34%

6. FTSU Feedback

6 staff provided feedback, 1 stated they will not speak up again.

Measure	Overall Trend
Service is easily accessible	Mostly Agree / Strongly Agree
Regular feedback provided	Mostly Agree / Strongly Agree
Outcomes achieved	Mostly Agree / Strongly Agree
Would refer FTSU to a colleague	1 Disagree, others Agree / Strongly Agree

The negative feedback indicates that their concern was 'not taken seriously' and their barrier to speaking up indicated 'not knowing the problem will be addressed' and they will not refer FTSU to another colleague. However, they do also state that their outcome was achieved. Upon looking into this feedback further, FTSU appropriately signposted services as the staff member was escalating their concerns independently.

7. Recommendations

The Committee is asked to note the critical importance of maintaining a healthy Freedom to Speak Up culture across the organisation for two major reasons:

1. Providing an additional/alternative route for staff to speak up/raise concerns
2. Provide relevant leaders and managers with additional insight through staff voice and lived experience.

In addition, FTSUG will be implementing recommendations from the Dash Review and closely monitor and evaluate any barriers faced by staff based on their protected characteristics. To overcome these, FTSUG will continue to work closely with EDI considering findings from WRES/WDES.

Actions required from the leadership group is to continue to support FTSU Service keeping in line with the NHSE guidelines.

Report to:	Public Board of Directors	Agenda item:	17.2
Date of Meeting:	3 June 2026		

Title of Report:	Freedom to Speak Up (FTSU) Annual Report 2025/2026
Status:	For Information, Discussion and Assurance
Board Sponsor:	Kheelna Bavalia, Interim Chief Medical Officer
Author:	Parmi Perera, Freedom to Speak Up Guardian (FTSUG)
Appendices	None

1. Executive Summary of the Report

This report provides **assurance on the effectiveness of Freedom to Speak Up arrangements at RUH** for the reporting period, including access, themes, learning, and alignment with national and Group requirements.

FTSU arrangements operated effectively during the period, with **continued staff access, appropriate escalation, and executive oversight**.

The Board can take assurance that FTSU remains a **credible, accessible, and independent route for staff voice**.

2. Recommendations (Note, Approve, Discuss)

The Board is asked to note the contents of the report, which is provided for information, discussion and take assurance that FTSU arrangements are effective and support the forward actions identified.

3. Legal / Regulatory Implications

Following the [Dash review](#) of patient safety across the health and care landscape, the government has agreed that the National Guardian's Office will close at the end of June 2026.

From 1 July 2026, NHS England will deliver some activities previously undertaken by the National Guardian's Office, and healthcare organisations will take on greater responsibility and accountability for embedding effective Freedom to Speak Up arrangements.

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

Principal risk:

- There is a risk that staff feel unable to speak up, limiting organisational learning and potentially impacting patient safety.
-

Current assurance level:

- Current controls provide **reasonable assurance**, supported by case escalation, leadership engagement, and triangulation with workforce and safety intelligence.

Planned strengthening:

- Clarified reporting routes and strengthened monitoring of detriment and feedback.

5. Resources Implications (Financial / staffing)

N/A

6. Equality and Diversity

FTSUG quarterly triangulates with RUH HR Director, Workforce lead and EDI colleagues to discuss and share insights of FTSU data.

7. References to previous reports/Next steps

Previous report to Public Board was FTSU Q2 report.

As per previous board recommendations, FTSU has engaged with HR, Culture Team and Workforce and requested a triangulation committee, this will be followed up with RUH HR Director.

8. Freedom of Information

Public

9. Sustainability

N/A

10. Digital

N/A

RUH FTSU Annual Report 2025-2026

1. Purpose

The purpose of this report is to provide MEC and Board with an overview of themes, breakdown of concerns per staff groups and divisions and the demographics of staff accessing the FTSU service. It will provide an opportunity to discuss areas that need a more focused and deliberate approach, seek assurance that progress is made within the Trust in relation to the National FTSU agenda. It will also highlight concerns related to quality/safety and the staff experience and provide insight to support proactive planning.

2. Background

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC's report "[The Freedom to Speak Up](#)" (2015).

These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

The office leads, trains and supports a network of Freedom to Speak Up Guardians in England and conducts speaking up reviews to identify learning and support improvement of the speaking up culture of the healthcare sector.

There are over 1,200 guardians in NHS and independent sector organisations, national bodies and elsewhere that ensure workers can speak up about any issues impacting on their ability to do their job. The National Guardian's Office also provides challenge and learning to the healthcare system as part of its remit.

3. Updates regarding FTSU

3.1 Updates from the National Guardian's Office (NGO) and NHS England

From 1 July 2026, following a recommendation in July 2025 by the [Dash review](#) of patient safety across health and care, NHS England will deliver some activities previously undertaken by the National Guardian's Office (NGO). Trusts, primary care organisations, integrated care boards (ICBs) and independent providers will be taking on greater responsibility and accountability for embedding effective Freedom to Speak Up arrangements.

Key Points:

NHS England will:

- support existing guardian networks and individual guardians, including managing general enquiries through the national contact centre and escalating specialist queries to the NHS England Freedom to Speak Up team
- provide and maintain the platform for free online guardian foundation training

Author: Parmi Perera, Freedom to Speak Up Guardian	Date: 18 May 2026
Document Approved by: Kheelna Bavalia, Interim Chief Medical Officer	Version: 1
Agenda Item: 16.2	Page 3 of 8

- collect Freedom to Speak Up data nationally and use both qualitative and quantitative insights to strengthen system learning. Insight will be shared routinely with guardian networks
- review national Freedom to Speak Up policy and guidance across all sectors, starting with primary care organisations

NHS healthcare providers and commissioners will:

- have sole responsibility for ensuring that information about how to contact their Freedom to Speak Up guardian is kept accurate, made publicly available and is accessible
- routinely submit their Freedom to Speak Up data through NHS England's national data collection system (for 2026/27, this will be trusts and ICBs only)
- ensure that any guardian they appoint completes the mandatory guardian foundation training before starting their role and support their continuing professional development
- ensure appropriate psychological support is available for their guardians once the nationally sourced independent Employee Assistance Programme ends on 31 December 2026

3.2 South West Regional and BSW FTSU Updates

FTSUG continues to participate in regular regional meetings and workshops, including sessions focused on FTSUG wellbeing.

FTSUG also meets monthly with the BSW Group FTSUG to support alignment, shared learning, and professional peer support.

3.3 Local FTSU Updates

- At the end of each quarter, data was submitted to the NGO data portal.
- FTSUG continues to engage with executive, divisional and other leaders (Patient Safety, Safeguarding, Quality Assurance and Staff Governors) to share FTSU data to discuss emerging trends and improvement opportunities.
- FTSU continues to raise awareness and engage with staff with the aid of a communication plan.
- FTSUG continues to attend Trust, local inductions and will attend team meetings where appropriate. In addition, FTSUG will do walk-arounds visiting various wards/departments and run awareness stalls.
- FTSU Champion network is kept updated and expanded with further recruitments.

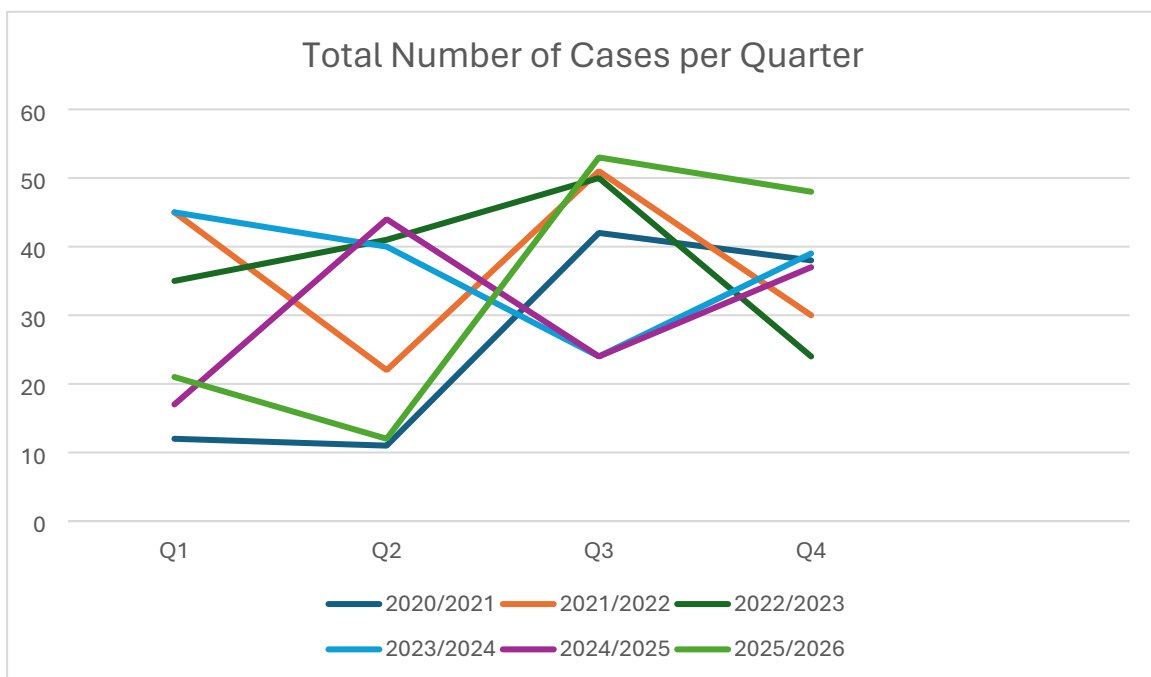
3.4 Key Changes in 2025/2026

- RUH FTSUG commenced work in December 2025 following a year of maternity leave. Salisbury FTSUG covered RUH FTSU service from June-December 2025.
- FTSU executive lead has changed from Chief of Staff to Chief Medical Officer.

4. Summary of Annual (2025-2026) FTSU Data

4.1 Breakdown of Total Number of Cases per Quarter from 2020-2026

Year	Total number of cases
2020/2021	103
2021/2022	148
2022/2023	150
2023/2024	148
2024/2025	122
2025/2026	134



There is no clear trend between quarters per year. It has been noted that when the FTSUG changes, the number of staff raising concerns has a slight decrease. This could be due to time taken to settle in new role and focus shifting away from raising awareness and visibility.

4.2 Breakdown of Themes

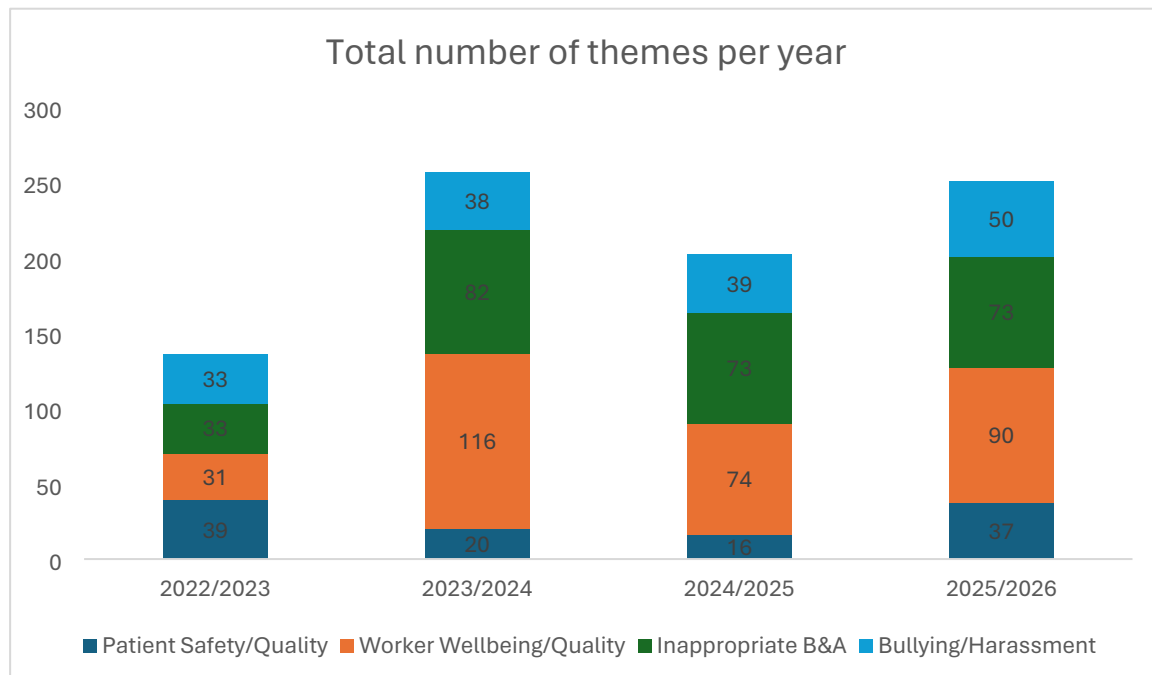
There are 4 officially reported themes (Patient Safety/Quality, Worker Wellbeing/Quality, Inappropriate Behaviours and Attitudes and Bullying and Harassment). In addition, at the

RUH concerns around 'Processes/Systems' are also collected as staff has raised concerns around policies etc.

Please note that each concern may contain more than 1 theme.

'Worker wellbeing/quality' remain the most common theme of concern, closely linked to 'Inappropriate behaviours and attitudes. There is no noticeable difference compared to previous year, which ties in with the 'NHS Staff Survey People Promise element 4' findings.

The number of 'Bullying and harassment' cases has seen an increase though this may not always indicate a formal 'bullying and harassment' being pursued via HR. These themes simply indicate the perspective of the staff raising concerns. FTSU data for this theme has increased, like the 'NHS Staff Survey The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it' data.



4.3 Cases raised 'Anonymously'

Year	Total number of cases raised anonymously
2020/2021	1
2021/2022	1
2022/2023	0
2023/2024	22
2024/2025	48
2025/2026	29

At the RUH, staff have the additional opportunity to raise concerns anonymously via the 'Report and Support' platform which may indicate a higher number of 'anonymous' concerns.

In the past, group concerns have been raised in an anonymously collective manner which also increases the number.

In comparison to the 'NHS Staff Survey; I feel safe to speak up about anything that concerns me in this organisation' where RUH staff stated a slightly more negative response, FTSU data suggests staff feeling more confident in raising concerns openly.

4.5 Cases involving alleged detriment

This factor is checked with staff at the point of raising concerns as well as during the post closure, check in. In addition, staff are encouraged to inform FTSUG of any detriment because of speaking up, at any point during the process. This allows to review the culture around a positive speaking up culture.

This factor is discussed with the NED and Executive Director for FTSU.

Year	Total Number of cases where staff are stating they are facing detriment because of speaking up
2020/2021	1
2021/2022	4
2022/2023	0
2023/2024	19
2024/2025	6
2025/2026	8

The joint NHS England/National Guardian's Office Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services states: "You (leaders) and your senior colleagues need to communicate that detriment will not be tolerated. When it does occur, it is important that you act – and are seen to act."

The National Guardian's Office recognises that most people speak up in the first instance to their line manager. Therefore, training line managers to listen well and respond to often difficult to hear matters is vital. Poor responses from managers or fear of your manager or colleagues blaming or punishing you for speaking up is a real barrier to raising concerns.

A positive tone from the most senior managers and leaders in an organisation is crucial for creating a positive speaking up culture. This requires leaders to ensure they are clear about the speaking up arrangements in place and any role they have in receiving or responding to concerns. The behaviours of leaders should exemplify the behaviour they want to see from all workers. Part of this should include communicating how the organisation will protect and support those who do speak up, and demonstrating the positive impact speaking up has on the organisation.

5. FTSU Feedback

13 staff provided feedback and it is summarised as below:

The responses highlight a generally positive experience with the Freedom to Speak Up service, particularly valuing its confidentiality, empathetic listening, and non-judgmental support. Many respondents felt safe, heard, and reassured, with several stating they would feel comfortable speaking up again.

6. Recommendations

The Committee is asked to note the critical importance of maintaining a healthy Freedom to Speak Up culture across the organisation for two major reasons:

1. Providing an additional/alternative route for staff to speak up/raise concerns
2. Provide relevant leaders and managers with additional insight through staff voice and lived experience.

In addition, FTSUG will be implementing recommendations from the Dash Review and closely monitor and evaluate any barriers faced by staff based on their protected characteristics. To overcome these, FTSUG will continue to work closely with EDI considering findings from WRES/WDES.

Actions required from the leadership group is to continue to support FTSU Service keeping in line with the NHSE guidelines.

Report to:	Public Board of Directors	Agenda item:	17
Date of Meeting:	3 June 2026		

Title of Report:	2026/27 – 2028/29 Medium Term Plan
Status:	For information
Board Sponsor:	John Palmer, Managing Director
Authors:	Rhiannon Hills, Director of Transformation Jon Lund, Director of Operational Finance Business Planning Subject Matter Experts (SMEs)
Appendices:	1: Medium Term Plan 2026/27 – 2028/29 summary

1.	Executive Summary of the Report
This report provides the Board of Directors with a summary of the RUH's Medium Term Plan 2026/27 – 2028/29, focussing on the plan for this financial year. Business plan submission In autumn 2025 the RUH began development of a Medium Term Plan, in part in response to the October 2025 publication of NHS England's <i>Medium Term Planning Framework – delivering change together 2026/27 to 2028/29</i>. The plan was developed in collaboration with our BSW Hospitals Group partners, Great Western Hospitals NHS Foundation Trust and Salisbury Foundation Trust, and with the BaNES, Swindon and Wiltshire Integrated Care Board (BSW ICB). The Medium Term Plan was submitted to NHS England as part of the BSW ICB submission of the system plan on 12 February 2026. Following submission of the plan, the regional executive team assessed the BSW plan and asked that the RUH reviewed our submission in a number of areas. As a result, two changes were made to the plan - 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. Together, these two changes addressed the feedback from the regional team and to reflect local changes across BSW Hospitals Group to improve our financial position. The revised plan was submitted on 18 March 2026, and sets out our objectives for the next three years, covering performance activity, workforce, finance, transformation and quality, to meet the needs of our local population and national goals. We have now moved into monitoring delivery against the operational plan. Medium Term Plan 2026/27 – 2028/29 Appendix 1 provides an overview of the Medium Term Plan 2026/27 – 2028/29, including: - Review of last year's delivery against our plan for 2025/26 - The Breakthrough Objectives and Corporate Projects agreed for 2026/27	

Author: Rhiannon Hills, Director of Transformation / Jon Lund, Director of Operational Finance Document Approved by: John Palmer, Managing Director Agenda Item: 17	Date: 28 May 2026 Version: 1.0 Page 1 of 4

- **Performance plan**, which ensures compliance with RTT, cancer and diagnostic performance targets planned, and improvement in urgent and emergency care access targets over the three years, achieving the national target for 4 hour performance in March 2029.
- **Workforce plan**, outlining our intention to maintain static workforce numbers. Reduced staff numbers in some areas, related to efficiency and corporate redesign, will be offset by increased substantive staff in clinical specialities to reduce outsourcing costs and improve service sustainability.
- Milestones outlined for the **transformation** over the next three years in clinical services, corporate services, digital and the RUH estate
- Stretching **financial plan**, requiring a £55.0m recurrent Cost Improvement Programme over the next 3 years, with highest savings plan in 2026/27 and forecasting a breakeven position in all years.

The plan notes several enablers required to deliver the plan, including significant demand management to bring urgent and emergency care (UEC) attendances back within funded levels and required capital investment in UEC and inpatient wards.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is asked:

- **To note** the summary of the 2026/27 – 2028/29 Medium Term Plan, approved by the Extraordinary Board of Directors meeting on 10 February 2026,
- **To note** the risks contained within the plan and mitigations planned to address these.

3. Legal / Regulatory Implications

We are mandated to submit an annual plan that works to support the achievement of the system control total and address our underlying deficit while also delivering key performance and quality standards. To enable this, we must have a robust approach and process for business planning.

Non delivery of statutory targets may result in regulatory action.

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

There are a number of risks to delivery of the plan resulting from the financial and operational context within which we are planning.

Key risks to delivery of the plan are:

- Sustained growth in urgent care demand continues to exert pressure on UEC performance, flow and capacity, impacting on quality, safety of care and financial sustainability. The plan is reliant on a high level of demand management and a reduction in non-criteria to reside patients.
- The Medium Term Financial Plan is stretching but deliverable. However an unprecedented level of savings are required, particularly in 2026/27, in excess of the productivity opportunity identified through national benchmarking and in advance of critical enablers such as capital investment and Shared EPR go-live.
- Capacity to deliver change, given the scale of transformation required.
- Workforce - there remains a risk that if savings schemes are not delivered, it will require workforce reductions over and above what has been planned. Sickness levels have increased across the organisation coupled with sustained periods of winter pressures increasing risk to staff morale, health and well-being.

5. Resources Implications (Financial / staffing)

The financial and workforce requirements for 2026/27 are a significant ask in addition to the savings delivered during 2025/26.

Financial and workforce controls remain in place, with undelivered savings from 2025/26 rolling forward. The financial framework for 2026/27 is assuming 2.2% new growth funding as well as new 2.5% efficiency expectations, with rolled-over divisional budgets and vacancy factors.

6. Equality and Diversity

Equality and Diversity is a critical lens through which we must consider all our Trust plans. A Quality and equality impact assessment (QEIA) has been undertaken as part of the planning process. For all transformational changes identified in the plan EQIAs will be completed as part of the programme set up.

In addition, taking positive action to reduce health inequalities remains a key priority including a continued focus on digital inclusion and working with our Mental Health partners to improve services for those requiring mental health support.

7. References to previous reports/Next steps

Monthly Business Planning Updates to FPC and MEC and Board of Directors

8. Freedom of Information

Public Board

9.	Sustainability
The Trust is required to contribute to delivery of the BSW Medium Term Financial Plan (MTFP) which sets out the requirement of all organisations in the system to support a route back to financial breakeven. Considering our impact on environmental sustainability and our local population is an important part of our role as an Anchor institution. Project Clean Heat, our decarbonisation project, will continue in 2026/27 with some capital contribution from the Trust to enable ongoing progress towards carbon net zero.	
10.	Digital
Digital is a key enabler to support the transformation changes and is in line with the Government drive from analogue to digital set out in the NHS 10 Year Plan. There is an on-going challenge to access digital capacity and funding to support transformation in light of the Shared EPR project timelines. The revised shared EPR planning timetable has now been proposed and estimates of impact on activity and performance shared. RUH go live most likely to be end of October 2027. It has been agreed that for the purposes of the submission, no adjustment to activity or financial plans will be applied. Mitigations will be sought through front loading activity and additional Independent Sector (IS) capacity to mitigate any loss of capacity. Further work to explore digital opportunities is underway, in particular around digital communication and process automation e.g. ambient voice technology (AVT).	

RUH Medium Term Plan 2026/27 – 2028/29

The RUH, where you matter



Delivering on our vision – business planning



To ensure we are providing high quality care for the people and communities we serve, we need to plan for our future.

We are now working together as part of BSW Hospitals Group with Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust. This partnership helps us improve services across Bath and North East Somerset, Swindon and Wiltshire.

Like all NHS organisations, we have developed a three year plan setting out how we will use our resources and meet national priorities. This includes improving access to services, supporting our workforce and maintaining financial sustainability.

We know the challenges are significant, with growing demand and pressure on services. Our plan contains a number of delivery risks resulting from the financial and operational context we are working in. We are working to mitigate those risks in collaboration with our partners. We have also already made strong progress, including improvements in elective, diagnostic and cancer care. We are working hard to build on these improvements as we start to deliver this plan.

We are ambitious for the future. This plan sets out how we will continue to improve services and outcomes for our patients through our *Improving Together* approach.

Review of 2025/26

The RUH, where you matter

2025/26 RUH plan

Trust Priorities 2025/26

The **people** we care for

The **people** we work with

The **people** in our community

Vision Metrics (7-10 Years)



Breakthrough Objectives 2025/26



Corporate Projects 2025/26



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

Overview of RUH progress against standards

During 2025/26, the RUH focussed on 10 key standards, shown in this table.

Recognising that we needed to make a material improvement in all areas, in September 2025 we launched our 'Call to Action', asking the whole organisation to focus efforts on urgent and emergency care, financial recovery, safety, referral to treatment (RTT) times, cancer standards and diagnostics.

Together, over the six months to the end of the year, we delivered:

- **Urgent and emergency care** – despite unprecedented growth in demand, improvement in 4 and 12 hour ED performance, although still below national expectations
- Strong recovery in **elective, diagnostic** and **cancer** standards, in most to above national standards
- A recovery of our **financial** position to meet our plan.

The RUH, where you matter

	Metric	25/26 Year End plan	Mid year (September 2026)	March 2026
Urgent and Emergency Care	4-hour ED performance (type 1 / all types)	72% / 78%	57.6% / 67.6%	62.6% / 71.9%
	12-hour ED performance	4.9%	9.0%	8.2%
	Ambulance handover	33 mins	74.9 mins	44.9 mins
Elective	18w RTT Performance	68.7%	58.2%	69.1%
	52 Week Waiters	<1%	1.93%	0.55%
Diagnostics	DM01	16.1%	34.8%	13.9%
Cancer	28 day FDS	80%	53.7%	80.7%
	31 day	94%	91%	95.3%
	62 day RTT	75%	58.3%	68.5%
Finance	2% productivity improvement	£20.5m	£32.0m	£20.5m

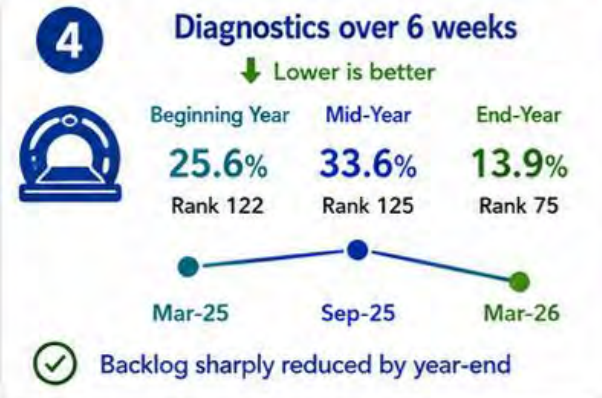
We have further to go together, but going in to 2026/27 we are on an improving trajectory.

RUH Bath – Beginning-, Mid- and End-Year Results

Visualising improvement and recovery across key operational measures (Mar-25, Sep-25, Mar-26)



End-year recovery is evident across key standards, with the strongest gains in RTT, diagnostics and cancer performance.



Overall Direction of Travel

- End-year improved vs mid-year across all 7 metrics
- 6 of 7 metrics improved vs beginning-year baseline
- Biggest recovery areas: FDS, diagnostics and RTT
- League table position improved materially in key areas

*Mapped ED methodology gives the clearest comparable urgent care measure; non-mapped result shown for completeness.

RUH Bath – Percentage Improvement Rankings

How RUH's improvement ranked nationally from beginning-year to end-year, and from mid-year to end-year



National improvement rankings show the strongest RUH recovery in Faster Diagnosis, diagnostics, RTT and mapped ED performance.

Improvement rank: Mar-25 to Mar-26

Lower rank number = better improvement rank nationally

1		Mapped A&E 4-hour	Rank 6	+9.5 percentage points
2		Faster Diagnosis Standard (28-day)	Rank 8	+9.9 percentage points
3		Diagnostics over 6 weeks	Rank 10	11.7 point reduction (lower is better)
4		31-day cancer	Rank 12	+5.9 percentage points
5		RTT performance	Rank 30	+8.6 percentage points
6		Non-mapped A&E 4-hour	Rank 42	+4.1 percentage points
7		62-day cancer	Rank 107	-5.5 percentage points vs baseline

Improvement rank: Sep-25 to Mar-26

Lower rank number = better improvement rank nationally

1		Faster Diagnosis Standard (28-day)	Rank 2	+27.2 percentage points
2		Diagnostics over 6 weeks	Rank 7	19.7 point reduction (lower is better)
3		RTT performance	Rank 14	+9.1 percentage points
4		Mapped A&E 4-hour	Rank 27	+4.4 percentage points
5		Non-mapped A&E 4-hour	Rank 29	+5.0 percentage points
6		62-day cancer	Rank 29	+10.4 percentage points
7		31-day cancer	Rank 33	+3.6 percentage points

Key Messages



Top 10 nationally for Mar-to-Mar improvement in mapped ED, FDS and diagnostics



Top 10 nationally from mid-year to year-end in FDS and diagnostics



RTT showed major year-end recovery and ranked 14th nationally from mid-year



62-day cancer recovered strongly from mid-year, but remained below the Mar-25 baseline

2025/26 highlights

The **people** we care for

Began offering patients chemotherapy, immunotherapy and hormonal therapy at Frome Medical Practice, bringing care closer to home for the over 200 patients already treated there

Opened the new Sulis Orthopaedic Centre to reduce waiting times for NHS patients

Celebrated our Endoscopy team achieving JAG accreditation for high quality gastrointestinal endoscopy services

Launched mouth care boxes for our inpatient wards, improving oral hygiene care

Set up a new support group for patients with heart failure

Began recruiting patients to a new national stroke study for small vessel stroke, part of our extensive clinical research programme with over 200 active programmes

The **people** we work with

Launched our Compassionate Cancer Support policy to support staff working with cancer, in partnership with a national charity, Working With Cancer.

Took part in the national Volunteer to Career scheme, supporting people into NHS careers

Celebrated our colleagues throughout the year, handing out 21 awards to teams and individuals, alongside national awards and recognition of many of our staff

Celebrated the 50th anniversary of the RUH Radiology department

Shared inspiring stories of our staff as part of our *Start your story at the RUH* recruitment campaign

The **people** in our community

Continued work on Project Clean Heat, our plan to decarbonise the RUH estate, installing solar panels and air and water source heat pumps across our site

Worked with local Diabetes charities and patient support groups to transform our Diabetes Centre with patient-designed murals

With a local grocer, launched a new fresh produce stall outside the main entrance to the RUH

Held our second RUH Community Day, inviting our local community in to meet staff, learn more about the RUH and get health and wellbeing advice

Worked with partners on the development of Trowbridge Integrated Care Centre, providing outpatient maternity and specialty clinics from the new facility

With Bath and North East Somerset Council, began offering a birth registration services for babies in our Neonatal Intensive Care Unit

The RUH, where you matter

Medium term plan - 2026/27

The RUH, where you matter

National planning context



The national planning guidance, *Medium Term Planning Framework – delivering change together* was published in October 2025. Key messages:

Delivering recovering and improving access

A clear expectation to restore core performance standards with sustained reduction in waiting times and improved access to urgent, elective, cancer and diagnostic services.

Focussing resources on frontline care

Requirement to reduce unwarranted variation and overhead, releasing capacity and investment back in to clinical services and workforce.

Transforming care

Continued emphasis on delivering the NHS 10 Year Plan three strategic shifts – treatment to prevention, analogue to digital, hospital to community.

Enabling locally led transformation

Systems and providers are expected to take greater ownership for delivery, working collaboratively to meet the needs of their populations

Strengthening delivery arrangements

Increased focus on robust planning, financial sustainability and demonstrable outcomes over the three year period

Medium Term Plan – summary



Our three year plan sets out how we will improve services for patients, support our staff and ensure we are financially sustainable.

It focussed on delivering **better access to care and improved outcomes** for our population, including reducing waiting time for treatment, improving urgent and emergency care, ensuring timely diagnosis and treatment for conditions such as cancer.

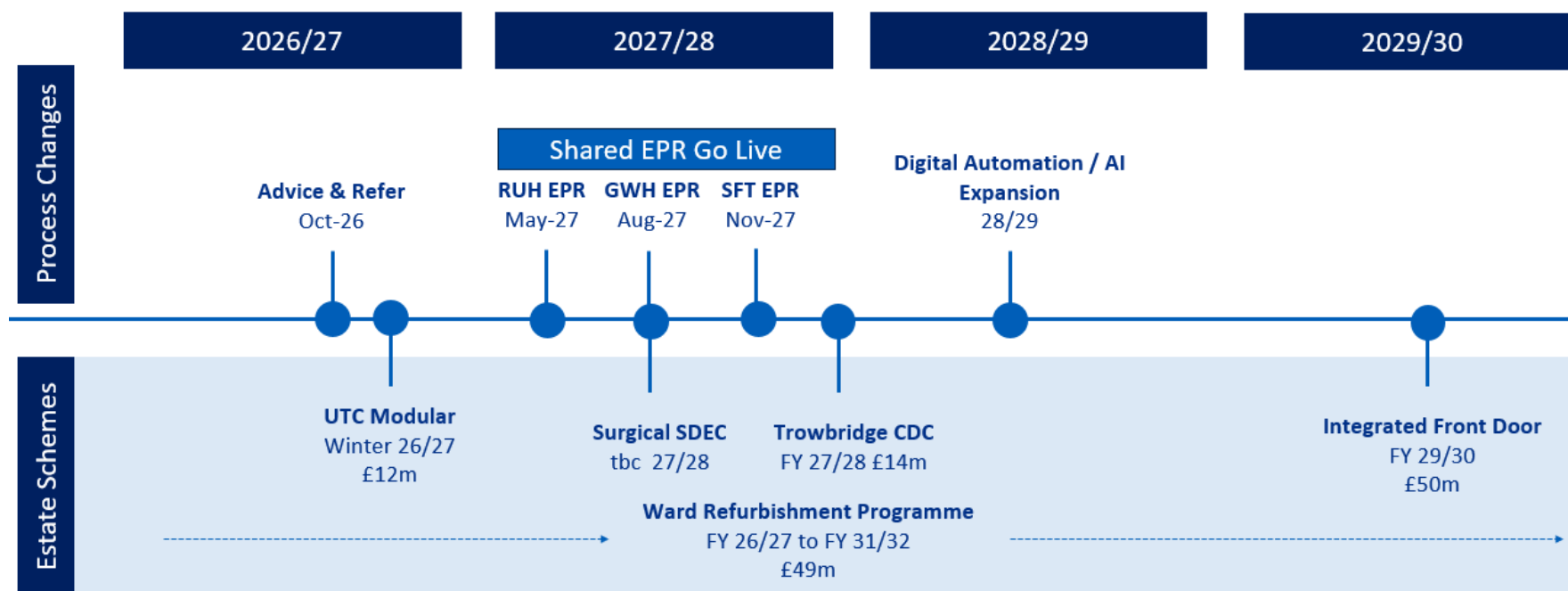
Alongside this, the plan describes how we will **increase the amount of care** we provide, making better use of our theatres, clinics and diagnostics, while also supporting more people to received care closer to home where appropriate.

A key part of the plan is delivering significant **improvements in productivity and efficiency**, so that we can reinvest resources into frontline services and live within our means. This includes reducing reliance on temporary staffing, simplifying how we work and using technology to support us, and growing our portfolio of commercial activities.

Overall, the plan describes how we will build on our early improvements in 2025/26 to recover performance, transform the way care is delivered, and create a sustainable future for our services over the next three years.

Medium Term Plan – summary

The plan also sets out how we **will invest in our services and infrastructure**, including digital systems, estate improvements and new ways of working, to ensure we can meet future demand and continue to improve care. The image below summarises planned capital investment over the next three years:



On the next slide, we summarise the outcomes our Medium Term Plan 2026/2027 – 2028/29.

	Metric	RUH plan Mar '26	26/27 national standard	26/27 RUH Plan	27/28 national standard	27/28 RUH Plan	28/29 national standard	28/29 RUH Plan
UEC	4-hour ED performance (type 1 / all types)	72% / 78%	82% by Mar '27	75.3%	83%	80.2%	85%	85.0%
	12-hour ED performance	4.9%	3.9%	6.3%	Year on year reduction	5.3%	Year on year reduction	5.0%
	Ambulance handover	33 mins	Reduce toward 15 mins	30 mins	Further improvement	29 mins	15 mins	28 mins
Elective & Diagnostic	18w RTT Performance	68.7%	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	<1%	Improvement on 1%	198 (0.8%)		62 (0.4%)		0
	DM01	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	80%	80% annual ave	80.0%	80% annual ave	80.5%	80% annual ave	80.7%
	31d	94%	94%	94.2%	96%	96.0%	96% annual ave	96.1%
	62d RTT	75%	80%	80.5%	82.5%	82.7%	85%	85.1%
Workforce	30% Reduction in agency use	5.0 WTE	30% improvement relative to M6	-5wte	Improvement	-2wte	Zero agency spend	0
	10% reduction in bank spend	261 WTE	10% reduction relative to M6	-10%	Improvement	-10%	30% reduction relative to 25/26	-10%
	Sickness rate (rolling 12 month average)	5.3%	Improvement	4.8%	Improvement	4.6%	4.1%	4.4%
Finance	2% productivity improvement	6.7%	% for RUH (2% improvement)	5.0%		2.7%	“Sustained improvement”	1.5%
	Savings Plan	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	£20.5m	Balance or surplus	0.0m	Balance or surplus	0.0m	Balance or surplus	0.0m

Setting our 2026/27 priorities

Using our Improving Together improvement methodology, we have set our Breakthrough Objective, Corporate Project and Strategic Initiatives for 2026/27. Together, these harness our collective efforts to deliver the outcomes set out in the Medium Term Plan.

Breakthrough Objectives

A set of key objectives derived from the most pressing organisational issues. They are defined with yearly targets and deployed to relevant frontline teams to focus on.

They require a significant breakthrough in addressing a problem and constitute a major stretch for the organisation.

12-18 months timeframe

Corporate Projects

Direct and significant contribution to the Breakthrough objectives or a national mandate

Large scale change that requires resources from across the organisation

Benefits in year

Strategic Initiatives

Longer-term initiatives which support the Trust strategy. They have an executive sponsor and involve multiple teams.

3 – 5 years timeframe

2026/27 priorities

The RUH,
where you matter

Our Strategic Initiatives

Our 2026/27 Breakthrough Objectives

Our Corporate Projects

The **people** we care for

Partnerships

As a community, we face significant challenges. We will create strong partnerships to deliver the best possible services for our patients



Achieve safety standards



Eliminate Corridor Care
Reduce NC2R Length of Stay
Zero 52 weeks
Cancer 28-day diagnosis 80%
Diagnostic Waits 12.5%

The **people** we work with

Service Redesign

We have £140m capital funding to transform our hospital and we will use it to design services and spaces that are truly fit for the future



Support and empower our staff



Improve sickness rate absence to 4.8%
Develop and deliver the first phase of our People Plan

The **people** in our community

Commercial Opportunities

We can harness commercial opportunities to fuel innovation, grow new services, and reinvest in the NHS for the future



Making the most of our resources



Deliver £37.6m of Savings
Exceed 2% Productivity

UTC Modular Build
Advice & Refer
Demand Management & Discharge

Healthier Workforce Programme
Clinical Admin Transformation
Medical E-Rostering
Staff Accommodation

Digitalisation of Outpatients
Shared EPR
Trowbridge Neighbourhood & Community Diagnostic Centre
Project Clean Heat

What our plan is reliant on



Fewer people needing hospital care where appropriate

The plan assumes that, working with our partners in BSW, we can safely reduce demand on urgent and emergency services by supporting more people in the community and avoiding unnecessary attendances.

Investment in key facilities and buildings goes ahead

Delivery depends on funding for improvements such as a new Urgent Treatment Centre and longer-term redevelopment of the hospital front door

We continue to receive national and system funding support

The plan assumes specific funding is secured (e.g. for cancer care and elective recovery) and that additional activity above plan will be paid for.

We can treat more patients and reduce waiting times with available capacity

It relies on increasing activity and making full use of available theatres, clinics and diagnostic services, with potential to do more if extra funding is available

Workforce changes improve efficiency without impacting care

The plan assumes we can reduce reliance on temporary staff, manage vacancies, and reshape the workforce while maintaining safe, high-quality services.

Significant cost savings and productivity improvements are delivered

A key assumption is that ambitious efficiency savings and productivity gains can be achieved across the organisation.

National funding assumptions hold true

This includes pay awards and inflation being funded as expected and key programmes (like go live of Shared Electronic Patient Record) being delivered without major disruption.

Ongoing improvement support and transformation capacity is maintained

The plan assumes continued support for improvement and enough organisational capacity to deliver major changes alongside day-to-day services.

RUH 5 Year Strategic Staircase

While we are focussed on delivery in 2026/27, we are also taking a longer term view of our future, outlined in the strategic staircase.

The staircase will continue to evolve as we make progress, but helps focus our efforts on the big strategic changes we want to make for our patients, our staff and our communities.

2025/26	2026/27	2027/28	2028/29	2029/30
Group • Corp Services - First Phase Services • EPR preparation • Clinical Transformation Preparation • Group Governance preparation Care Organisation • Risk Model: Design and Build • Statutory Target Recovery • Call to Action • Turnaround • CQC ED Response Capital • UEC Environmental improvements • UTC Business Case • Integrated Front Door BC • MEA – asset realisation £20.5m Deficit	Group • Corporate Services – Second Phase Services • EPR – 1 year out • Clinical Transf'ion: Phase 1 • Group Governance established • Commercial Strategy established Care Organisation • UEC Build – Phase 1 • RTT Compliance 52 weeks • CQC Requires Improvement Back to Good plan • Digital – Ambient Voice Technology roll out Capital • UEC Modular (£12m) • Estates Safety Fund £5.3m • Build SULIS Business Case for Private Patient Expansion – Manor House • Sale and leaseback residences and car park c. £11m	Group • EPR implementation x 3 • Clinical Transformation: Phase 2 • GWH PFI completion • R&D Expansion • Collaboration with Universities • Group Elective Strategy Care Organisation • EPR imp October • UEC Build – Phase 2 • CQC Good • Digital Implementation Plan • Administration Transformation • Robotic Surgery Expansion Capital • Integrated Front door (£50m) • Estates Safety Fund ward refurbishment (£8.9m pa) • Increase Sulis NHS Private Patient footprint • Backlog maintenance plan c. £9m	General Election Group • Clinical Transformation: Phase 3 • Optimise EPR Care Organisation • UEC Build – Phase 2 • Digital Plan Implemented • CQC Outstanding • Launch of Integrated Training School • Corporate Administration Transformation Capital • Integrated Front door (£50m) • Estates Safety Fund Ward refurbishment (£8.9m pa) • Expand to SULIS Swindon • Backlog maintenance programme Break even	Group • Clinical Transformation: Phase 4 • Optimise EPR Care Organisation • UEC – Integrated Front Door completion • Digital Plan Implemented Capital • Integrated Front door (£50m) • Estates Safety Fund Ward refurbishment (£8.9m pa) • Expand to SULIS Swindon • Backlog maintenance programme • Rejoin Future Hospitals Programme? Break even

Moving in to delivery – Q1 2026/27

The RUH, where you matter

Q1 2026/27



We are now moving in to delivering the plan.

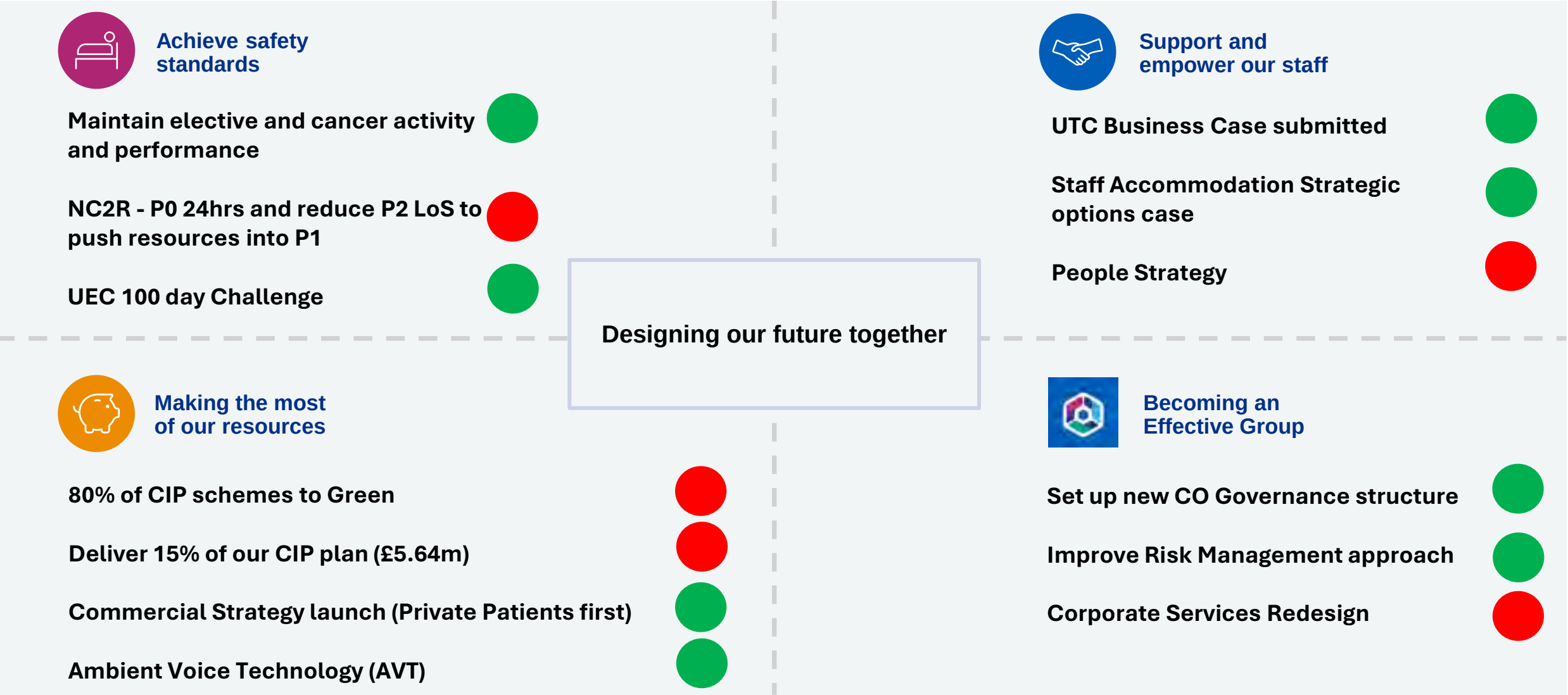
Our *Improving Together* framework gives us the tools, behaviours and routines to deliver and monitor our priorities. Priorities have been cascaded through our Divisions, specialties and teams, so everyone can understand how they contribute.

The next two slides summarise our:

- Priority corporate projects for the first quarter of 2026/27
- Performance against the standards set out in the plan in April 2026, the first month of 2026/27, in our Business Plan Scorecard.

The *Integrated Performance Framework* to Board of Directors provides Board of Directors with a monthly overview of our progress against the standards and objectives outlined in the plan.

What do we need to achieve in Quarter 1?



Business Plan scorecard

2026/27 Business Plan Scorecard

		Performance against trajectory (in year)			3 Year Plan Profile		
Domain	Metric	26/27 NHSE Instruction	Current Month Trajectory	Apr-26	Year End 26/27 RUH Plan	Year End 27/28 RUH Plan	Year End 28/29 RUH Plan
UEC	ED Attendance Growth	Versus 25/26 actual	-0.5%	3.6%	-0.5%		
	NEL Admission Growth	Versus 25/26 actual	-4.6%	12.4%	-4.6%		
	Eliminating Corridor Care	0> 45mins by Nov '26	Trajectory	556 (15%)	0	0	0
	4-hour ED performance (type 1)	66.9% by Mar '27	58.7%	61.2%	66.9%	72.9%	79.1%
	4-hour ED performance (all types)	82% by Mar '27	69.1%	71.1%	75.3%	80.2%	85.0%*
	12-hour ED performance	96.1%	Trajectory	92.0%	93.7%	94.7%	95.0%
	Ambulance handover	Reduce toward 15 mins	33 mins	33.1 mins	30 mins	29 mins	28 mins
Elective & Diagnostic	GP Referral Growth	Per planning assumption	0.0%	10.9%	0.0%		
	18w RTT Performance	74.7% for RUH	68.3%	70.3%	74.7%	83.4%	92.0%
	52 Week Waiters	Reduction towards zero	331	183	198	62	0
	52 Week Waiters %	Improvement on 1%	0.9%	0.5%	0.8%	0.4%	0%
	Diagnostics 6 week wait	13.1% for RUH	14.6%	14.7%	12.50%	9.0%	1.0%
Cancer	28 day FDS	80% annual ave	80.2%	79.1%*	80.0%	80.5%	80.7%
	31 day	94%	92.8%	92.5%*	94.2%	96.0%	96.1%
	62 day RTT	80%	75.3%	68.9%*	80.5%	82.7%	85.1%
Workforce	30% Reduction in agency use	30% improvement from M06	Trajectory	13.3 WTE	5 WTE	3 WTE	0
	10% reduction in bank spend	10% reduction from M06	Trajectory	283.7 WTE	237 WTE	-10%	-10%
	Sickness rate (rolling 12 month average)	Improvement	Trajectory	5.5%	4.8%	4.6%	4.4%
Finance	2% productivity improvement	(min 2% improvement)	6.7%	6.5%	5.0%	2.7%	1.5%
	Savings Plan	37.6m (£56.6m over 3 yrs)	1,883	1,400	37.6m	10.3m	8.7m
	Balanced or surplus financial position	Balance or surplus	-1,610	-2,886	0.0m	0.0m	0.0m
Discharge	Non Criteria to Reside (NC2R)	Number of NC2R	86	89			
	Pathway 0 - Home	% within 24 hours	tba	94.0%			
	Pathway 1 - Home with support	% within 48 hours	tba	50%			
	Pathway 2 - Community setting	% within 48 hours	tba	15%			
	Pathway 3 - Residential care	% within 7 days	tba	60%			

* draft - unvalidated position

Report to:	RUH Public Board of Directors	Agenda item:	18
Date of meeting:	3 June 2026		

Report title:	Statutory Governance Framework to support implementation of the BSW Hospitals Group			
Status:	Information	Discussion	Assurance	Approval
				X
Approval Process: (where has this paper been reviewed and approved):	Group Executive Committee and Non-Executive Governance Reference Group have reviewed SoRD and SFIs.			
Prepared by:	Caroline Coles, Company Secretary, GWH Simon Hackwell, Governance Advisor, Teneo			
Executive Sponsor:	Lisa Thomas, Managing Director GWH, Group Governance Lead.			
Appendices	Appendix 1 : Scheme of Reservation and Delegation Appendix 2 : Standing Financial Instructions (SFIs) Appendix 3 : Audit Committee Terms of Reference Appendix 4 : Remuneration Committee Terms of Reference			
BAF Risk Link	-			

Recommendation:

The Board is asked to:

1. Approve the Scheme of Reservation and Delegation of Royal United Hospitals Bath NHS Foundation Trust
2. Approve the Standing Financial Instructions of Royal United Hospitals Bath NHS Foundation Trust and give delegated authority to the Group CFO to make any further changes as set out in the report.
3. Approve the Terms of Reference for the Audit Committee.
4. Approve the Terms of Reference for the Remuneration Committee
5. Agree the amendment to the quoracy of the General Purpose Joint Committee (Group Board) to ensure at least one Executive Director is present.

Executive Summary:

This paper seeks approval of the remaining statutory governance instruments required to support the implementation of the BSW Hospitals Group model. This will create alignment of the governance arrangements across the three Care Organisations to ensure the Group can operate safely and effectively.

The Group Governance Framework and Partnership Agreement, previously approved by the Board, established the legal basis for joint working and the creation of the Group Board. The instruments presented here complete that framework through alignment of the Scheme of Reservation and Delegation, Standing Financial Instructions (SFIs), and Committees in Common Terms of Reference.

These changes do not alter the statutory powers of the Board. Each Trust Board retains full sovereignty, with the framework clarifying how certain functions are exercised jointly through the Group Board within defined limits.

Approval will ensure a clear, consistent and legally robust governance framework is in place to support safe and effective Group working from 1 July 2026.

The Board is also asked to make an amendment to the Partnership Agreement.

Group Vision Metrics	Select as applicable:
Developing an engaged workforce	x
Making our teams diverse and inclusive	x
Making our services safer	x
Improving timely access to our services	x
Improving the experience of those who use our services	x
Improving our financial sustainability	x
Improving health equity	x

Statutory Governance Framework to support implementation of the BSW Hospitals Group

1. Introduction and Background

- 1.1 The Group Governance Framework establishes the statutory basis for governance within the Group model, confirming that governance is exercised through the NHS Act 2006, Trust Constitutions, and Standing Orders.
- 1.2 The Partnership Agreement and aligned Standing Orders, approved by the Board on 7 May 2026, established the General Purpose Joint Committee (the "Group Board") as the

mechanism for joint exercise of functions, while preserving the sovereignty of each Trust Board and the requirement that Reserved Functions remain with those Boards.

- 1.3 The governance instruments presented in this paper complete the statutory governance framework required for the lawful operation of the Group model.

2. What Has Changed

- 2.1 No new statutory powers are created. Each Trust Board retains full authority as defined in the NHS Act 2006 and its Constitution.
- 2.2 The change is in how those powers are exercised: certain functions are now discharged jointly through the Group Board, within the limits set out in the PCA and Scheme of Reservation and Delegation.
- 2.3 To support this, governance arrangements have been aligned across the three Trusts to ensure:
- Consistent application of governance frameworks
 - Clear delegation and accountability arrangements
 - A shared understanding of Reserved and Joint Functions
- 2.4 These changes enable coordinated decision-making at Group level while maintaining the sovereignty and statutory responsibilities of each Trust Board.

3. Statutory Governance Instruments

- 3.1 The statutory governance framework defines the authority of the Boards, supported by operational control systems (risk, assurance and internal control) to enable effective discharge of duties.
- 3.2 The framework comprises:
- *Foundation Trust Constitutions*
Establish each Trust as a statutory corporation and confirm the Board as the decision-making body. These have been aligned (where applicable) to reflect Group arrangements and were approved on 7 May 2026 (Board) and are on the Council of Governors agenda for 10 June 2026, effective from 1 July 2026.
 - *Scheme of Reservation and Delegation*
Defines matters reserved to each Trust Board and those delegated to the Group Board, establishing the boundary for lawful delegation. (Appendix 1 for approval)
 - *Standing Financial Instructions (SFIs)*
Set out the framework for financial control, stewardship, and value for money. These



apply to all functions, including those exercised through the Group Board, and have been aligned across the three Trusts. (Appendix 2 for approval).

The SFIs are very detailed and may require some further refinement as they are implemented. In approving the SFIs, the Board is asked to delegate authority to the Group Chief Finance Officer to make amendments between formal reviews, provided that any such amendment does not:

- materially alter the financial thresholds set out in Appendix 1 (minor adjustments, for example to reflect inflation, are permitted);
- vary any power reserved to the Board or Council of Governors under the Scheme of Reservation and Delegation;
- create any change that is in conflict with the Trust's Standing Orders or Constitution.

All amendments made under this authority shall be notified to the Company Secretary before taking effect and recorded in a change log. The change log shall be reported to the Board for ratification.

- 3.3 Together, these form the complete statutory governance framework. Approval remains a matter reserved to each Trust Board.

4. Committees in Common

- 4.1 As part of the Group model, the statutory Care Organisation committees below will operate as Committees in Common to support joint oversight and assurance. It is therefore necessary to align the terms of reference for these committees across the Care Organisations.

- 4.2 The following Terms of Reference are presented for approval:

- Audit Committee (appendix 3 for approval)
- Remuneration Committee (appendix 4 for approval)

- 4.3 These committees will support aligned assurance while maintaining reporting and accountability to individual Trust Boards.

5. Amendment to Partnership Agreement

- 5.1 The Partnership Agreement approved by the Board on 7th May 2026 requires an amendment. This is relation to the quorum arrangements for the Group Board. Currently the quorum arrangements set out in the Terms of Reference for the General Purpose Joint Committee (Group Board) state the quorum is:

- At least half of voting members are present

- At least half of those present are *Non-Executive Directors*

5.2 Therefore, the Group Board would be quorate if the Chair and 11 NEDs were present and no Executive Directors were present. While this does not directly infringe any legal requirements (as it is permissible for committees and joint committees to be comprised entirely of NEDs) it is not in keeping with the intention that decision should be made by a unitary board. It is proposed to amend the terms of reference to change the quoracy arrangements for the General Purpose Joint Committee to be:

- At least half of voting members are present
- At least half of those present are Non-Executive Directors
- At least one Executive Director is present.

6 Conclusion

6.1 Approval of this framework establishes a lawful, coherent and auditable basis for governance across the BSW Hospitals Group, enabling effective delegation while preserving Board sovereignty.

7. Recommendations

The Board is asked to:

1. Approve the Scheme of Reservation and Delegation of Royal United Hospitals Bath NHS Foundation Trust
2. Approve the Standing Financial Instructions of Royal United Hospitals Bath NHS Foundation Trust and give delegated authority to the Group CFO to make any further changes as set out in the report.
3. Approve the Terms of Reference for the Audit Committee.
4. Approve the Terms of Reference for the Remuneration Committee
5. Agree the amendment to the quoracy of the General Purpose Joint Committee (Group Board) to ensure at least one Executive Director is present.

[Insert Trust Name]

Scheme of Delegation

This scheme sets out the powers of the Trust ("the Powers") that are reserved to the Board of Directors ("the Board") and the Scheme of Delegation.

All Powers which have not been retained by the Board or delegated to a committee of the Board shall be exercised on behalf of the Board by the Chief Executive. All powers delegated by the Chief Executive can be reassumed by him/her should the need arise. If the Chief Executive is absent powers delegated to him/her may be exercised by a nominated Officer after taking appropriate advice from the Chief Finance Officer.

The Board remains accountable for all of its functions, including those which have been delegated. The Board may request at any time information about the exercise of delegated functions to enable it to maintain its monitoring role. In the absence of a Director or Officer to whom powers have been delegated those powers shall be exercised by that Director's or Officer's superior.

The tables below show the scheme of reservation and delegation.

Section 1- Scheme of Reservation (Council of Governors)

THE COUNCIL	DECISIONS RESERVED TO THE COUNCIL
THE COUNCIL	The specific statutory powers and duties of the Council of Governors are to: • appoint and, if appropriate, remove the Chair of the Board; • appoint the Vice Chair of the Board; • appoint and, if appropriate, remove the other non-executive directors; • decide the remuneration and allowances, and the other terms and conditions of office, of the chair and the other non-executive directors; • approve the appointment of the chief executive; • appoint and, if appropriate, remove the external auditor; and • receive the annual accounts, any report of the auditor on them

	and the annual report; • hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; • approve significant transactions, mergers and acquisitions and applications for separation and dissolution; • decide, where the Trust intends to carry out activity which is not providing goods and services for the purposes of the health service in England, whether that work would significantly interfere with the Trust's principal purpose i.e. the provision of goods and services for the Health Service in England or the performance of other functions; • approve any proposed increases in private patient income of 5% or more in any financial year. • approve amendments to the Trust's Constitution (this function is shared with the Board of Directors).
COUNCIL OF GOVERNORS' NOMINATIONS AND REMUNERATION COMMITTEE	The Council of Governors shall establish the Council of Governors' Nominations and Remuneration Committee to: • Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Non-Executive Directors and make recommendations to the Council with regard to any changes; • Give full consideration to and make plans for succession planning for the Non- Executive Directors taking into account the challenges and opportunities facing the foundation trust and the skills and expertise needed on the Board of Directors in the future; • Agree with the Council of Governors a clear process for the nomination of a Non- Executive Director; • Be responsible for identifying and nominating for appointment, candidates to fill posts within the Committee's remit as and when they arise; • Evaluate the balance of skills, knowledge and experience on the Board of Directors, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular Non-Executive Director appointment;

	• The Committee will consider any matters relating to the continuation in office of any Non-Executive Director at any time including the suspension or termination of service; • The Committee shall make recommendations to the Council of Governors concerning the re-appointment of any Non-Executive Director at the conclusion of their three-year term of office having given due regard to their performance and ability to continue to contribute to the Board of Directors in the light of the knowledge, skills and experience required; • The Committee shall recommend to the Council of Governors a remuneration and terms of service policy for Non-Executive Directors, taking in account the views of the Chair (except in respect of his/her own remuneration and terms of service) and the Chief Executive, Director for People and any external advisers; • In accordance with all relevant laws and regulations, recommend to the Council, the remuneration and allowances, and the other terms of conditions of office of Non- Executive Directors; • Agree the process and receive and evaluate reports about the performance of individual Non-Executive Directors and consider this evaluation output when reviewing remuneration levels.

Section 2- Scheme of Reservation (Board of Directors)

THE BOARD	DECISIONS RESERVED TO THE BOARD
THE BOARD	General Enabling Provision The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
THE BOARD	Regulations and Control 1. Approve the Standing Orders (SOs) as set out in the constitution, a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders (See SOs for procedure). 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 5.3. 5. Approve a scheme of delegation of powers from the Board to Committees (SO5.2) 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member of the Board may remain involved with the matter under consideration. 7. Require and receive the declaration of Officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from Committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all

	Committees and Sub- Committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 15. Ratify use of the Trust seal. 16. Discipline members of the Board or employees who are in breach of statutory requirements or Standing Orders.
THE BOARD	Appointments/ Dismissal 1. Appoint and dismiss Committees (and individual members) that are directly accountable to the Board. 2. Approve proposals on the appointment, appraisal, discipline and dismissal of Executive Directors made by the Nominations & Remuneration Committee of the Board, subject to the Trust's Constitution. 3. Confirm appointment of members of any Committee of the Trust as representatives on outside bodies. 4. Appoint, appraise, discipline and dismiss the Secretary. 5. Approve remuneration proposals of the Nominations & Remuneration Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Nominations & Remuneration Committee. Note: (1) The Chief Executive is to be appointed (and removed) by the Non-Executive Directors, subject to the approval of a majority of the members of the Council of Governors present and voting at a meeting of the Council of Governors. (2) The Executive Directors are to be appointed (and removed) by a Committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors, being the Nominations & Remuneration Committee, acting in that capacity.
THE BOARD	Strategy, Plans and Budgets 1. Define the strategic aims and objectives of the Trust. 2. Identify the key strategic risks, evaluate them and ensure adequate responses are in place and are monitored. 3. Approve proposals for ensuring quality and developing clinical

	governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 4. Approve and monitor the Trust's policies and procedures for the management of risk. 5. Approve Outline and Final Business Cases for Capital Investment in excess of £1,000,000. 6. Commitment of capital expenditure up to and including £250,000 is delegated to the Capital Prioritisation and Management Group (CPMG). Commitment of capital expenditure between £250,001 and £1,000,000 is delegated to the Care organisation Management Committee. These sub-delegations are set out in section 3 and Standing Financial Instructions Appendix 1. 7. Approve Outline and Final Business Cases for Revenue Investment in excess of £1,000,000 8. Revenue business cases up to and including £1,000,000 are approved by the Care Organisation Management Committee. Revenue business cases up to £75,000 are approved by Divisional Review. These sub-delegations are set out in Section 3 and in Standing Financial Instructions Appendix 1. 9. Approve budgets. 10. Approve annually the Trust's organisational development proposals. 11. Ratify proposals for acquisition, disposal or significant change of use of land and/or buildings. 12. Approve the introduction or discontinuance of any significant activity or operation. 13. Approve PFI proposals. 14. Approve the opening of bank or investment accounts. 15. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to, over £1,500,000. Note: following Board approval of the Contract Recommendation Report, contracts in the band £1,500,000–£1,999,999 are executed by the Managing Director. Contracts exceeding £2,000,000 are executed by the Group Chief Executive or Board Chair. See Standing Financial Instructions Appendix 1. 16. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer (for losses and special payments) previously approved by the Board. 17. Approve individual compensation payments made outside of legal/

	statutory or mandatory requirements over £50,000. 18. Approve proposals for action on litigation against or on behalf of the Trust. 19. Review use of NHS Resolution risk pooling schemes (LTPS/PES/CNST/RPST).
THE BOARD	Policy Determination 1. Approve Trust's management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
THE BOARD	Audit 1. To approve audit arrangements (including arrangements for the separate audit of funds held on trust) and to receive reports of the Audit Committee and Charities Committee meetings and take appropriate action. 2. Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. Note: The appointment or dismissal of the Auditor is reserved to the Council of Governors. 3. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
THE BOARD	Annual Reports and Accounts 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust. 3. Receipt and approval of the Trust's Quality Accounts.
THE BOARD	Monitoring 1. Receipt of such reports as the Board sees fit from committees in respect of their exercise of powers delegated or from Directors and Officers of the Trust. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and Social Care and/ or NHS England and the Charity Commission where Board certification is required

	shall be reported, at least in summary, to the Board. 3. Receive reports from the Chief Finance Officer on financial performance against budget.

Section 3 - Decisions/duties delegated by the Board to Committees

COMMITTEE	DECISIONS/DUTIES DELGATED BY THE BOARD TO COMMITEES
RISK AND ASSURANCE COMMITTEE	The Committee will advise and support the Board through: • overseeing the identification, assessment, monitoring and mitigation of strategic and major operational risks across all areas of the Group ensuring alignment with the NHS Code of Governance and the Trusts' constitutions. • monitor the Group Risk Register and Board Assurance Framework content, ensuring effective risk management and appropriate assurance against the Group's principal risks. • review the effectiveness of first line (operational management and service delivery) and second line (oversight functions such as risk management, compliance, health & safety, information governance) assurance through management reports, performance data, and oversight function reporting. • working in partnership with the Trust Audit Committee, which has complementary responsibility for reviewing the design and effectiveness of governance and assurance frameworks and receiving third line assurances (internal audit, external audit, and counter-fraud). Together, both committees provide comprehensive oversight on behalf of the Group Board and Trust Boards
Audit Committee	The Committee will advise and support the Board through: • focusing on enhancing the Trust's governance, risk management, and internal control frameworks. • oversee the integrity of financial statements, ensuring the effectiveness of the internal audit function, monitoring compliance with legal and regulatory requirements, and assessing the independence and performance of external auditors. • scrutinise financial reporting processes, internal controls, and the management of financial and operational risks.

	ensure that the Trust operates in a transparent, efficient, and accountable manner, thereby contributing to the Trust's overall integrity and public confidence in its operation.
BOARD OF DIRECTORS NOMINATIONS AND REMUNERATION COMMITTEE	The Committee shall determine the appropriate remuneration and terms of service for the Chief Executive, Executive Directors and other senior employees. They shall: - advise about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors (and other relevant senior employees), including: (i) all aspects of salary (including any performance-related elements / bonuses); (ii) provisions for other benefits, including pensions and cars. - determine arrangements for termination of employment and other contractual terms; - monitor and evaluate the performance of individual officer members (and other senior employees); - make such recommendations to the Board on the remuneration and terms of service of Executive Directors (and other relevant senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate; - decide on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate; - Monitor the skills and knowledge mix of the Board and make recommendations for future Executive and Non-Executive Director appointments; - The Committee shall report in writing to the Board its decisions and the basis for its recommendations; - The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and Officers not covered by the Committee;
CHARITIES COMMITTEE	In line with its role as a corporate trustee for any funds held in trust, whether charitable or non-charitable, the Board of Directors will establish a Charities

	Committee to administer those funds in accordance with all applicable statutory, legal and regulatory requirements, including guidance issued by the Charity Commission. The Charities Committee is delegated authority to: (a) Administer charitable and non-charitable funds held on trust on behalf of the Board of Trustees, in accordance with the objects of each fund. (b) Exercise oversight of expenditure management (including dispositions) in respect of charitable funds, having regard to: the objects of each trust fund and designated objectives; the availability of liquid funds; the powers of delegation available to commit resources; and the avoidance of the use of exchequer funds to discharge trust fund liabilities. (c) Approve fund-raising appeals expected to raise less than £100,000. Note: fund-raising appeals expected to raise in excess of £100,000 require Board approval. (d) Receive and adopt the annual Trustees' Report and, where applicable, approve the return to the Charity Commission. (e) Receive regular reports from the Chief Finance Officer on the receipt of Funds held on Trust, investment performance and disposition of resources. This paragraph must be read in conjunction with Standing Financial Instructions section 27 and any separate Charities SFIs in force.
TRUST MANAGEMENT EXECUTIVE	The Trust Management Executive (operating as the Care Organisation Management Committee) is accountable to the Board of Directors for the operational management of the Trust and the delivery of objectives set by the Board of Directors. The Trust Management Executive will set appropriate frameworks, policies and procedures to support delivery of the organisational objectives and will continually monitor and review the operational performance of the Trust and put in place corrective measures where necessary. The Care Organisation Management Committee is delegated authority to: (a) Approve Outline and Final Business Cases for Capital Investment between £250,001 and £1,000,000 (see also Standing Financial Instructions Appendix 1 Capital Business Case Authorisation Limits).

	(b) Approve Outline and Final Business Cases for Revenue Investment up to and including £1,000,000 (see also Standing Financial Instructions Appendix1 Revenue Business Case Authorisation Limits).
Capital Prioritisation and Management Group (CPMG)	The CPMG is delegated authority to: (a) Approve Outline and Final Business Cases for Capital Investment up to and including £250,000 (see also Standing Financial Instructions Appendix 1). (b) Confirm capital affordability and prioritise schemes within the approved capital programme before commitment of expenditure. (c) Approve property purchases, licences and leases up to £250,000 (including VAT) in accordance with SFI section 16.

Section 4 – Duties from the NHS Foundation Trust Accounting Officer Memorandum (IRG 24/15 5 August 2015)

DELEGATED TO	DUTIES DELEGATED
ACCOUNTING OFFICER	The Accounting Officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The Accounting Officer must ensure that: • there is a high standard of financial management in the NHS foundation trust as a whole; • financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the NHS foundation trust; • financial considerations are fully taken into account in decisions on NHS foundation trust policy proposals.
ACCOUNTING OFFICER	The essence of the accounting officer's role is a personal responsibility for: • the propriety and regularity of the public finances for which he or she is answerable • the keeping of proper accounts; • prudent and economical administration in line with the principles set out in Managing public money¹; • the avoidance of waste and extravagance; • the efficient and effective use of all the resources in their charge.

¹ www.gov.uk/government/publications/managing-public-money

ACCOUNTING OFFICER	The Accounting Officer must: • personally sign the accounts and, in doing, so accept personal responsibility for ensuring • their proper form and content as prescribed by NHS England in accordance with the Act: • comply with the financial requirements of the NHS provider licence; • ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonable accuracy, at any time, the financial position of the NHS foundation trust); • ensure that the resources for which he or she is responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official; • ensure that assets for which he or she is responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate; • ensure that any protected property (or interest in) is not disposed of without the consent of NHS England; • ensure that conflicts of interest are avoided, whether in the proceedings of the board of directors, council of governors or in the actions or advice of the NHS Foundation Trust's staff, including himself or herself; • ensure that, in the consideration of policy proposals relating to the expenditure for which he or she is responsible as accounting officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the board of directors.
ACCOUNTING OFFICER	Ensure that effective management systems appropriate for the achievement of the NHS Foundation Trust's objectives, including financial monitoring and control systems, have been put in place. An Accounting Officer should also ensure that managers at all levels: • have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives; • are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made

	available to organisations or individuals outside the NHS Foundation Trust), including a critical scrutiny of output and value for money; • have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.
ACCOUNTING OFFICER	Must make sure that the arrangements he/she puts in place for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standard and practices set out in the <i>Public Sector Internal Audit Standards</i>²
ACCOUNTING OFFICER	See that appropriate advice is tendered to the board of directors and the council of governors on all matters of financial propriety and regularity and, more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. The Accounting Officer will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to their own duty as accounting officer to justify, to the Public Accounts Committee (PAC), transactions for which they are accountable.
ACCOUNTING OFFICER	Set out in writing his/her objection to any proposal or course of action of the Council of Governors or the Board of Directors which may infringe the requirements of propriety or regularity, and the reasons for this objection. Inform NHS England should any decision to proceed be taken which infringes the requirements of propriety or regularity despite his/her objection. Inform the Trust's External Auditors and NHS England if the decision is taken and the Accounting Officers objections are overruled.
ACCOUNTING OFFICER	Inform the Board of Directors and Council of Governors, of any issue relating to the wider responsibilities for economy, efficiency and effectiveness, and provide advice to the Board of Directors and Council of Governors on a recommended course of action. If the Accounting Officer's advice is not taken, he/she should seek an instruction to proceed in writing from the Board or Council before proceeding.

² www.gov.uk/government/publications/public-sector-internal-audit

ACCOUNTING OFFICER	The Accounting Officer may be required to appear before the Public Accounts Committee and will furnish the information and evidence required by the Committee.
BOARD OF DIRECTORS	Appoint an acting Accounting Officer (normally the Director of Finance) if an Accounting Officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more.

Section 5 – Authorities/duties delegated from Standing Orders

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
CHAIR	Final authority in interpretation of Standing Orders (SOs) as set out in the Constitution
CHAIR	Call meetings.
CHAIR	Chair all Board meetings.
CHAIR	Give final ruling in questions of order, relevancy and regularity of any matters.
CHAIR	Having a second or casting vote
BOARD	Suspend Standing Orders, provided that at least two-thirds of Directors are present (including at least one Executive Director and one Non-Executive Director) and a majority of those present vote in favour. Any decision and matters discussed during suspension shall be recorded and reviewed by the Audit Committee.
AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)

BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Board.) Decisions put to a vote shall be determined by a simple majority of Directors present and voting. The Chair has a casting vote in the event of equality. No business shall be transacted unless at least half of voting Directors are present, including at least one Executive Director and at least one Non-Executive Director. Directors excluded due to conflicts of interest do not count towards the quorum.
CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within the Standing Orders and this scheme of reservation and delegation may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
CHIEF EXECUTIVE	Functions of the Trust which have not been retained as reserved by the Board or delegated to a committee of the Board, shall be exercised by the Chief Executive on behalf of the Board.
CHIEF EXECUTIVE	The Chief Executive shall prepare a scheme of delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
ALL	Disclosure of non-compliance with Standing Orders and this scheme of reservation and delegation to the Head of Corporate Governance as soon as possible.
THE BOARD	Declare relevant and material interests.
BOARD OF DIRECTORS' SECRETARY	Maintain Register(s) of Interests of members of the Board upon receipt of new or amended information.
ALL STAFF	Comply with the Directors' Code of Conduct and any guidance and best

	practice advice issued by NHS England.
ALL	Disclose relationship between self and candidate for staff appointment. (Board of Directors' Secretary to report the disclosure to the Board.)
HEAD OF CORPORATE GOVERNANCE/ NOMINATED OFFICER	Keep common seal of the Trust in safe place and maintain a register of sealing.
CHIEF EXECUTIVE	Sign all documents which will be necessary in legal proceedings.

Section 6 – Authorities/duties delegated from Standing Financial Instructions

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.
CHIEF EXECUTIVE	Responsible as the Accounting Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
CHIEF EXECUTIVE, MANAGING DIRECTOR & CHIEF FINANCE OFFICER	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
CHIEF FINANCE	To ensure all Board members, officers and employees, present and future, are

OFFICER / MANAGING DIRECTOR	notified of and understand Standing Financial Instructions.
CHIEF FINANCE OFFICER	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared, documented and maintained; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include: i. Design, implementation and supervision of systems of internal financial control; ii. The provision of financial advice to members of Board and Officers; iii. Maintaining such accounts, certificates etc. as are required for the Trust to carry out its statutory duties.
ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and the Scheme of Delegation.
MANAGING DIRECTOR	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
AUDIT COMMITTEE	Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control.
CHAIR OF AUDIT COMMITTEE	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.

CHIEF FINANCE OFFICER	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
CHIEF FINANCE OFFICER	Review, appraise and report in accordance with guidance within the Government Internal Audit Standards.
MANAGING DIRECTOR & CHIEF FINANCE OFFICER	Monitor and ensure compliance with any relevant guidance issued by NHS England or NHS Counter Fraud Authority.
CHIEF FINANCE OFFICER	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
MANAGING DIRECTOR	Compile and submit to the Board a Plan which takes into account financial targets and forecast limits of available resources.
CHIEF FINANCE OFFICER	Submit budgets to the Board for approval
CHIEF FINANCE OFFICER	Ensure adequate training is delivered on an ongoing basis to budget holders.
MANAGING DIRECTOR	Delegate budget to budget holders.
MANAGING DIRECTOR & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
CHIEF FINANCE OFFICER	Devise and maintain systems of budgetary control.
BUDGET HOLDERS	Ensure that: • they deliver their budgets as agreed in the Annual Plan

	• any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board • the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement • no permanent employees are appointed without the approval of the Chief Finance Officer other than those provided for in the budgeted establishment as approved by the Board • identifying and implementing cost improvements, cost savings and income generation initiatives to achieve a return that meets the requirements of NHS England; and • effective systems exist within the directorate to ensure that all expenditure is authorised in advance of commitment and that the individuals incurring expenditure fully understand their budgetary control responsibilities.
MANAGING DIRECTOR	Identify and implement cost improvements and income generation initiatives with budget holders in line with the Annual Plan and a balanced budget.
CHIEF FINANCE OFFICER	Submit financial monitoring returns.
EXECUTIVE DIRECTORS	Submit governance returns.
CHIEF FINANCE OFFICER	Preparation of annual accounts and reports.
CHIEF FINANCE OFFICER	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
CHIEF FINANCE OFFICER	Advise the Board on the Trust's ability to pay interest on and repay capital debt and new borrowing.

CHIEF FINANCE OFFICER	Report periodically on current debt, loans and overdrafts.
BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust.
CHIEF FINANCE OFFICER	Will advise the Board on investments and report, periodically, on performance of same.
CHIEF FINANCE OFFICER	Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.
CHIEF FINANCE OFFICER	Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.
ALL EMPLOYEES	Duty to inform the Chief Finance Officer of money due from transactions which they initiate/deal with.
MANAGING DIRECTOR	Must ensure the Trust enters into suitable legally binding agreements with service commissioners for the provision of NHS services
MANAGING DIRECTOR	Waive formal tendering procedures where permitted under SFI section 10. All waivers to be reported to the Chief Finance Officer for onward reporting to the Audit Committee.
CHIEF FINANCE OFFICER	Report waivers of tendering procedures to the Audit Committee.
MANAGING DIRECTOR	The Managing Director or their nominated officer should evaluate the quotation and select the quote which gives the best value for money.
MANAGING DIRECTOR OR CHIEF FINANCE OFFICER	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Managing Director or the Chief Finance Officer.

MANAGING DIRECTOR OR NOMINATED REPRESENTATIVE	Responsible for the receipt and safe custody of tenders received.
MANAGING DIRECTOR	Shall maintain a register to show each set of competitive tender invitations despatched.
MANAGING DIRECTOR & CHIEF FINANCE OFFICER	Where one tender is received will assess for value for money and fair price.
MANAGING DIRECTOR	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Managing Director.
CHIEF FINANCE OFFICER	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
MANAGING DIRECTOR	The Managing Director shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
MANAGING DIRECTOR	The Managing Director shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
MANAGING DIRECTOR	The Managing Director shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
BOARD OF DIRECTORS	Establish a Board of Directors Nominations and Remuneration Committee.
	Advise and make recommendations to the Board about remuneration and terms of service for the Chief Executive and other Executive Directors (and other senior Officers);

BOARD OF DIRECTORS NOMINATIONS AND REMUNERATION COMMITTEE	• Ensure they are fairly rewarded having proper regard to the Trust's circumstances and performance and provisions of national arrangements; • Monitor and evaluate performance of individual Executive Directors and some senior officers; • Decide on and oversee appropriate contractual arrangements for all Executive Directors and senior Officers; • Monitor skills and knowledge mix of the Board and make recommendations for future Director's appointments to the Board of Directors Nominations and Remuneration Committee.
BOARD OF DIRECTORS NOMINATIONS AND REMUNERATION COMMITTEE	Report in writing to the Board its decisions and its bases about remuneration and terms of service of directors and senior employees.
BOARD OF DIRECTORS	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Board of Directors Nominations and Remuneration Committee.
CHIEF FINANCE OFFICER	Approval of variation to funded establishment of any department.
CHIEF FINANCE OFFICER	Payroll: (a) specifying timetables for submission of properly authorised time records and other notifications; (b) final determination of pay and allowances; (c) making payments on agreed dates; (d) agreeing method of payment;
CHIEF FINANCE OFFICER	Issue instructions listed in the SFI.

NOMINATED MANAGERS*	(a) Submit time records and other notifications in accordance with agreed timetables. (b) Complete time records and other notifications in required form. (c) Submitting termination forms in prescribed form and on time.
CHIEF FINANCE OFFICER	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
BOARD	(a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and (b) Deal with variations to, or termination of, contracts of employment.
CHIEF FINANCE OFFICER	Determine the level of delegation of non-pay expenditure to budget managers. BOARD OF DIRECTORS — Purchase orders/invoices exceeding £1,000,000; other payments exceeding £100,000; non-SLA sales orders and credit notes exceeding £1,000,000. CHIEF EXECUTIVE — Purchase orders/invoices up to £1,000,000; other payments up to £100,000; non-SLA sales orders and credit notes up to £1,000,000. CHIEF FINANCE OFFICER — Purchase orders/invoices up to £1,000,000; other payments up to £100,000; non-SLA sales orders and credit notes up to £1,000,000. CARE ORGANISATION MANAGING DIRECTOR — Purchase orders/invoices up to £1,000,000; other payments up to £100,000; non-SLA sales orders and credit notes up to £1,000,000. EXECUTIVE DIRECTORS — Purchase orders/invoices up to £500,000; other payments up to £50,000; non-SLA sales orders and credit notes up to £500,000. DIVISIONAL DIRECTOR — Purchase orders/invoices up to £50,000; other payments up to £1,000; non-SLA sales orders and credit notes up to £10,000.

	BUDGET HOLDERS / HEADS OF SERVICE — Purchase orders/invoices up to £10,000; other payments up to £500; non-SLA sales orders and credit notes up to £1,000. BUDGET MANAGER — Purchase orders/invoices up to £2,000; other payments up to £100; non-SLA sales orders and credit notes up to £500. Note: All figures exclude VAT. 'Other payments' includes overtime, waiting list initiatives and travel and subsistence. Petty cash: budget holder approval only for amounts under £25; above £25 requires advance approval from the Head of Financial Services. Full limits are set out in SFI v0.4 Appendix 1.
CHIEF FINANCE OFFICER	(a) Set out the list of managers who are authorised to place requisitions/ orders for the supply of goods and services. (b) Set out the maximum financial level for each requisition/ order and the system for authorisation above that level.
CHIEF FINANCE OFFICER	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
CHIEF FINANCE OFFICER	Shall be responsible for the prompt payment of accounts and claims in accordance with contract terms or national guidance.
CHIEF FINANCE OFFICER	(a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; (b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; (c) Be responsible for the prompt payment of all properly authorised accounts and claims; (d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; (e) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise

	requiring early payment; (f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; (g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
CHIEF FINANCE OFFICER	Approve proposed prepayment arrangements.
BUDGET HOLDER	Ensure that all items due under a prepayment contract are received and immediately inform the appropriate Director or Chief Executive if problems are encountered.
MANAGING DIRECTOR	Authorise who may use and be issued with official orders.
OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
MANAGING DIRECTOR	Capital investment programme: (a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans (b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; (c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences;
CAPITAL PRIORITISATION AND MANAGEMENT GROUP	Ensure that a business case is produced for every significant capital expenditure proposal.

CHIEF FINANCE OFFICER	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
CHIEF FINANCE OFFICER	Issue procedures for management of contracts involving stage payments.
CHIEF FINANCE OFFICER	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
CHIEF FINANCE OFFICER	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender.
MANAGING DIRECTOR	Issue a Scheme of Delegation for capital investment management.
CHIEF FINANCE OFFICER	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
CHIEF FINANCE OFFICER	Maintenance of asset registers and arranging for a physical check of assets against the asset register.
CHIEF FINANCE OFFICER	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
MANAGING DIRECTOR	Overall responsibility for fixed assets.
CHIEF FINANCE OFFICER	Approval of fixed asset control procedures.
BOARD, EXECUTIVE MEMBERS AND STAFF	All significant discrepancies revealed by verification of physical assets to fixed asset registers to be notified to the Chief Finance Officer.
BOARD, EXECUTIVE MEMBERS AND STAFF	Responsibility for security of Trust property.

DIRECTORS AND SENIOR OFFICERS	Apply such appropriate routine security practices in relation to Trust property.
BOARD, EXECUTIVE MEMBERS AND STAFF	Report any damage to the Trust's premises, vehicles and equipment or any losses in accordance with Trust procedure.
MANAGING DIRECTOR	Delegate overall responsibility for control of stores (subject to the Director of Finance's responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.
DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks.
DESIGNATED ESTATES MANAGER	Responsible for control of stocks of fuel oil and coal.
DESIGNATED MANAGER / PHARMACEUTICAL OFFICER	Security arrangements and custody of keys.
CHIEF FINANCE OFFICER	Set out procedures and systems to regulate the stores.
CHIEF FINANCE OFFICER	Agree stocktaking arrangements.
CHIEF FINANCE OFFICER	Approve alternative arrangements where a complete system of stores control is not justified.
CHIEF FINANCE OFFICER	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
DESIGNATED PHARMACEUTICAL	Operate system for slow moving and obsolete stock, and report to the Chief Finance Officer evidence of significant overstocking.

OFFICER	
CHIEF FINANCE OFFICER	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Managing Director and the Chief Finance Officer.
CHIEF FINANCE OFFICER	Where a criminal offence is suspected, the Chief Finance Officer must inform the police if theft or arson is involved. In cases of fraud and corruption the Chief Finance Officer must inform the relevant LCFS and NHS Counter Fraud Authority Regional Team in line with Secretary of State directions.
CHIEF FINANCE OFFICER	Notify Local Counter Fraud Service and External Audit of all frauds.
CHIEF FINANCE OFFICER	Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
CHIEF FINANCE OFFICER	Approve write off of losses (within limits delegated by Board).
CHIEF FINANCE OFFICER	Consider whether any insurance claim can be made.
CHIEF FINANCE OFFICER	Maintain losses and special payments register.
CHIEF DIGITAL AND INFORMATION OFFICER	Responsible for accuracy and security of computerised data.
CHIEF FINANCE	Satisfy him/her that new computer systems (including finance systems) and

OFFICER	amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.
CHIEF DIGITAL AND INFORMATION OFFICER	Shall publish and maintain a Freedom of Information Scheme or adopt a model Publication Scheme approved by the information Commissioner.
RELEVANT OFFICERS	Send proposals for general computer systems to the Chief Digital and Information Officer.
CHIEF FINANCE OFFICER	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review.
CHIEF FINANCE OFFICER	Seek periodic assurances from the provider that adequate controls are in operation.
CHIEF DIGITAL AND INFORMATION OFFICER	Ensure that risks to the Trust from use of IT are identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans
CHIEF FINANCE OFFICER	Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that: (a) systems acquisition, development and maintenance are in line with corporate policies such as an Digital Strategy; (b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists; (c) Finance staff have access to such data; (d) Have adequate controls in place; and (e) such computer audit reviews as are considered necessary are being carried out

MANAGING DIRECTOR	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission and that the Trust will not accept responsibility or liability for patient's property unless the procedures are followed.
CHIEF FINANCE OFFICER	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
MANAGING DIRECTOR	Retention of document procedures in accordance with Department of Health Guidance.
CHIEF RISK OFFICER	Develop a risk management programme in line with NHS assurance framework requirements, which must be approved and monitored by the Board.
BOARD OF DIRECTORS	Approve and monitor risk management programme.
BOARD OF DIRECTORS	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
CHIEF FINANCE OFFICER	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme.
CHIEF FINANCE OFFICER	Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this

	decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
CHIEF FINANCE OFFICER	Establish procedures for the management of expense claims.
CHIEF FINANCE OFFICER	Approve the contract or transaction in relation to credit finance commitments
CHIEF FINANCE OFFICER	Approve leasing agreements and hire purchase undertakings.
CHIEF FINANCE OFFICER	Maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust as trustees of non-exchequer funds.
CHIEF FINANCE OFFICER	Arrange for the administration of all existing charitable Funds held on Trust
CHIEF FINANCE OFFICER	Ensure that all charitable Funds held on Trust are currently registered with the Charities Commission in accordance with the Charities Act 2016 or subsequent legislation.
CHIEF FINANCE OFFICER	The Chief Finance Officer shall recommend the creation of a new charitable fund where funds and/or other assets, received in accordance with the Trust's policies cannot adequately be managed as part of an existing fund
ALL OFFICERS	Immediately hand over all gifts, donations and proceeds of fund-raising activities, which are intended for the Trust's use to the Chief Finance Officer.
CHIEF FINANCE OFFICER	Produce guidelines to Officers as to how to proceed when offered funds.

CHIEF FINANCE OFFICER	Ensure that in respect of legacies and bequests, • all correspondence concerning a legacy is dealt with on behalf of the Trust; • where necessary, grant of probate is obtained or apply for a grant of letters of administration, where the Trust is the beneficiary; and • that arrangements regarding the administration of a will are negotiated with executors and to discharge them from their duty
THE BOARD	Give final approval for major appeals, defined as events raising in excess of £100,000.
CHARITIES COMMITTEE	Give final approval for smaller appeals, defined as events anticipating to raise less than £100,000
CHARITIES COMMITTEE	Be responsible for all aspects of the management of the investment of Funds held on Trust.
CHIEF FINANCE OFFICER	Be responsible for the appropriate treatment of all investment income.
CHARITIES COMMITTEE	Exercise of expenditure discretion (can be delegated to the Chief Finance Officer).
CHIEF FINANCE OFFICER	Advise the Charities Committee and, with its approval, shall ensure that appropriate banking services are available to the Trust as corporate trustee
CHIEF FINANCE OFFICER	• Appropriate records of all donated assets owned by the Trust are maintained, and that all assets, at agreed valuations are brought to account; • appropriate measures are taken to protect and/or to replace assets; • donated assets received on trust shall be accounted for appropriately;

	and all assets acquired from charitable Funds held on Trust which are intended to be retained within the trust funds are appropriately accounted for.
CHIEF FINANCE OFFICER	Ensure that regular reports are made to the Charities Committee and the Board with regard to, inter alia, the receipt of Funds held on Trust, investments of these trust funds and the disposition of resources
CHIEF FINANCE OFFICER	Prepare the Annual Accounts
CHIEF FINANCE OFFICER	In relation to the non-charitable trust funds prepare any required returns to NHS England.
CHIEF FINANCE OFFICER	Prepare an annual trustees report regarding charitable trust funds and make the required return to the Charities Commission
CHIEF FINANCE OFFICER	Maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.
CHIEF FINANCE OFFICER	Determine a basis for the distribution of investment income to the charitable Funds held on Trust and the recovery of administration costs.
CHIEF FINANCE OFFICER	Ensure that the records, accounts and returns receive adequate scrutiny by the Trust's Internal Audit during the year
CHIEF FINANCE OFFICER	Advise the Board of Trustees Committee of the outcome of the annual audit.
CHIEF FINANCE OFFICER	Identify all costs directly incurred in the administration of all Funds held on Trust and charge such costs to the appropriate trust accounts
CHIEF FINANCE	Ensure that the Trust's liability to taxation and excise duty is managed

OFFICER	appropriately
MANAGING DIRECTOR	Ensure that all intellectual property is identified, protected and used for the benefit of the Trust, the NHS and service users.
MANAGING DIRECTOR	Ensure that all intellectual property is identified and properly recorded in the Trust's Intellectual Property register.
MANAGING DIRECTOR	Ensure all third party intellectual property, upon which the Trust's intellectual property relies is properly licensed and confers rights to sub-license as part of the Trust's intellectual property.
ALL STAFF	Required to identify and protect the intellectual property of the Trust and ensure that is properly recorded in the Trust's Intellectual Property register.
MANAGING DIRECTOR	Responsible for compliance with the SFIs as they relate to the identification, protection, use and licensing of Trust and third party intellectual property.

[Insert Trust Name]

Standing Financial Instructions

Reference Number:	
Author & Title:	
Responsible Director:	
Review Date:	
Ratified by:	
Date Ratified:	
Version:	

Related Policies and Guidelines	

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1. Policy Summary

- 1.1 [Insert Trust name] (the "Trust") was authorised as an NHS Foundation Trust by NHS England, the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act") on [Insert date]
- 1.2 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SOs) of the Foundation Trust's Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS England, which this document represents).
- 1.3 The NHS England Single Oversight Framework details how NHSE oversees and supports providers in delivering consistently safe, effective, compassionate patient care within health systems that are financially and clinically sustainable. Additional financial guidance includes *Code of Practice issued by the National Audit Office (NAO)*, and the most recent *DHSC Group accounting Manual*. Other relevant guidance may be issued which should be applied alongside these instructions.
- 1.4 References to Managing Director and Care Organisation Managing Director are the same role. References to Chief Executive and Chief Finance refer to the Group Chief Executive and Group Chief Finance Officer respectively.

2. Policy Statements

- 2.1 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust (collectively called the "Scheme of Delegation").
- 2.2 These SFIs identify the financial responsibilities which apply to everyone employed by, or working for the Foundation Trust and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.
- 2.3 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Chief Finance Officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders of the Board of Directors (as well as the separate Standing Orders of the

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Council of Governors). Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can in certain circumstances be regarded as a disciplinary matter that could result in an employee's dismissal.

- 2.4 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these SFIs to the Chief Finance Officer, as soon as possible

3. Duties and Responsibilities

Foundation Trust Board of Directors

- 3.1 The Board exercises financial supervision and control by:
- a. Formulating the financial strategy of the Trust;
 - b. Requiring the submission and approval of Budgets within approved allocations and overall income;
 - c. Defining and approving essential features in respect of important procedures and financial systems (including (but not limited to) the need to obtain value for money) and the Trust's statutory duty under Section 63 of the 2006 Act (General duty of NHS foundation trusts) to exercise its functions effectively, efficiently and economically; and
 - d. Defining specific responsibilities placed on Directors and employees as indicated in the Scheme of Delegation.
- 3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Scheme of Delegation. All other powers have been delegated to such executive directors in the Scheme of Delegation or, committees of the Board, as established by the Trust. The Board must approve the terms of reference of all committees reporting directly to the Board.
- 3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Regulatory Framework and the Scheme of Delegation. The extent of delegation shall be kept under review by the Board

The Chief Executive, Managing Director and Chief Finance Officer

- 3.4 The Chief Executive and the Chief Finance Officer will delegate their detailed

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responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control. Following the establishment of the BSW group the Chief Executive retains all statutory functions and remains the Accountable and Accounting Officer. The day-to-day discharge of these duties will be through the Managing Director. Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and as accounting officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for [Insert Trust name] activities; is responsible to the Chair and members of the Board for ensuring that its financial obligations and targets are met and has overall responsibility for [Insert Trust name] system of internal control.

- 3.5 It is a duty of the Managing Director to ensure that existing Directors and Officers and all new appointees are notified of and put in a position to understand their responsibilities within these SFIs.

Chief Finance Officer

- 3.6 The Chief Finance Officer is responsible for:

These SFIs and for keeping them appropriate and up to date;

- a. Implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;
- b. Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- c. Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and
- d. Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:
 - i. Design, implementation and supervision of systems of internal financial control;
 - ii. The provision of financial advice to members of the Trust Board and employees
 - iii. The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Board may require for the purpose of carrying out its statutory duties.

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Council of Governors

- 3.7 All members of the Council of Governors, severally and collectively are responsible for:
- a. Holding the Non – Executive Directors individually and collectively to account for the performance of the Board of Directors, and
 - b. Representing the interest of the members of the Trust as a whole and the interests of the public.

Board of Directors and Employees

- 3.8 All directors and employees, severally and collectively, are responsible for:
- a. The security of Trust property
 - b. Avoiding loss;
 - c. Exercising economy and efficiency in the use of resources; and
 - d. Conforming to the requirements of NHSE, the Terms of Authorisation, the Constitution, Standing Orders, Standing Financial Instructions and the Delegation of Powers.

Contractors and their employees

- 3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Managing Director to ensure that such persons are made aware of their duties under these Standing Financial Instructions.
- 3.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

4. Audit

Audit Committee

- 4.1 In accordance with the Constitution the Board of Directors shall establish an Audit Committee, with clearly defined terms of reference. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives. The

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Committee is also responsible for:

- a. overseeing Internal and External Audit services with an active involvement in the selection and performance monitoring of the assurance providers to ensure a cost-efficient service is provided;
- b. all audit recommendations will be reported and monitored by the Audit & Risk Committee;
- c. reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;
- d. monitoring compliance with the Constitution and Standing Financial Instructions;
- e. examining the circumstances associated with occasions when the Constitution and associated Standing Financial Instructions are waived, and
- f. reviewing schedules of losses, compensations, and settlements with staff, and making recommendations to the Board;
- g. reviewing schedules of debtors/creditors balances over 6 months old and over a de minimis limit as defined by the Audit Committee and related explanations/action plans;
- h. reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board on the adequacy of internal mechanisms for identifying all principal risks and providing reasonable assurance that risk management arrangements are robust;
- i. where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair of the Audit Committee should immediately inform the Managing Director and raise the matter at the next meeting of the Board. Exceptionally, the matter may need to be referred to NHS England.

- 4.2 It is the responsibility of the Chief Finance Officer to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if the Internal Audit service provider is changed.

Chief Finance Officer

- 4.3 To support the Audit Committee in their role, it is the responsibility of the Chief Finance Officer is to:
- a. Ensure there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an internal audit function;
 - b. Decide at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of section 5.1.5 of this document, in relation to fraud and corruption);
 - c. Ensure that an annual internal audit report is prepared (with interim progress reports) for the consideration for the Audit Committee. The report must cover:

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d. A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DHSC. This opinion provides assurances to the Accounting Officer, especially when preparing the Statement of Internal Control and also provides assurances to the Audit Committee;

- i. Any major internal financial control weaknesses discovered;
- ii. Progress on the implementation of internal audit recommendations;
- iii. Progress against plan over the previous year;
- iv. Strategic audit plan covering the coming three years;
- v. A detailed work-plan for the coming year.

4.4 The Chief Finance Officer and designated auditors are entitled without necessarily giving prior notice to require and receive:

- i. Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- ii. Access at all reasonable times to any land, premises or members of the Board or employee of the Trust;
- iii. The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and
- iv. Explanations concerning any matter under investigation.

Role of Internal Audit

4.5 Internal Audit provides an independent and objective opinion to the Managing Director, the Audit Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

4.6 Internal Audit will review, appraise and report upon:

- a. The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
- b. The adequacy and application of financial and other related management controls;
- c. The suitability of financial and other related management data;
- d. The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
 - i. Fraud and other offences (responsibility for investigation of any suspected or alleged fraud is held by the Local Counter Fraud Specialist);
 - ii. Waste, extravagance, inefficient administration;
 - iii. Poor value for money or other causes;

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iv. Any form of risk, especially business and financial risk but not exclusively so.

- e. The adequacy of management action in response to audit recommendations;
- f. Any investigations / project work agreed with and under terms of reference laid down by the Chief Finance Officer;
- g. The Trust's compliance with the Care Quality Commission Essential Standards of Quality and Safety.

- 4.7 Internal Audit shall also independently verify the Assurance Statements in accordance with guidance within the Government Internal Audit Standards.
- 4.8 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.
- 4.9 The Head of Internal Audit, or equivalent title, will normally attend the meetings of the Audit Committee and has a right of access to all Audit Committee members, the Chair and Managing Director.
- 4.10 The Head of Internal Audit shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the "Code of Practice issued by the National Audit Office (NAO)," the "DHSC Group Accounting Manual" and the "NHS FT Accounting Officer memorandum."
- 4.11 The Head of Internal Audit shall report to the Chief Finance Officer and shall refer audit reports to the appropriate officers designated by the Managing Director. Failure to take remedial action within a reasonable period shall be reported to the Managing Director. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation on the objectivity of the audit, the Head of Internal Audit shall have the right to report direct to the Chair or any Non-Executive Director. The reporting system shall be reviewed at least every 3 years.
- 4.12 Managers in receipt of audit reports referred to them have a duty to take appropriate remedial action within the timescales specified in the report. The Chief Finance Officer shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate remedial action had failed to take place within a reasonable period, the matter shall be reported to the Chief Finance Officer. Changes implemented must be maintained in the future and not viewed as merely satisfying an immediate audit point.

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External Audit

- 4.13 The External Auditor is appointed by the Council of Governors with advice from the Audit Committee. If there are any problems relating to the service provided by the External Auditor this should be resolved in accordance with the Code of Practice issued by the National Audit Office (NAO)
- 4.14 The Trust and the External Auditor must comply with the Code of Practice issued by the National Audit Office (NAO), and fulfil the relevant responsibilities laid out in schedule 7 and schedule 10 of the 2006 Act.
- 4.15 Officers in receipt of audit reports referred to them, have a duty to take appropriate remedial action, if any, within the agreed time-scales specified within the audit reports.
- 4.16 Prior approval must be sought from the Audit Committee (the Council of Governors may also be notified) for each discrete piece of additional external audit work (i.e. work over and above the audit plan, approved at the start of the year.) awarded to the external auditors. Competitive tendering is not required and the Chief Finance Officer is required to authorise expenditure.
- 4.17 The External Auditor shall be routinely invited to attend and report to meetings of the Audit Committee, and shall be entitled to meet the Audit Committee in the absence of Trust employees, if they so desire.

Fraud and Corruption

- 4.18 In line with their responsibilities, the Managing Director and the Chief Finance Officer shall monitor and ensure compliance with any relevant guidance issued by NHS England or NHS Counter Fraud Authority on fraud and corruption.
- 4.19 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the Standards for Providers – Fraud, Bribery and Corruption.
- 4.20 The Chief Finance Officer is responsible for notifying the police when appropriate, during an investigation, following advice from the LCFS in line with the NHS Counter Fraud Authority Fraud and Corruption Manual and guidance.
- 4.21 The LCFS shall report to the Chief Finance Officer and shall work with staff in the NHS Counter Fraud Service (NHS Counter Fraud Authority) in accordance with the NHS Counter Fraud and Corruption Manual.
- 4.22 The Chief Finance Officer should also prepare a “Counter Fraud Policy and Response Plan” that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

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- 4.23 The LCFS will attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Managing Director of **[Insert Trust name]**
- 4.24 The LCFS shall be accountable to the Chief Finance Officer. The reporting system for Counter Fraud services shall be agreed between the Chief Finance Officer, the Audit Committee and the LCFS. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Counter Fraud and Corruption Manual and guidance. The reporting system shall be reviewed at least every 3 years.
- 4.25 The LCFS will provide a written report, at each Audit Committee meeting, on counter fraud work within **[Insert Trust name]**.
- 4.26 The LCFS will, at the beginning of each Financial Year, prepare a written work plan outlining the LCFS' projected work for that Financial Year.

The LCFS shall:

- a. Keep full and accurate records of any instances of fraud and suspected fraud;
 - b. Report to the Audit Committee any weaknesses in fraud-related systems and any other matters which may have fraud-related implications for the Trust;
 - c. Request from the Managing Director all necessary support to enable him/her to efficiently, effectively and promptly carry out his/her functions and responsibilities, including working conditions of sufficient security and privacy to protect the confidentiality of his work;
 - d. Participate in activities which NHS England directs, or in which NHS Counter Fraud Authority is engaged, including national anti-fraud measures.
- 4.27 Any Officer discovering or suspecting a loss of any kind must immediately inform the Managing Director, the Chief Finance Officer, or the LCFS.
- 4.28 In accordance with the Freedom to Speak Up (Raising Concerns Policy), the Trust shall have whistle – blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by NHS Counter Fraud Authority (NHS CFA).
- 4.29 The Trust will report annually on how it has met the standards set by NHS Counter Fraud Authority (NHS CFA) in relation to anti-fraud, bribery and corruption work and the Chief Finance Officer shall sign off the annual review and authorise its submission to NHS Counter Fraud Authority (NHS CFA).

Security management

- 4.30 In line with their responsibilities, the Trust Managing Director will monitor and ensure compliance with the Directions issued directly by the Secretary of State for Health on

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NHS security management.

- 4.31 The Trust shall nominate an Executive Director to be responsible to the Board for security management matters and the promotion of security management measures within the Trust.
- 4.32 The Trust will appoint at least one person as a Local Security Management Specialist, in accordance with any guidance issued by NHS England or the NHS Counter Fraud Authority on suitability criteria for such appointees.
- 4.33 The Local Security Management Specialist will report directly to the nominated Executive Director lead and will work with NHS England and the NHS Counter Fraud Authority.
- 4.34 The Local Security Management Specialist will, at the beginning of each Financial Year, prepare a written work plan outlining the Local Security Management Specialist's projected work for that Financial Year.
- 4.35 The Local Security Management Specialist shall be afforded the opportunity to attend Audit Committee meetings and other meetings of the Board, or its committees, as required.
- 4.36 The Trust shall also nominate a Non-Executive Director to be the lead Non-Executive Director for security management matters

5. Business Planning, Budgets, Budgetary Control and Monitoring

Preparation and Approval of Business Plans and Budgets

- 5.1 The Managing Director, with the assistance of the Chief Finance Officer, will compile and submit to the Board of Directors, the Council of Governors, and NHS England strategic plans and operational business plans in accordance with the guidance issued by NHS England with regards timing and Trust financial duties. The Trust operational business plans will contain:
- 5.2 A statement of the significant assumptions on which the plan is based;
 - a. Details of major changes in workload, delivery of services or resources required to achieve the plan.
 - b. The Financial Plan for the Year

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c. Such other contents as may be determined by NHS England.

5.3 The annual plan must be approved by the Trust board and submitted to the NHSE in accordance with their requirements.

5.4 In a suitable timeframe to enable compliance with NHS England's Risk Assessment Framework, the Chief Finance Officer will, on behalf of the Managing Director, prepare and submit an annual budget for approval by the Board of Directors. Such budgets will:

- a. Be in accordance with the Trust values, and the aims and objectives set out in the annual Business Plan;
- b. Accord with workload and manpower plans;
- c. Be produced following discussion with appropriate budget holders;
- d. Be prepared within the limits of available funds;
- e. Identify potential risks and mitigating actions;
- f. Be based on reasonable and realistic assumptions; and
- g. Enable the Trust to comply with the whole regulatory framework for Foundation Trusts. Officers shall provide the Chief Finance Officer with all financial, statistical and other relevant information as necessary for the compilation of such business plans, estimates and forecasts.

5.5 The Chief Finance Officer has overall responsibility to ensure that adequate financial systems are in place to monitor and control financial performance to enable [Insert Trust name] to fulfil its statutory responsibility to meet its annual revenue and capital targets.

5.6 The Chief Finance Officer has the authority to request budget holders to formally sign off annual budgets, as an acknowledgement of ownership.

Budgetary Control and Reporting

5.7 The Chief Finance Officer shall monitor financial performance against budget and business plan, projecting anticipated performance for future periods, report to the Board, and advise on any actions he or she deems appropriate.

5.8 All officers whom the Board of Directors may empower to engage staff, to otherwise incur expenditure, or to collect or generate income, shall comply with those systems. The systems of budgetary control shall incorporate the reporting of, and investigation into, financial, activity, or workforce variance from the budget. The Chief Finance Officer shall be responsible for providing budgetary information and advice to enable the Managing Director and other officers to carry out their budgetary responsibilities.

5.9 The Chief Finance Officer shall keep the Managing Director and the Board of Directors informed of financial consequences of changes in policy, pay awards and other events

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and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

- 5.10 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.
- 5.11 No budget-holder is authorised to overspend their budget. Where overspending is occurring, the budget holder must account to their Divisional Management Team or line manager for the overspending and identify means of addressing it. It is accepted that a budget may be exceeded for a short period in the year due to the phasing of expenditure.
- 5.12 Each budget holder is responsible for ensuring that no permanent employees are appointed without going through the Trust's recruitment process to ensure budgetary approval has been agreed, other than medical and nursing staff provided for within the budgeted workforce establishment.
- 5.13 The Managing Director will delegate to budget holders responsibility for identifying and implementing cost improvement programmes and income generation initiatives in order to deliver a budget that will enable compliance with NHS England's Single Oversight Framework, finance and use of resources.

Budgetary Delegation

- 5.14 The Managing Director, through the Chief Finance Officer may delegate the management of a budget to permit the performance of a defined range of activities, This delegation must be in writing and be accompanied by a clear definition of:
- a. The amount of the budget;
 - b. The purpose of each budget heading;
 - c. Individual and group responsibilities;
 - d. Authorities to exercise virement;
 - e. Achievement of planned levels of service; and
 - f. Provision of regular reports.
- 5.15 The Managing Director and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.
- 5.16 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Managing Director, subject to any authorised use of virement.
- 5.17 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Managing Director or the Chief Finance Officer.

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Capital Expenditure

- 5.18 The general rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the most recent version of the DHSC Group Accounting Manual. (The particular applications relating to capital are contained in section 15 of these SFIs)

Performance Monitoring Forms and Returns

- 5.19 The Chief Finance Officer is responsible for ensuring that the appropriate financial monitoring forms are submitted to the requisite monitoring organisations. The relevant Executive Director is responsible for ensuring that the appropriate Governance returns are submitted to the requisite monitoring organisations. The figures reported should reflect the same figures, though not necessarily presented in the same format, as those reported to the Board of Directors.

6. Annual Report and Accounts and Quality Accounts

- 6.1 The Chief Finance Officer, on behalf of the Trust, will keep accounts in such form as NHS England may direct, and produce annual accounts and financial returns for NHS England.
- 6.2 The Head of the Corporate Governance will prepare an Annual Report in accordance with the guidance in the DHSC Group Accounting Manual.
- 6.3 The Trust's Annual Report and the Annual Accounts and financial returns to NHS England must be audited by the external auditor in accordance with appropriate international auditing standards.
- 6.4 The Annual Report and Accounts (including the auditor's report) shall be approved by the Board of Directors.
- 6.5 The Annual Report and Accounts (including the auditor's report) is submitted to NHS England (in accordance with its timetable) by the Chief Finance Officer and put forward to be laid before Parliament each year.
- 6.6 The Annual Report and Accounts (including the auditor's report) must be published and presented to a general meeting of the Council of Governors by 30th September each year and made available to the public for public inspection at the Trust's headquarters and

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made available on the Trust's website. Any summary financial statements published are, in addition to, and not instead of, the full annual accounts.

- 6.7 The Chief Nurse will prepare the Trust Quality Account in the format prescribed by NHS England.

7. Bank Accounts

General

- 7.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by NHS England.
- 7.2 The Board shall approve the banking arrangements.

Bank and Government Banking Services (GBS)

- 7.3 **In line with public sector practice, the Trust's principal bankers are those** commercial banks working in partnership with the GBS; however, these SFIs will apply to any other accounts opened in the name of the Trust or its subsidiaries from time to time.
- 7.4 The Chief Finance Officer is responsible for:
- a. Bank accounts and GBS accounts;
 - b. Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;
 - c. Ensuring payments made from bank or Government Banking Service accounts do not exceed the amount credited to the account except where arrangements have been made;
 - d. Ensuring cash is managed in line with **[Insert Trust name]** Licence Conditions and its Investment and Borrowing Strategies. Further details of which can be found in the Finance Department's Treasury Management Policies;
 - e. Establishing separate bank accounts for the Trust's non-exchequer funds;
 - f. Ensuring covenants attached to bank borrowings are adhered to.

Banking Procedures

- 7.5 The Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

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- a. Those members of staff with mandated authority to carry out transactions (by signing transfer authorities or cheques or other orders) drawn on the Trust's accounts; and
 - b. The conditions under which each bank and GBS account is to be operated.
- 7.6 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated. All funds shall be held in accounts in the name of the Trust. No officers other than the Chief Finance Officer shall open any bank account in the name of the Trust.

Tendering and Review

- 7.7 The Board of Directors will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.
- 7.8 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board.
- 7.9 If however, the Chief Finance Officer decides, that it is not in Trust's best interests to use commercial banking services, but instead to solely use the GBS services, then no tender will be required. This should be reported to the Board of Directors.

External Borrowing

- 7.10 The Chief Finance Officer will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing. The Chief Finance Officer is also responsible for reporting periodically to the Board of Directors concerning the originating debt and all loans and overdrafts
- 7.11 The Board of Directors will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Managing Director and the Chief Finance Officer.
- 7.12 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Managing Director or the Chief Finance Officer. The Board of Directors must be made aware of all short term borrowings at the next Board meeting.
- 7.13 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. All short-term borrowing requirements must be authorised by the Chief Finance Officer.
- 7.14 All long-term borrowing must be consistent with the plans outlined in the current Business Plan.

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Investments

- 7.15 Temporary cash surpluses may be held only in such public or private sector investments as authorised by the Board.
- 7.16 The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.
- 7.17 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

8. Income, Fees and Charges and Security of Cash, Cheques and other Negotiable Instruments

Income Systems

- 8.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection, and coding of all monies due.
- 8.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

Fees and Charges

- 8.3 The Trust shall follow the financial regime as determined by the Department of Health.
- 8.4 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DHSC or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's "Commercial Sponsorship – Ethical standards in the NHS" shall be followed.
- 8.5 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.
- 8.6 Contracts must confirm to the strategy and business plans of the Trust and shall be approved according to the limits specified at SFI Appendix 1.

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Debt Recovery

- 8.7 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.
- 8.8 Any potential write off of bad debt shall be processed through the losses and special payments process, and shall be authorised by the Chief Finance Officer or Deputy Chief Finance Officer. All write offs will be reported to the Audit Committee detailing the actions taken to recover the debt and the factors considered in making the decision to write off the debt.
- 8.9 Overpayments should be detected (or preferably prevented) and recovery initiated under normal procedures. Where overpayments have been made for 3 or more occasions and the individual or organisation is refusing to pay the Trust Local Counter Fraud Specialist should be consulted.

Security of Cash, Cheques and Other Negotiable Instruments

- 8.10 The Chief Finance Officer shall be responsible for:
- a. Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
 - b. Ordering and securely controlling any such stationery;
 - c. The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
 - d. Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.
- 8.11 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or IOUs. All cheques, postal orders, cash, etc., shall be banked promptly and intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.
- 8.12 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in appropriate sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the depositors absolving the Trust from responsibility for any such loss.
- 8.13 All cheques must be dispatched to Financial Services. A record of all cheques received must be maintained at point of receipt before being despatched to Financial Services. A

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list of these cheque details is to be sent to the Financial Services Manager.

Money Laundering

- 8.14 To minimise the risk of being used for money laundering purposes and avoid the need to comply with Money Laundering Regulations the Trust will not accept payment in cash exceeding £1000 for any single transaction other than in respect of funds banked on behalf of a patient who has been admitted with such funds.

9. Contracts for the Provision of Healthcare Services

Commissioning

- 9.1 The Board of Directors shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.
- 9.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable legally binding agreements with service commissioners for the provision of NHS services. This responsibility has been delegated to the Chief Finance Officer who is responsible for commissioning NHS service agreements for the provision of services to patients in accordance with the Business Plan and for establishing the arrangements for non-contracted activity. In carrying out these functions, the Chief Finance Officer will pay due regards to:
- a. The costing and pricing of services (in accordance with the National Tariff) and the activity / volume of services planned;
 - b. The standards of service quality expected;
 - c. Payment terms and conditions;
 - d. Amendments to NHS contracts and contracted activity;
 - e. The relevant national service framework, if any; and
 - f. Any other matters relating to contracts of a legal or non-financial nature.

Contract Pricing and Reporting

- 9.3 NHS contracts should comply with the most recent guidance from the DHSC and be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income.
- 9.4 The Chief Finance Officer will need to ensure that regular reports are provided to the

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Board detailing actual and forecast income from the contract. This will include information on costing arrangements; any pricing of NHS contracts at marginal cost must be undertaken by the Chief Finance Officer and reported to the Board.

- 9.5 The Chief Finance Officer must ensure that the process undertaken to cost procedures provided at the Trust as part of the annual reference cost collection adheres to the guidance published by the DHSC annually. The Trust's process must be reported to Audit Committee to provide assurance that the submission will accurately represent the cost of each procedure,

Content of Contracts

- 9.6 All agreements should aim to implement the agreed priorities contained within the relevant plans and wherever possible, be based upon integrated care pathways to reflect expected patient experience.
- 9.7 Where the Trust makes arrangements for the provision of services by non- NHS providers, the Managing Director is responsible for ensuring that the agreements put in place have due regard to the quality and the cost- effectiveness of the services provided.
- 9.8 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services (clinical or non-clinical), the responsible Officer should ensure that an appropriate contract is present and signed by both parties. The Procurement team will provide professional advice on the structure and content on this type of contract and should approve the contract before being signed by the delegated Officer.
- 9.9 Contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement if shorter than one year so as to ensure value for money.

10. Tendering, quotation and contracting procedure

Duty of compliance

- 10.1 The procedure for awarding all contracts by or on behalf of the Trust shall comply with Trust SOs and SFIs.
- 10.2 Procurement and contracting shall be undertaken in accordance with all applicable UK procurement legislation and statutory guidance, including the Procurement Act 2023 and associated regulations, the Provider Selection Regime where applicable, and any directions or guidance issued by the Department of Health and Social Care or the Cabinet Office. These requirements shall have effect as if incorporated into these Standing

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Orders and Standing Financial Instructions.

- 10.3 The Trust has policies and procedures in place for the control of all tendering activity carried out on behalf of the Trust.
- 10.4 The Trust shall comply as far as is reasonably practicable with the requirements of the latest DHSC guidance on capital investment and the procurement and management of consultants within the NHS.

Thresholds Tender Guide/Placing Contracts/Waivers

- 10.5 The Trust shall ensure that competitive tenders or quotations are invited for:
- a. The supply of goods, materials and manufactured articles;
 - b. The rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC);
 - c. For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and
 - d. Where the Trust elects to invite bids for the supply of healthcare services these SOs and SFIs shall apply as far as they are applicable to the respective competitive exercise.
- 10.6 The following table outline the correct procurement process to be followed relative to value and the type of product or service being purchased.
- 10.7 Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract and include the whole life costs, not the annual value and should not seek to circumvent public sector procurement regulations.
- 10.8 For the purpose of these SFI's the definition of a Contract is a voluntary, deliberate, and legally binding agreement between two or more competent parties. Contracts are usually written but may be spoken or implied, and generally have to do with employment, sale or lease, or tenancy.
- 10.9 A contractual relationship is evidenced by (1) an offer, (2) acceptance of the offer, and a (3) valid (legal and valuable) consideration. Each party to a contract acquires rights and duties relative to the rights and duties of the other parties. However, while all parties may expect a fair benefit from the contract (otherwise courts may set it aside as inequitable) it does not follow that each party will benefit to an equal extent.
- 10.10 Where the opportunity has been advertised the Trust may shortlist suppliers, via a transparent supplier selection process, to take forward to the next stage of the procurement process.

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- 10.11 Threshold limits represent the contract's lifetime value (e.g. a 5 year contract of £25,000 per year requires £125,000 method, sign off and authorisation).
- 10.12 The cumulative amount spent with the supplier over a rolling 12 month period (e.g. 5 separate spends of £5k each will trigger the appropriate procurement process in line with the values above).
- 10.13 In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the Contract Recommendation Report (CRR). Where market engagement outcomes meet the criteria set out above, this shall be recorded within the CRR and no separate Waiver (STA/STW) approval is required
- 10.14 Authorisation to sign a Contract and recommendation report requirements are detailed in Table below.

Financial Limits for the Procurement Process & Placing Contracts

- 10.15 Under no circumstances should any member of the Trust sign and authorise a Contract from a supplier unless they are permitted under SFI's to do so as detailed in this Table.

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Contract Value Thresholds and Approval Requirements Table

Contract value excl. VAT	quotes / tenders	Min number invited to quote / tender where available	Form of Contract	CRR required	Authorisation to approve CRR	Authority to sign a contract
<10k	Quotation may be obtained by end user	1	PO	No	NA	Associate Director of Procurement
>10k - 24,999k	Quotations may be obtained by end user - CRR & Procurement Act 2023 notices issued by procurement	2	PO	No	NA	Associate Director of Procurement
25 - 149,999k	Quotations obtained by Procurement - CRR & Procurement Act 2023 notices issued by procurement	3	Purchase Order and/or contract, as appropriate to the procurement	yes - Level 1 CRR	Associate Director of Procurement	Associate Director of Procurement
150 - 499k	Tender by procurement	4	Purchase Order or contract, as appropriate to the procurement	Yes - Level 2 CRR	Director of Procurement	Director of Procurement
500 - 999k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 2 CRR	Care Organisation Finance Lead	Care Organisation Finance Lead
1,000 - 1,499k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 2 CRR	Group CFO or Managing Director	Group CFO or Managing Director
1,500 - 1,999k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 3 CRR	Group CFO	Group CFO or Group CEO
>2,000k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 3 CRR	Board	Group CEO / Board Chair

10.16 The Managing Director, Chief Finance Officer, Director of Procurement, Associate Director of Procurement, and Chief Pharmacist are authorised to sign and enter into contracts on behalf of the Trust, subject to their delegated limits as set out in the above table.

This authority applies only where a valid Contract Approval Document (Contract Recommendation Report) has been approved by the relevant Executive Director or the Trust Board Chair.

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The Chief Pharmacist's authority to sign contracts is limited to pharmaceutical contracts only.

- 10.17 The Managing Director shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contract.

Electronic Tendering

- 10.18 All invitations to tender should be on a formal competitive basis applying the principles set out below using the Trust E-Tendering Portal. This requirement applies to formal competitive procurement exercises as defined in the Contract Value Thresholds and Approval Requirements table
- 10.19 All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 10.2 – 10.13 Issue of all tender documentation should be undertaken by the Procurement Department electronically through a secure website with controlled access using secure login, authentication and viewing rules.
- 10.20 All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. All actions and communication by both procurement staff and suppliers are recorded within the system audit reports.

Manual Tendering – General Exception Rules

- 10.21 No tenders should be conducted manually unless there is a clear valid exception that is signed off by the Director of Procurement. All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:
- a. A plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word 'Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender);
 - Or
 - b. In a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.
- 10.22 Every tender for goods, materials or manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 7.5.

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10.23 Where appropriate tenders for building and works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or NEC 3 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers.

10.24 Every tender for goods, materials, services (including consultancy services) or disposals shall embody the NHS Standard Contract Terms and Conditions as are applicable. Every supplier must have given a written undertaking not to engage in collusive tendering or other restrictive practice.

Receipt, Safe Custody and Record of Formal Tenders submitted manually

10.25 All tenders on the approved form shall be addressed to the appropriate officer according to the appropriate limits specified in the Contract Value Thresholds and Approval Requirements Table

10.26 The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

10.27 The appropriate officer shall designate an officer or officers, not from the originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with SFI 10.7.

Opening Formal Tenders

10.28 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened either electronically or if manually by two officers designated by the officer as appropriate.

10.29 Every tender received shall be stamped with the date of opening and if manually opened they shall be initialled by two of those present at the opening.

10.30 A permanent record shall be maintained to show for each set of competitive tender invitations dispatched:

- a. The names of firms/individuals invited;
- b. The names of and the number of firms/individuals from which tenders have been received;
- c. The total price(s) tendered;

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- d. Closing date and time;
- e. Date and time of opening; and
- f. The persons present at the opening shall sign the record, where a manual process has been conducted.

10.31 Except as in the paragraph below, a record shall be maintained of all price alterations on tenders, i.e. where a price has been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be logged and where a manual process has been conducted it should be initialled by two of those present at the opening.

10.32 A report shall be made in the record if, on any one tender, price alterations are considered so numerous as to render the procedure set out in the paragraph above unreasonable.

Admissibility and Acceptance of Formal Tenders (Electronically & Manually)

10.33 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Finance Officer, Director of Procurement or nominated officer. All decisions should be recorded in line with the procurement process.

10.34 Tenders received after the due time and date may be considered only if the Chief Finance Officer or Director of Procurement or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Finance Officer, or nominated officer, shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting. All decisions in relation to tenders received after the due time and date should be recorded in the procurement log.

10.35 Technically late tenders (i.e. those despatched in good time but delayed through no fault of the supplier) may at the discretion of the Chief Finance Officer or nominated officer be regarded as having arrived in due time. A record supporting this decision should be recorded in the procurement log.

10.36 Materially incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the supplier upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under SFI 10.33.

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- 10.37 Where examination of tenders reveals a need for clarification, the supplier is to be given details of such clarifications and afforded the opportunity of confirming or withdrawing his offer.
- 10.38 Necessary discussions with a supplier of the contents of their tender, in order to elucidate technical points etc., before the award of a contract, will not disqualify the tender.
- 10.39 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Finance Officer.
- 10.40 Where only one tender/quotation is received the Director of Procurement /nominated officer (within delegated limits) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.
- 10.41 All tenders shall be evaluated on the basis of Most Advantageous Tender) and in conjunction with published Award Criteria and Weightings.
- 10.42 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Managing Director or nominated officer (within Contract Value Thresholds and Approval Requirements Table)
- 10.43 All tenders should be treated as confidential and should be retained for inspection.

Extensions to Contract

- 10.44 In all cases where optional extensions to contract are outlined at the time of tendering, in the recommendation report, the authority to approve contract extensions is given to the Director of Procurement up to the value of the original contract (including formally agreed variations).

Quotation & Tendering Procedures

- 10.45 Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts according to the financial limits specified with Contract Value Thresholds and Approval Requirements Table.
- 10.46 Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in Contract Value Thresholds and Approval Requirements Table

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- 10.47 Tender documents will be issued by procurement on behalf of the Trust. Procurement will arrange for them to be opened in accordance with the SFIs of the Trust.
- 10.48 No tender shall be considered which bears any mark or name indicating the sender.
- 10.49 Where the total contract value exceeds £25,000, the Trust shall ensure that appropriate transparency and advertising requirements are met in accordance with applicable UK procurement legislation and statutory guidance, including publication of required notices on the Central Digital Platform or other prescribed portals. The Trust must also ensure that contract award information is published where required. Transparency requirements apply below statutory thresholds, but they do not, on their own, trigger a requirement to run a competitive procurement.
- 10.50 Where the total contract value exceeds the relevant statutory procurement thresholds, the Trust is committed to conducting a legally compliant procurement process in accordance with applicable UK procurement legislation, including the Procurement Act 2023 and associated regulations, or the Provider Selection Regime where applicable.
- 10.51 Where appropriate, pharmacy orders must be placed against nationally or regionally/divisionally agreed pharmacy contracts, which should cover the majority of Pharmacy Department activity, and the Chief Pharmacist is responsible for signing pharmaceutical contracts on behalf of the Trust in accordance with delegated authority.
- 10.52 Tender lists for building and engineering works will be compiled from “Construction line” the Trust’s approved list of Contractors.
- 10.53 Where there is a wide discrepancy between the estimate and / or approved funding and the final total tendered cost involving an increase in expenditure this is to be reported to the Chief Finance Officer for further instructions.
- 10.54 The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in Contract Value Thresholds and Approval Requirements Table
- 10.55 Quotation/tenders will be completed accordance with these SFIs.
- 10.56 Adjudication must be made in accordance with SFI 10.33 to 10.43 a recommendation report shall be prepared by procurement for approval or to seek authorisation, according to delegated limits.
- 10.57 Acceptance of the tender/quotation must comply with the financial limits set out in Contract Value Thresholds and Approval Requirements Table. All contract documentation must be finalised promptly (ideally prior to the commencement of the contract) after the award of contact.

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10.58 The waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee regularly.

Quotation & Tendering Procedures Summary – Contracts

10.59 Competitive quotation/tenders will be obtained for all items according to the financial limits specified in Contract Value Thresholds and Approval Requirements Table

10.60 Any selection or pre-qualification stage shall be conducted in accordance with applicable UK procurement legislation and statutory guidance, including the Procurement Act 2023 and associated regulations, with requirements being proportionate and limited to the supplier's capacity and capability to perform the contract.

10.61 Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract, not the annual value and should not seek to circumvent public sector procurement regulations. Appropriate contractual arrangements will be required for all Waiver(STA/STW) over £25,000 as per Contract Value Thresholds and Approval Requirements Table

10.62 Quotations/ tenders shall be invited for all purchases over a period of time in line with Contract Value Thresholds and Approval Requirements Table.

10.63 Quotations/ tenders will be issued in accordance with these SFI's and shall incorporate standard NHS Terms and Conditions of Contract or applicable building works and capital projects terms and conditions such as JCT and NEC.

10.64 After tenders/quotations have been opened, procurement will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 10.33 to 10.43.

10.65 A Recommendation Report prepared by the Procurement Team should be submitted for approval or to seek authorisation as per Contract Value Thresholds and Approval Requirements Table according to delegated limits.

10.66 All waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee regularly highlighting all waivers over £10,000 in line with waivers approved by the Chief Finance Officer or Nominated Officer (Site Director of Finance)

10.67 All competitive quotations and tenders shall be conducted through the Trust's e-tendering portal in accordance with applicable UK procurement legislation and transparency requirements All Trust quotation/tenders or waivers over £25,000 in value must result in a signed contract between the supplier and the Trust under agreed terms and conditions, clear specifications and KPI's where appropriate. These will be retained through the Trust Procurement Source to Contract System. Any exceptions to this are at

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the discretion of the Director of Procurement.

Waiving or Variation of Competitive Tendering/Quotation Procedure

10.68 Appropriate contractual arrangements will be required for all Waivers (STA/STW) over £25,000 as per Contract Value Thresholds and Approval Requirements Table

10.69 In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a Waiver (STA/STW) will not be required.

10.70 Formal competition need not be applied (and therefore a Waiver (STA/STW) is not required) where:

- a. The estimated expenditure does not, or is not reasonably expected to, exceed the Contract value set out in Contract Value Thresholds and Approval Requirements Table
- b. The supply is proposed under special arrangements negotiated by the Department of Health, which the Trust is required by the Independent Regulator to comply with
- c. The requirement is covered by an existing contract, and the additional expenditure does not either constitute a material difference (e.g. change of scope, or increase in value of 20% or more), or result in a shift in the economic balance of the contract in favour of the contractor
- d. The expenditure relates to agency pay however internal governance and authorisation will apply
- e. National public sector or NHS agreements including NHS Supply Chain are in place and have been approved by the Department of Health
- f. A direct award to a supplier on a national or regional framework is permissible and recommended according to the rules of the framework. On these occasions a recommendation report will require authorisation in accordance with Contract Value Thresholds and Approval Requirements Table the Trust will be required to demonstrate in the report, with supporting evidence, that a direct award offers value for money and is in the best interests of the Trust
- g. Attendance at seminars, conferences, training, or participation in mandatory accreditation, quality assurance schemes or similar unique events
- h. A consortium arrangement is in place, and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members

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- i. A commissioning body is market testing the whole business to ensure value for money and the Trust requires a partner or subcontractor to respond to the invitation to tender. The selection of the partner by the Trust need not be separately competed
- j. The requirement is for the securing of a named individual on a temporary basis to fulfil a role and where substitution of another resource is not acceptable. In this case this does not constitute a procurement, but the nominated Officer must still ensure value for money

Applicability of SFIs on Tendering and Contracting to funds held on trust

- 10.71 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's funds held on trust and private resources.
- 10.72 Where a requirement has been identified for goods and services to be paid for by charitable funds additional authorisation is required from the Charities and Technical Accountant.
- 10.73 The Charities and Technical Accountant will ensure that the particular fund in question has had a spending plan for the relevant financial year submitted and approved by the Charities Committee. In the instance where no plan has been approved, the request will be returned to the relevant department.
- 10.74 Tenders funded by charitable monies must be carried out in accordance with the Procurement Act 2023 and associated regulations. The appropriate procurement route and applicable threshold will be determined by the nature and total value of the project.

Financial Standing and Technical Competence of Suppliers

- 10.75 The Chief Finance Officer may make or organise any enquiries they deem appropriate concerning the financial standing and financial suitability of Suppliers. The Delegated Officer with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.
- 10.76 If in the opinion of the Chief Finance Officer or Delegated Officer, with lead responsibility for clinical governance, specialist services or skills are required then appropriate checks must be carried out as to the technical and financial capability of those suppliers that are invited to tender.

Governance

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10.77 Separation of Duties: The principles of public accountability require a total separation of the responsibilities of finance staff and purchasing staff. For this reason, finance staff are not permitted to raise orders; neither are they permitted to authorise the payment of orders without the necessary signatures. Equally, procurement staff are not permitted to authorise the payment of invoices other than from their own management budgets.

11. Terms of Service, Allowances and Payment of Members of the Board and Employees

Board of Directors Nominations and Remuneration Committee

- 11.1 The Board of Directors has constituted a Nominations and Remuneration Committee to be responsible for identifying and nominating for appointment, candidates to fill executive director posts, and with approval by the Council of Governors, to fill the position of Managing Director. The Committee is also responsible for determining the Chief Executive, Managing Director, and Executive Directors' level of remuneration.
- 11.2 Full details of the responsibilities of the Board of Directors Nominations and Remuneration Committee are included in the Scheme of Reservation and Delegation.
- 11.3 The Committee shall report in writing to the Board its decisions and the basis for its recommendations.

Council of Governors' Nominations and Remuneration Committee;

- 11.4 The Council of Governors has constituted a Nominations and Remuneration Committee to be responsible for identifying and nominating for appointment, candidates to fill Non-Executive Director (including the Chair) posts as and when they arise. The Committee's recommendation(s) for appointments are referred to the full Council of Governors for approval. The Committee shall recommend to the full Council of Governors, the level of remuneration for the Chair and Non- Executive Directors.
- 11.5 Full details of the responsibilities of the Council of Governors Nominations and Remuneration Committee are included in the Scheme of Reservation and Delegation.

Funded Establishment

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- 11.6 The manpower plans incorporated within the annual budget will form the funded establishment.
- 11.7 The funded establishment of any department may not be increased without the approval of the Chief Finance Officer.

Staff Appointments

- 11.8 No Director or Officer may engage, re-engage or re-grade Officers, re- deploy either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:
- 11.9 Authorised to do so by the Managing Director or the Chief Finance Officer;
- 11.10 Within the limit of his approved budget and funded establishment as defined in the Scheme of Delegation;
- 11.11 All changes with a financial impact have been through the appropriate Divisional process for authorisation.
- 11.12 Divisional management shall maintain good controls with regards staff appointments to ensure each department remain within their delegated budgetary limits.
- 11.13 All appointments must adhere to the Trust Recruitment and Selection Policy.
- 11.14 The Board will approve procedures presented by the Managing Director for the determination of commencing pay rates, condition of service, etc., for employees.
- 11.15 Managers will ensure that all new employees and bank workers have produced the relevant documentation and completed the relevant signing on procedure with People Directorate prior to starting.
- 11.16 The People Directorate shall be notified immediately upon the effective date of any change in state of employment or personal circumstances of an employee being known.
- 11.17 All time records, pay sheets, and other pay records and notifications shall be in a form approved by the Trust Executive and shall be certified and submitted in accordance with agreed instructions.
- 11.18 The Chief Finance Officer shall devise and maintain a system of establishment controls which shall include regular reports to each manager on the staff in post in their departments.

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Contracts of Employment

11.19 The Board shall delegate responsibility to a manager for:

- a. ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
- b. dealing with variations to, or termination of, Contracts of Employment.

Processing Payroll

11.20 The Chief Finance Officer is responsible for:

- a. Specifying timetables for submission of properly authorised time records and other notifications;
- b. The final determination of pay;
- c. Making payment on agreed dates; and
- d. Agreeing method of payment.

11.21 The Chief Finance Officer will issue instructions regarding:

- a. Verification and documentation of data;
- b. The timetable for receipt and preparation of payroll data and the payment of employees;
- c. Maintenance of subsidiary records for superannuation, income tax, national insurance and other authorised deductions from pay;
- d. Security and confidentiality of payroll information;
- e. Checks to be applied to completed payroll before and after payment;
- f. Authority to release payroll data under the provisions of the Data Protection Act;
- g. Procedures for payment by bank credit to employees
- h. Procedures for the recall of bank credits;
- i. Pay advances and their recovery;
- j. The recovery of salary overpayments;
- k. Maintenance of regular and independent reconciliation of pay control accounts;
- l. Separation of duties for preparing records and handling cash; and
- m. A system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

11.22 Appropriately nominated managers have delegated responsibility for:

- a. Submitting time records, and other notifications in accordance with agreed timetables;

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- b. Completing time records and other notifications in accordance with the Chief Finance Officer instructions and in the form prescribed by the Chief Finance Officer; and
- c. Submitting termination forms in the prescribed form immediately upon knowing the effective date of any employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Payroll Department must be informed immediately.

11.23 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that a suitable arrangement is made for the collection of payroll deductions and payment of these to appropriate bodies.

11.24 The Chief Finance Officer shall ensure adequate internal controls and audit review procedures are in place, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

11.25 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered.

12. Terms of Service, Allowances and Payment of Members of the Board and Employees

Delegation of Authority

12.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Finance Officer will determine the level of delegation to Budget Managers.

12.2 The Council of Governors will need to be consulted on significant transactions which the Trust are obliged to report to NHS England prior to entering the transaction. Such transactions may take the form of Assets, Income or capital as set out in Annex 9 of the Trust constitution.

12.3 Organisational transactions that meet the following criteria must be reported to NHS England:

- a. Most mergers and acquisitions as well as larger capital investment projects and property transactions, and potentially some major service contracts. Potential transactions

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should be reported if the ratio of the gross assets, income or consideration attributable to the transaction exceeds 10% of the trust's gross assets, income or total capital respectively.

- b. A transaction that could be reviewed by the Competition and Markets Authority (under the Enterprise Act 2002).
- c. A statutory transaction.

12.4 The Chief Finance Officer will set out:

- a. The list of managers who are authorised to place requisitions/orders for the supply of goods and services
- b. The maximum financial level for each requisition/order and the system for authorisation above that level (see Appendix 1).
- c. The Chief Finance Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

Choice, Requisitioning, Ordering, Receipt And Payment For Goods And Services

Requisitioning

12.5 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice from Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Managing Director) shall be consulted.

System of Payment and Payment Verification

12.6 All goods and services must be supported by an approved requisition and purchase order before being ordered or supplied. Ordering without a purchase order is only permitted for specific, pre-approved categories (e.g. agency staff or utilities). Any other non-compliant spend will be treated as unauthorised

12.7 The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. For the avoidance of doubt, all contract-based expenditure must be supported by either an approved purchase order or an approved contract mechanism authorised by Finance

12.8 The Chief Finance Officer will:

- a. Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; once approved, the thresholds are incorporated in these SFIs and regularly reviewed;
- b. Prepare procedural instructions (where not already provided in the Scheme of

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Delegation or procedure notes for budget holders) on the obtaining of goods, works and services incorporating the thresholds;

- c. Be responsible for the prompt payment of all properly authorised accounts and claims as per the current Department of Health guidance;
- d. Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).
- e. Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

- i. **Authorisation:** A list of directors/employees authorised to certify invoices and the expenditure that has been authorised.

- ii. **Certification** that:

- Goods have been duly received, examined and are in accordance with specification and the prices are correct;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the timesheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- The account is arithmetically correct;
- The account is in order for payment.

- iii. **Payments and Creditors:** A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts for otherwise requiring early payment.

- iv. **Financial Procedures:** Instructions to employees regarding the handling and payment of accounts within the Finance department.

Prepayments

12.9 Prepayments are only permitted where exceptional circumstances apply. In such instances:

- a. Prepayments are only permitted where the financial advantages outweigh the

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disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

- b. The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments.
- c. There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained.
- d. The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed.

12.10 The Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Managing Director if problems are encountered.

Duties of Managers and Officers

12.11 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

- a. Official orders must be made electronically in accordance with the Scheme of Delegation set out in Appendix 1.
- b. all contracts (except as otherwise provided for in the Scheme of Delegation and the associated Limits of Delegation Policy), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;
- c. All contracts above the specified thresholds must be advertised and awarded in accordance with this policy and applicable UK procurement legislation.
- d. For all contracts with a single supplier whose value exceeds £2m p.a. the lead officer within the Trust shall be designated as the “contract owner” for that contract and shall:-
 - i. Ensure the contract is entered on the central contract register maintained by the Procurement & Supply Chain department.
 - ii. Ensure that all contract documentation is lodged with the Procurement & Supply Chain department (a copy may also be retained within the originating department for administrative convenience).
 - iii. Ensure appropriate contract management is in place.
 - iv. Ensure that any significant change to the contract/service is formally agreed and documented as required by the SFI’s or Limits of Delegation Policy and current Procurement regulation

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- e. where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health / NHS England; this is available from the central procurement team on request.
- f. no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
- g. isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
- h. conventional hospitality, such as lunches in the course of working visits in accordance with the Trusts hospitality policy;

12.12 (This provision needs to be read in conjunction with paragraph 33 of the Constitution and the principles outlined in the national guidance contained in HSG 93(5) “Standards of Business Conduct for NHS Staff”);

- a. no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Managing Director;
- b. all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash (subject to the petty cash limit – see scheme of delegated limits) .
- c. when commissioning consultancy provision, with a total value exceeding £50,000 (inclusive of VAT and all associated costs), including where this threshold is reached through a contract extension or variation will require prior approval from NHSE. Applies only to contracts accounted for as revenue expenditure
- d. verbal orders must only be issued very exceptionally - by an employee designated by the Managing Director and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
 - i. orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
 - ii. goods and services are not taken on trial, pilot or loan in circumstances that could commit the Trust to a future uncompetitive purchase; procurement advice should be sought
 - iii. changes to the list of employees and officers authorised to certify invoices are notified to the Chief Finance Officer;
 - iv. purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by Chief Finance Officer;
 - v. petty cash records are maintained in a form as determined by the Chief Finance Officer.
 - vi. Appropriate segregation of duties shall be maintained. While the requisitioner and goods receiver may be the same individual, no individual shall raise a requisition, receipt goods or services, and certify an invoice for payment. System controls prevent self-approval.
 - vii. The financial limits for officers’ approval of payments are set out in the Scheme of Delegated limits
 - viii. Under no circumstances should goods be ordered through the Trust for personal

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or private use.

- 12.13 The Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and HBN00-08 (formally ESTATECODE). The technical audit of these contracts shall be the responsibility of the relevant Director.

13. Wholly Owned Subsidiaries, Hosted Bodies, Partnerships and Collaborations

Wholly Owned Subsidiaries

- 13.1 Subsidiary companies are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, wholly owned subsidiaries are subject to their own governance arrangements, which are the responsibility of the subsidiary's board of directors, and therefore these Standing Financial Instructions are not applicable. Reference to the subsidiary's documentation will need to be made.

Hosted Bodies, Partnerships and Collaborations

- 13.2 Hosted bodies are organisations for which the Trust provides services under a service level agreement (SLA). The arrangements for administration of hosted bodies are managed by the Contracts Team.
- 13.3 Partnerships are organisations for which the Trust, in conjunction with other organisations, creates another separate entity under a Member's Agreement. These agreements are also managed by the Contracts Team
- 13.4 Dependent on the terms of the SLA, memorandum of understanding etc. these standing financial instructions may or may not be applicable. Individual SLAs, memorandum of understanding etc. should be referred to on a case-by-case basis.

14. External Borrowing, Public Dividend Capital and Investments

Public Dividend Capital (PDC)

- 14.1 The Accounting Officer is responsible for ensuring that the Trust pays annually to the

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Department of Health a dividend on its Public Dividend Capital at a rate to be determined from time to time by the Secretary of State in accordance with the 2006 Act and the Regulatory Framework.

- 14.2 The Trust will comply with the guidance on dividend payments in the DHSC Group Accounting Manual.

Other External Borrowing

- 14.3 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.
- 14.4 The total amount of the Trust's borrowing must be affordable within NHS England's risk framework and the related ratings.
- 14.5 Any application for a loan or overdraft facility must be approved by the Board of Directors, and will only be made by the Chief Finance Officer, or a person with specific delegated powers from the Chief Finance Officer.
- 14.6 All borrowing must be consistent with the plans outlined in the current Trust Business Plan approved by the Board.

Investments

- 14.7 The Trust may invest money for the purposes of its strategic objectives and operation functions. NHS England guidance is to be followed
- 14.8 The Audit Committee shall set the investment policy and oversee all investment transactions by the Trust. The Chief Finance Officer must ensure compliance with this policy at all times.
- 14.9 The Chief Finance Officer is responsible for advising the Board on investments and shall periodically report the performance of all investments held, to the Board through the Audit Committee.
- 14.10 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

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15. Capital Investment, Private Financing, Fixed Assets and Security of Assets

Capital Investment

- 15.1 The Trust will establish a Capital Prioritisation and Management Group (CPMG) to:
- a. Ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon Business Plans;
 - b. Be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
 - c. Ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including depreciation and interest payable.
- 15.2 For every significant capital expenditure proposal CPMG shall ensure that a business case is produced setting out:
- a. An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
 - b. An appropriately detailed analysis of expenditure and income flows anticipated, including documented responses from purchasers as appropriate, where significant a risk analysis testing the assumptions made;
 - c. Appropriate project management and controls are in place;
 - d. The involvement of appropriate Trust personnel and external agencies; and
 - e. Clear objectives that can be reviewed and measured as part of the post project evaluation (PPE), along with a date when the PPE will be completed.
 - f. That the Chief Finance Officer has certified professionally to the costs (including full VAT liability) and revenue consequences detailed in the business case.
- 15.3 Capital business cases shall be approved as follows:
- a. Commitment of expenditure up to £250,000: Capital Prioritisation and Management Group;
 - b. Commitment of expenditure in excess of £250,000 and up to £1,000,000: Management Committee; and
 - c. Commitment of expenditure in excess of £1,000,000: Board of Directors.

The values quoted above are inclusive of VAT.

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- 15.4 For capital schemes where the contracts stipulate stage payments, the Chief Finance Officer will issue procedures for their management. The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.
- 15.5 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme. The Chief Finance Officer shall issue to the Manager responsible for any scheme:
- a. Specific authority to commit expenditure;
 - b. Authority to proceed to tender; and
 - c. Approval to accept a successful tender.
- 15.6 The Managing Director will issue a Scheme of Delegation for capital investment management.
- 15.7 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.
- 15.8 The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the "Construction Industry Scheme" in accordance with any guidance issued by HM Revenue and Customs.

Private finance

- 15.9 Proposals to use private sector finance for capital schemes need to be approved by CPMG prior to requesting approval by the Board of Directors. Both CPMG and the Board of Directors should be satisfied that the use of private finance represents value for money and genuinely transfers risk to the private sector as appropriate.

Asset registers

- 15.10 The Chief Finance Officer is responsible for the maintenance of registers of assets, and arranging for a physical check of assets against the asset register to be conducted once a year.
- 15.11 The Chief Finance Officer shall prepare procedural instructions on the disposal of assets.
- 15.12 The Trust will maintain an asset register recording fixed assets. As a minimum, the data set to be held within these registers shall be as specified in the Group Accounting Manual

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as issued by NHS England.

15.13 Additions to the fixed asset register must be clearly identified to a scheme which will in turn have an identified and appropriate budget holder / project manager and be validated by reference to:

- a. Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
- b. Stores, requisitions and wages records for own materials and labour including appropriate overheads; and
- c. Lease agreements in respect of assets held under a finance lease and capitalised.

15.14 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). It is the responsibility of the appropriate manager to inform the Chief Finance Officer that an asset is to be disposed of.

15.15 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

15.16 The value of each asset shall be depreciated using methods and rates as specified in the Group Accounting Manual issued by the DHSC.

Security of assets

15.17 The overall control of fixed assets is the responsibility of the Chief Executive.

15.18 Asset control procedures (including fixed assets, cash, cheques, negotiable instruments and donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

- a. Recording managerial responsibility for each asset;
- b. Identification of additions and disposals;
- c. Identification of all repairs and maintenance expenses;
- d. Physical security of assets;
- e. Periodic verification of the existence of, condition of, and title to, assets recorded;
- f. Identification and reporting of all costs associated with the retention of an asset; and
- g. Reporting, recording and safekeeping of fixed assets, cash, cheques and negotiable instruments.

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- 15.19 All significant discrepancies revealed by verification of physical assets to fixed asset registers shall be notified to the Chief Finance Officer.
- 15.20 Whilst each Officer has a responsibility for the security of property of the Trust, it is the responsibility of Directors and Senior Officers in all disciplines to apply appropriate routine security practices in relation to Trust property. Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.
- 15.21 Where practical, assets should be marked as "Trust Property".
- 15.22 Any employee wishing to use Trust assets for private use must comply with the Trust's policies. The use of Trust assets for these purposes must not impact negatively on the services provided for NHS patients, both operationally and financially.

16. Property (Land and Buildings)

- 16.1 Significant changes relating to the Trust's Estate must receive the prior approval of CPMG and the Board of Directors.
- 16.2 The following matters related to property must be approved by the Trust Board:
- a. Estates Strategy;
 - b. Acquisition of freehold property over £100,000 (including VAT); and
 - c. Acquisition of property where the total value of the agreement is over £100,000 (including VAT) by means of as lease, whether it is deemed to be an operating or finance lease.
- 16.3 Property purchases, licenses and leases up to £250,000 each (including VAT) may be authorised by CPMG, provided that they fall within the Board's approved Estates Strategy and that the costs are within 10% of an independent valuation.
- 16.4 The detail of required in any property report to the Board of Directors should be determined by the materiality of the purchase or lease payments and any contentious issues, and must contain:
- a. Details of the purchase or lease payments;
 - b. Details of the period of the lease;
 - c. Details of the required accounting treatment;
 - d. Annual running costs of the property;

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- e. Funding sources within the Trust of both capital and revenue aspects of the acquisition;
- f. The results of property and ground surveys;
- g. Professional advice taken and the resultant cost;
- h. Details of any legal agreement entered into;
- i. Any restrictive covenants that exist on the property; and
- j. Planning permission.

16.5 Any property acquisition should be in accord with Estate code, the Department of Health and Social Care guidance.

16.6 The contracts to acquire the property must be signed by two Executive Directors, one of whom must be the Chief Executive or Managing Director.

16.7 Board of Directors approval must be obtained for the disposal of any property over £100,000 (including VAT) which is recorded on the balance sheet of the Trust, A business case must be presented to the Trust which must include:

- a. The proceeds to be received;
- b. Any warrants or guarantees being given; and
- c. Independent valuations obtained.
- d. The disposal must be effected in full accord with Estate code.
- e. Disposals of protected assets require the approval of NHS England

16.8 Major divestments as defined in the Foundation Trust Compliance Framework require the approval of NHS England.

16.9 The granting of property leases by the Trust must have Board approval where the annual value of the lease is in excess of £250,000.

17. Inventory and Receipt of Goods

General

17.1 Inventory stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

- a. Kept to a minimum practical level;
- b. Subjected to regular stock take – perpetual and/or annual
- c. Valued at the lower of cost and net realisable value;
- d. Controlled on a First In First Out (FIFO) logic wherever possible, and

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e. Be kept as secure as practically possible.

17.2 The cost of inventory shall be determined on the FIFO basis, and shall be the purchase price without overhead, but include VAT where this cannot be reclaimed on purchase.

Control of Stores and Stocktaking

17.3 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Managing Director. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer, the control of fuel oil by a designated Estates Manager.

17.4 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/pharmaceutical officer. Wherever practicable, stocks should be marked as Trust property.

17.5 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

17.6 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one officer other than the storekeeper, and a member of the Finance Department shall be invited to attend.

17.7 Any surplus or deficiencies revealed on stocktaking shall be reported to the Chief Finance Officer and correctly reflected in the accounts.

17.8 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

17.9 The designated manager/pharmaceutical officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also SFI 18, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

17.10 Breakages and other losses of goods in stock shall be recorded as they occur.

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17.11 Inventory that has deteriorated, or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net realisable value. The write down shall be approved by the Chief Finance Officer and recorded.

17.12 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 18.

Goods supplied by NHS Supply Chain

17.13 The authorised person shall check receipt against the delivery note and report any exceptions to the delegated officer as approved by the Chief Finance Officer. The delegated officer will be responsible for satisfying himself that the goods have been received before accepting the recharge.

18. Disposals and Condemnations, Losses and Special Payments

Disposals and Condemnations

18.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations and capital assets, and ensure that these are notified to managers.

18.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will:

- a. Establish whether it is needed elsewhere in the Trust
- b. Determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

18.3 All unserviceable articles shall be:

- a. Condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer; and
- b. Recorded by the condemning officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of.

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- c. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

18.4 The Condemning Officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

Losses and Special Payments

18.5 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments in accordance with the DHSC Group Accounting Manual and prepare a register. The Chief Finance Officer must ensure that a Counter Fraud Policy is in place that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for it investigating it.

18.6 In cases involving suspected fraud, the Chief Finance Officer must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

18.7 Any employee discovering or suspecting a loss of any kind must immediately act according to the Trusts Counter Fraud and Corruption Policy.

18.8 Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the LCFS and/or NHS Counter Fraud Authority (NHSCFA) in accordance with NHS Standard Contract and NHSCFA Standards for Providers: Fraud, Bribery and Corruption.

18.9 The Chief Finance Officer must notify the NHS Counter Fraud Authority and the External Auditor of all frauds, and monitor compliance with the NHS Standard Contract and with any other instructions issued by NHS Counter Fraud Authority.

18.10 The Directorate or Service Manager shall inform the Chief Finance Officer of all other losses or recoveries of losses so that they can be entered in the losses and special payments register.

18.11 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

- a. The Board, and
- b. The External Auditor.

18.12 Within limits delegated to it by the Board, the Chief Finance Officer shall approve the

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writing off of losses.

18.13 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in personal and company insolvencies.

18.14 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

18.15 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write off action is recorded.

18.16 All losses and special payments must be reported to the Audit Committee annually.

19. Information Technology

Responsibilities and duties of the Chief Finance Officer

19.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised data of the Trust, shall:

- a. Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act and UK GDPR;
- b. Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;
- c. Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment and have relevant technical and organisational security measure in place, including data security measures, disaster recovery and back-up arrangements;
- d. Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as may be considered necessary are being carried out;

19.2 Ensure that any personal data breach under the UK GDPR or the Data Protection Act 2018, or any other incident required by law to be reported, is reported to the Information Commissioner's Office;

- a. Prepare and maintain an IT strategy and Cyber Security strategy for regular approval by the Management Board; and

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- b. Ensure that all purchases of hardware/software are in compliance with the Trust's IT strategy.

System Development

- 19.3 The Chief Finance Officer shall be satisfied that new computer systems (including finance systems) and amendments to current systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.
- 19.4 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of NHS bodies in the local health economy or nationally wish to sponsor jointly) all responsible Directors and employees will send to the Chief Finance Officer:
 - a. Details of the outline design of the system;
 - b. In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.
- 19.5 The Chief Finance Officer shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

Contracts for Computer Services with other health bodies or outside agencies

- 19.6 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.
- 19.7 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.
- 19.8 The Chief Finance Officer will ensure that relevant security details are provided in the contract in line with UK GDPR requirements and the Data Protection Act 2018. A Data

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Protection Impact Assessment (DPIA), Data Processing Agreement or an Information Sharing Agreement (ISA) if required, will be undertaken with the support of the Information Governance Team.

Risk Assessment

- 19.9 The Chief Finance Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

Requirements for Computer Systems which have an impact on corporate financial systems

- 19.10 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:
- a. Systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
 - b. Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
 - c. Finance staff have access to such data;
 - d. Have adequate controls in place; and
 - e. Such computer audit reviews as are considered necessary are being carried out.

20. Patients' Property

- 20.1 The Trust has a responsibility to provide safe custody for money and other Personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. This includes items of daily living such as glasses, false teeth, hearing aids etc.
- 20.2 The Managing Director is responsible for ensuring that patients or their carers', as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. This can be done by:
- a. Notices and information booklets;
 - b. Hospital admission documentation and property records;
 - c. The oral advice of administrative and nursing staff responsible for admissions.

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- 20.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of patients' money in order to avoid loss.
- 20.4 Where current guidance requires the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.
- 20.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965) the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of the property is £5,000 or less, forms of indemnity shall be obtained.
- 20.6 Staff should be informed, on appointment, by appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.
- 20.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

21. Standard of Business Conduct

- 21.1 The Trust's policy on acceptance of gifts and other benefits in kind by staff is embodied in the Trust's 'Managing Conflicts of Interest Policy.'
- 21.2 Declarations of gifts or other benefits must be made to the Head of Corporate Governance for the inclusion in the Register of Interests.
- 21.3 Staff should make themselves aware of, and comply with, the Trust policy on acceptance of gifts and other benefits in kind by staff.

22. Freedom of Information and Information Requests

- 22.1 The Trust's Information Governance Officer shall ensure that freedom of information requests are made available in line with the Trust Freedom of Information Publication Scheme.

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23. Retention of Records

- 23.1 The Managing Director, through the Chief Digital and Information Officer shall be responsible for maintaining archives for all records required to be retained in accordance with official guidelines.
- 23.2 The records held in archives shall be capable of retrieval by authorised persons.
- 23.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Managing Director. Detail shall be maintained of records so destroyed.

24. Risk Management and Insurance

Risk Management Programme

- 24.1 The Managing Director shall ensure that the Trust has a programme of risk management, in accordance with current NHS assurance framework requirements, which must be approved and monitored by the Board.
- 24.2 The programme of risk management shall include:
- a. A process for identifying and quantifying risks and potential liabilities;
 - b. The maintenance of a comprehensive risk register and assurance framework;
 - c. Engendering among all levels of staff a positive attitude towards the control of risk;
 - d. Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
 - e. Reports to the Board on significant risks and progress against action plans to address those risks;
 - f. Reports to the Board on the Assurance Framework and progress on action plans to address gaps in control and/or assurance as prioritised by the Board;
 - g. Contingency plans to offset the impact of adverse events;
 - h. Audit arrangements including; Internal Audit, clinical audit, health and safety review;
 - i. A clear indication of which risks shall be insured; and
 - j. Arrangements to review the Risk Management programme.
- 24.3 The existence, integration and evaluation of the above elements will assist in providing a basis for the Annual Governance Statement within the Annual Report and Accounts as required by current Department of Health and Social Care and NHS England guidance.

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- 24.4 All staff have responsibility in their own sphere of operation, every working day. Accordingly, all staff are responsible for ensuring that their own practice, and that of anyone whom they manage, reflects the principles outlined in the Risk Management Strategy.

Insurance: Risk Pooling Schemes administered by NHS Litigation Authority

- 24.5 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority under Section 71 (Schemes for meeting losses and liabilities, etc. of certain health service bodies) of the 2006 Act (the "Schemes") for some or all of the risks covered by the Schemes. If the Board decides not to use the Schemes for any of the risk areas covered by the Schemes, this decision shall be reviewed annually.
- 24.6 Where the Board decides to use the Schemes for one or other of the risks covered by the Schemes, the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the Trust's risk management program.
- 24.7 Where the Board decides not to use the Schemes for one or other of the risks covered by the Schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are to be insured under alternative arrangements (if any) as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
- 24.8 Insurance arrangements with commercial insurers and self-insurance are co-ordinated by the Head of Corporate Governance.
- 24.9 The Trust may enter into insurance arrangements with commercial insurers on the open market for one or other of the risks covered by the Schemes, or for any risks not covered by the Schemes.
- 24.10 The Trust may self-insure either on an individual basis or as part of a risk-pooling scheme with other organisations for one or other of the risks covered by the Schemes, or for any risks not covered by the Schemes.

25. Staff Expenses

- 25.1 Chief Finance Officer shall be responsible for establishing procedures for the management of expense claims submitted by Trust employees. The Chief Finance Officer

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shall arrange for duly approved expense claims to be processed through the Trust's payroll system. Expense claims shall be authorised in accordance with the Scheme of Delegation.

- 25.2 The Chief Finance Officer shall refer to the Trust's general policies on staff expenses and may reject expense claims where there are material breaches of Trust policies. In this regard the Chief Finance Officer shall liaise with the Managing Director where appropriate.

26. Credit finance Arrangements including Leasing Commitments

- 26.1 There are no grounds where any employee of the Trust can approve any contract or transaction which binds the Trust to credit finance commitments without the clear prior authority of the Chief Finance Officer. This includes all Executive Directors of the Trust as well as all officers. The Board has provided the Chief Finance Officer with sole authority to enter into such commitments, although these powers can be delegated by him/her to appropriate officers under his/her organisational control.
- 26.2 This instruction applies to leasing agreements and Hire Purchase undertaking which must be sent to the Chief Finance Officer for prior approval. No officer of the Trust outside the - organisational control of the Chief Finance Officer has any powers to approve such commitments.

27. Charitable Funds Held on Trust

General

- 27.1 This section must be taken in conjunction with the separate document, the Charities SFIs, which lays out, in more detail, the standards expected with regards the managements and use of charitable funds held on trust.

Corporate Trustee

- 27.2 The Trust is the sole corporate Trustee of the **[Insert Trust name]** Charitable Funds, and is responsible for the management of funds it holds on trust.
- 27.3 The discharge of the Trust's corporate trustee responsibilities are exercised separately and distinctly from its powers exercised as the Trust, and therefore these powers may not necessarily be discharged in the same manner. Nevertheless, there must still be

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adherence to the overriding general principles of financial regularity, prudence and propriety. The Trustees responsibilities cover both charitable and non-charitable purposes.

- 27.4 The Chief Finance Officer shall ensure that each Fund held on Trust which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements. The Chief Finance Officer shall, in exercising his/her responsibilities have regard to appropriate and independent legal advice, as and when required.
- 27.5 Oversight of the management of Funds held on Trust is delegated to the Board of Trustees Committee (Charity Committee) which will act as sub-committee of the Board chaired by a Non-Executive Director.
- 27.6 The overriding principle in managing Funds held on Trust is that the integrity of each trust fund must be maintained and all statutory and Trust obligations must be satisfied.
- 27.7 Charitable Funds held on Trust are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England. They are administered by the Board acting as Trustees for the Trust.
- 27.8 The Board shall delegate the majority of this Trustee role to the Charity Committee, as set out in the Committee's terms of reference.

Administration and Management of Charitable Funds

- 27.9 The Chief Finance Officer shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust as trustees of non-exchequer funds, including an Investment Register.
- 27.10 The Chief Finance Officer shall arrange for the administration of all existing Charitable Funds held on Trust. The **[Insert Trust name]** Charitable Fund has been formed under an **[Insert Trust name]** Deed dated **[insert Date]** as amended by a Supplemental Deed dated **[Insert date]**. Cost Centres and procedures shall be produced covering every aspect of the financial management of charitable Funds held on Trust, for the guidance of all Officers. Additional Deeds of Establishment shall identify the restricted nature of certain funds, as listed on the Charity Commission website, and it is the responsibility of fund managers, within their delegated authority, and the Board of Trustees Committee, to ensure that funds are utilised in accordance with the terms of the Deed of Establishment.
- 27.11 The Chief Finance Officer shall ensure that all Charitable Funds held on Trust are currently registered with the Charities Commission in accordance with the Charities Act 2016 or subsequent legislation.

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27.12 The Chief Finance Officer shall recommend the creation of a new charitable fund where funds and/or other assets, received in accordance with the Trust's policies cannot adequately be managed as part of an existing fund. All new funds should be covered by the Deed of Establishment and must be formally approved by the Board.

27.13 Where a new fund cannot be covered by an existing Deed of Establishment such as for a Restricted Fund, a new Deed will be required. The Deed must clearly identify, inter alia, the objects of the new fund, the capacity of the Trust to delegate powers to manage the fund and the power to assign the residue of the charitable fund to another fund contingent upon certain conditions (e.g. discharge of original objects).

27.14 All gifts accepted shall be received and held in the name of the Trust and administered in accordance with the Trust's policy, subject to the terms of specific funds. As the Trust can accept gifts only for all or any purposes relating to the NHS, Officers (including Directors) shall, in cases of doubt, consult the Chief Finance Officer before accepting any gifts.

27.15 All gifts, donations and proceeds of fund-raising activities, which are intended for the Trust's use, must be handed immediately to the Chief Finance Officer via the Finance Department or the Fundraising Office to be banked directly to the charitable funds bank account.

27.16 In respect of donations, the Chief Finance Officer shall provide:

a. Guidelines to Officers as to how to proceed when offered funds. These are to include:-

- i. The identification of the donors' intentions;
- ii. Where possible, the avoidance of new trusts; the avoidance of impossible, undesirable or administratively difficult objectives;
- iii. Sources of immediate further advice; and
- iv. Treatment of offers for personal gifts;
- v. Secure and appropriate receipting arrangements, which will indicate that funds have been accepted directly into the Trust's donated funds and that the donor's intentions have been noted and accepted.

b. In respect of legacies and bequests, the Chief Finance Officer, shall where required, after the death of a testator ensure that:

- i. All correspondence concerning a legacy is dealt with on behalf of the Trust. Only the Chief Finance Officer shall be empowered to give an executor a good discharge;

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- ii. Where necessary, grant of probate is obtained or apply for a grant of letters of administration, where the Trust is the beneficiary; and
- iii. Arrangements regarding the administration of a will are negotiated with executors and to discharge them from their duty.

27.17 In respect of fund-raising, the final approval for major appeals, defined as events raising in excess of £100,000 will be given by the Board. Final approval for smaller appeals, defined as events anticipating raising less than £100,000 are delegated to the Charities Committee.

Investment Management

27.18 The Charities Committee shall be responsible for all aspects of the management of the investment of Funds held on Trust and shall ensure that there is a clear policy outlining the procedures and decision making required. The Chief Finance Officer shall be responsible for the appropriate treatment of all investment income including all dividends, interest and other receipts.

27.19 Any significant concerns with regards returns on investments or risk with the investments must be reported to the Board of Trustees.

Expenditure management

27.20 The exercise of expenditure discretion (including dispositions) shall be managed by the Board of Trustees Committee. Day to day management may be delegated to the Director of Finance. In so doing the Board of Trustees Committee shall be aware of the following:

- a. The objects of various trust funds and the designated objectives;
- b. The availability of liquid funds within each trust fund;
- c. The powers of delegation available to commit resources;
- d. The avoidance of the use of exchequer funds to discharge trust fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;
- e. That trust funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Trust; and
- f. The definitions of “charitable purposes” as agreed by the Charity Commission.

27.21 The Fund Managers must adhere to the Charities Policy, Charity Commission Guidance and any other statutory rules that affect charitable funds when planning expenditure. Levels of authority with regards expenditure are outlined in the charities SFIs.

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Banking Services

27.22 The Chief Finance Officer shall advise the Board of Trustees Committee (the Charity Committee) and, with its approval, shall ensure that appropriate banking services are available to the Trust as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by NHS England or the Charity Commission.

Asset Management

27.23 Assets in the ownership of or used by the Trust as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The Chief Finance Officer shall ensure that:

- a. Appropriate records of all donated assets owned by the Trust are maintained, and that all assets, at agreed valuations are brought to account;
- b. Appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;
- c. Donated assets received on trust shall be accounted for appropriately;
- d. All assets acquired from charitable Funds held on Trust which are intended to be retained within the trust funds are appropriately accounted for.

Reporting, Accounting and Audit

27.24 The Chief Finance Officer shall ensure that regular reports are made to the Board of Trustees Committee and the Board with regard to, inter alia, the receipt of Funds held on Trust, investments of these trust funds and the disposition of resources.

27.25 The Chief Finance Officer shall prepare the Annual Accounts in the required manner, which shall be submitted to the Board within agreed timescales.

27.26 The Chief Finance Officer shall:

- a. In relation to the non-charitable trust funds prepare any required returns to NHS England; and
- b. Prepare an annual Trustees report regarding charitable trust funds and make the required return to the Charity Commission for adoption by the Board of Trustees Committee as required.

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Accounting and Audit

- 27.27 The Chief Finance Officer shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.
- 27.28 Distribution of investment income to the Charitable Funds held on Trust and the recovery of administration costs shall be on a basis determined by the Chief Finance Officer unless otherwise dictated by Charity SORP (Statements of Recommended Practice).
- 27.29 The Chief Finance Officer shall ensure that the records, accounts and returns receive adequate scrutiny by the Trust's Internal Audit during the year. She/he will liaise with the Internal Auditor and provide them with all necessary information.
- 27.30 The Board of Trustees Committee shall be advised by the Chief Finance Officer on the outcome of the annual audit.
- 27.31 The Chief Finance Officer shall identify all costs directly incurred in the administration of all Funds held on Trust, and subject to any legal restrictions, and with the agreement of the Board, shall charge such costs to the appropriate Trust accounts.

Administration Costs

- 27.32 The Chief Finance Officer shall identify all costs directly incurred in the administration of all Funds held on Trust, and subject to any legal restrictions, and with the agreement of the Board, shall charge such costs to the appropriate Trust accounts.

Taxation and Excise Duty

- 27.33 The Chief Finance Officer shall ensure that the Trust's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of all required returns, and the recovery of deductions at source

28. Intellectual Property

- 28.1 The Chief Executive, as the accounting officer, will need to ensure that all intellectual property is identified, protected and used for the benefit of the Trust, the NHS and service users. Such intellectual property shall consist of creations of the Trust for which it holds exclusive rights which includes, but is not limited to, trade secrets, publications, trademarks, designs and patents.

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Identify and protect all intellectual property and trade secrets

- 28.2 The Managing Director will ensure that all intellectual property is identified and properly recorded in the Trust's Intellectual Property register.
- 28.3 The Managing Director will ensure that all third party Intellectual Property, upon which the Trust's Intellectual Property relies and is recorded in the register, is properly licensed from the third party for the intended usage and confers rights to sub-license as part of the Trust's Intellectual Property.
- 28.4 All staff are required to identify and protect the intellectual property of the Trust and ensure that is properly recorded in the Trust's Intellectual Property register.
- 28.5 The Managing Director will ensure that a Non-Disclosure Agreement is signed with any third party before disclosure or receipt of confidential information with the third party.
- 28.6 The Managing Director will ensure that all contracts of employment include conditions under which confidentiality of Trust and third party information should be maintained as part of the staff conditions of employment.
- 28.7 All documents containing commercially sensitive information must be marked 'Commercial in confidence'.
- 28.8 The Managing Director will ensure that all publications produced by the Trust are marked as Trust copyright. This will include, amongst other items, research reports, manuals, policy documents.

Registering of trademarks and patents

- 28.9 The Managing Director will identify trademarks and patents of specific value to the Trust and wider NHS and ensure that it is appropriately registered with the relevant authorities.

Licensing of Intellectual Property

- 28.10 The Managing Director is responsible for ensuring that the Trust licenses Intellectual Property to protect the property and reputation of the Trust from misuse, and to derive benefit for the Trust, NHS and service users.
- 28.11 All uses of the Trust's intellectual property by a third party must be licensed, whether there is a fee for usage or not. The license should take into account:

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- a. The scope of usage of Intellectual Property, including territories where the Intellectual Property may be used and the uses to which it may be put.
- b. Conditions of usage setting out how the Intellectual Property may, or may not be used, both to protect the property's value and the reputation of the Trust.
- c. The term of the license, including any conditions by which the Trust may terminate the license, including misuse.
- d. The benefit accruing to the Trust from the licensee's use of the Intellectual Property. This may include a financial benefit, or where no financial benefit is requested, may include promotion of the Trust, sharing of information, or other non-financial benefit which is to the benefit of the Trust, the NHS or service users.

28.12 The Managing Director is responsible for ensuring that the Trust enters into legal agreements with third parties where there is joint ownership of Intellectual Property.

28.13 The Managing Director is responsible for entering into agreements to share Intellectual Property between the Trust and the staff who created the Intellectual Property. In making such agreements should take into account:

- a. The Trust's ability to use the Intellectual Property should not be limited;
- b. Staff members will have no ability to sub-license the Intellectual Property;
- c. The benefits from usage or licensing of the Intellectual Property may be distributed to all parties of the agreement, including staff.

29. Monitoring Compliance

29.1 The SFIs detail the method of control, review and assessment required to seek assurance that the instructions laid down by the Trust are adhered to. Annual reports to the relevant Board or Committee are produced as required to demonstrate compliance and performance against the SFIs.

30. Review

30.1 This policy will be subject to a planned review every three years as part of the Trust's Policy Review Process. It is recognised however that there may be updates required in the interim arising from amendments or release of new regulations, Codes of Practice or statutory provisions or guidance from the Department of Health or professional bodies. These updates will be made as soon as practicable to reflect and inform the Trust's revised policy and practise.

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31. Training

- 31.1 Managers are responsible for ensuring all their staff receive the type of initial and refresher training that is commensurate with their role(s).
- 31.2 Staff must refer to the Mandatory Training Profiles, available on the intranet, to identify what training in relation to [insert subject here] is relevant for their role and the required frequency of update. Further information is available on the statutory and mandatory training web pages about each subject and the available training opportunities.
- 31.3 The Mandatory Training Policy identifies how training non-attendance will be followed up and managed and is available on the intranet.
- 31.4 Training statistics for mandatory training subjects are collated by the Learning & Development team, and are reported to the Strategic Workforce Committee
- 31.5 Staff must keep a record of all training in their portfolio.
- 31.6 All staff and managers can access their mandatory training compliance records via the Trust's mandatory reporting tool (STAR) available on the intranet.

32. Definitions of Terms Used

- 32.1 Any expression, to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions.
- 32.2 Wherever the title Chief Executive, Managing Director, Director, or other nominated officer is used in these instructions, it should be deemed to include other officers who have been duly authorised to represent them in their absence.
- 32.3 Save as otherwise permitted by law, at any meeting of the Board the Chair of the Trust (or the person presiding over the meeting) shall be the final authority on the interpretation of the SFIs (on which she/he should be advised by the Chief Executive, Managing Director, or the Chief Finance Officer) and her/his decision shall be final and binding except in the case of manifest error.
- 32.4 Wherever a financial limit is stipulated in these SFIs but no value is given, reference should be made to the Trust's Financial Limits contained within the Scheme of Delegation, which shall be issued to accompany the SFIs and Standing Orders. The Board should periodically review the Financial Limits.
- 32.5 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in these SFIs shall bear the same meaning as in the Constitution.

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In these SFIs:

the 2006 Act means the National Health Service Act 2006 (as amended);

the 2012 Act means the Health and Social Care Act 2012;

Accounting Officer means a person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 of the 2006 Act. The Chief Executive of the Trust is the Accounting Officer;

Annual Accounts means those accounts prepared by the Trust pursuant to paragraph 25 of Schedule 7 to the 2006 Act;

Annual Report means a report prepared by the Trust pursuant to paragraph 26 of Schedule 7 to the 2006 Act;

Auditor means the Auditor of the Trust appointed by the Council of Governors pursuant to the Constitution;

Audit Committee means a committee of the Board as established pursuant to the Constitution;

Authorisation means the authorisation issued to the Trust by NHS England(formally Monitor) under section 35 of the 2006 Act;

Board means the Board of Directors as constituted in accordance with the Constitution;

Budget means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the business functions of the Trust;

Budget Holder means the Director or Officer with delegated authority to manage business activity for a specific area of the Trust;

Budget Manager means the Officer who has daily operational responsibility for the management of the Budget;

Chair means the Chair of the Trust;

Council of Governors means the Council of Governors as constituted in accordance with the Constitution;

Chief Executive accountable Officer for all aspects of performance of the three organisations with the BSW system particularly around quality and safety, performance, and finance;

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Constitution means the Constitution of the Trust together with the annexes;

Director means a member of the Board who has voting rights;

Executive Director means an executive member of the Board of the Trust;

Chief Finance Officer means the Chief Financial Officer of the Trust;

Financial Limits means the financial limits set out in the Scheme of Delegation;

Financial Year means each successive period of twelve months beginning with 1 April;

Funds held on Trust means those funds which the Trust holds at the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers gained under the 2006 Act and shall include the income and interest derived from the holding of such funds all or some of which may or may not be charitable;

Local Counter Fraud Specialist means the person appointed by the Trust to carry out the responsibilities and functions set out in Section 24 of the NHS National Contract and NHS Counter Fraud Authority Anti-Fraud & Bribery Standards for Provider organisations;

Local Security Management Specialist means the person appointed by the Trust to carry out the responsibilities and functions set out in Section 24 of the NHS National Contract and NHS Counter Fraud Authority Security Management Standards for Provider organisations;

Managing Director Responsible for the overall management and performance of their Trust

Member means a member of the Trust;

NHS England means the body which from the 1 April 2016 which brought together Monitor, NHS Trust Development Authority, Patient Safety, Advancing Change Team and Intensive Support Teams.

NHS Counter Fraud Authority means the division established by Direction 2 of the NHS Business Services Authority Directions 2006 (as amended by the NHS Business Services Authority Amendment Directions 2011);

Non-Executive Director means a non-executive member of the Board of the Trust including the Chair;

Officer means an employee of the Trust and for the avoidance of doubt does not include

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Non-Executive Directors;

Nominations and Remuneration Committee shall have the meaning ascribed to it in SFI 11;

Secretary means the Secretary of the Trust or any other person or body corporate appointed to perform the duties of the Secretary of the Trust, including a joint, assistant or deputy secretary;

Standing Financial Instructions (SFIs) means these Standing Financial Instructions which regulate the conduct of the Trust's financial matters;

Standing Orders means the Standing Orders for the Council of Governors and the Standing Orders for the Board;

Trust means [Insert Trust name]

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Appendix 1: Authorisation Limits

Business Case Approval

Capital Business Cases Authorisation Limits – Values include VAT

Spend (incl. VAT)	Who Approves
Up to £250,000	Capital Prioritisation and Management Group (CPMG)
£250,001 – £1,000,000	Care Organisation Management Committee
Over £1,000,000	Board of Directors

Revenue Business Cases Authorisation Limits – Values include VAT

Spend (incl. VAT)	Who Approves
Up to £75,000	Divisional Review
Up to £1,000,000	Care Organisation Management Committee
Over £1,000,000	Board of Directors

Financial Approval

Financial limits for the Procurement Process and Placing Contracts

Contract value excl. VAT	quotes / tenders	Min number invited to quote / tender where available	Form of Contract	CRR required	Authorisation to approve CRR	Authority to sign a contract
<10k	Quotation may be obtained by end user	1	PO	No	NA	Associate Director of Procurement
>10k - 24,999k	Quotations may be obtained by end user - CRR & Procurement Act 2023 notices issued by procurement	2	PO	No	NA	Associate Director of Procurement
25 - 149,999k	Quotations obtained by Procurement - CRR & Procurement Act 2023 notices	3	Purchase Order and/or contract, as appropriate to the procurement	yes - Level 1 CRR	Associate Director of Procurement	Associate Director of Procurement

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	issued by procurement					
150 - 499k	Tender by procurement	4	Purchase Order or contract, as appropriate to the procurement	Yes - Level 2 CRR	Director of Procurement	Director of Procurement
500 - 999k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 2 CRR	Care Organisation Finance Lead	Care Organisation Finance Lead
1,000 - 1,499k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 2 CRR	CFO or Managing Director	Group CFO or Managing Director
1,500 - 1,999k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 3 CRR	CFO	CFO or CEO
>2,000k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 3 CRR	Board	CEO / Board Chair

For contracts that cover more than one financial year this should include the total value of contracts, over the 5 years including whole life cost not just the annual charge.

Revenue Authorisation Limits – Values exclude VAT

Role / Authority	Purchase Orders and Invoices	Other Payments *	Non-SLA sales orders & Credit Notes
Board of Directors	>£1,000,000	>£100,000	>£1,000,000
Chief Executive	£1,000,000	£100,000	£1,000,000
Chief Finance Officer	£1,000,000	£100,000	£1,000,000
Care Organisation Managing Director	£1,000,000	£100,000	£1,000,000
Executive Directors	£500,000	£50,000	£500,000
Divisional Director	£50,000	£1,000	£10,000
Budget Holders / Heads of Service	£10,000	£500	£1,000
Budget Manager	£2, 000	£100	£500

*Inclusive of but not limited to all additional staff payments such as overtime, waiting list initiatives and travel and subsistence payments. Petty cash can only be issued with approval from the budget holder for amounts less than £25. Amounts above £25 need to be agreed in advance of the expenditure being incurred by the Head of Financial Services and reported to the Divisional Finance Manager.

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Audit Committee

Terms of Reference

Audit Committee (AC) – provides an independent and objective review of financial and corporate governance, assurance processes and risk management; is authorised to seek information and obtain independent professional advice; and focuses on internal/external audit, counter-fraud, and compliance with licences, standing orders and codes of conduct.

It is proposed that for the BSW Group the three Audit Committees will meet in common.

1. Authority

- 1.1 The Committee is established by the Board of Directors and will be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.
- 1.2 The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.
- 1.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
- 1.4 The Committee provides independent and objective oversight of the adequacy and effectiveness of the Trust's governance, risk management and internal control arrangements, and works closely with other Audit Committees within the BSW Hospitals Group to support alignment of work plans, oversight activities and shared learning.
- 1.5 In conducting its business, members must demonstrably consider the equality, diversity and inclusion implications of decisions they make and consider whether in the management of risk control, the Trust achieves positive change around inclusion, equality and diversity.

2. Purpose

- 2.1 The Audit Committee serves a crucial oversight role, primarily focused on enhancing the Trust's governance, risk management, and internal control frameworks. Its core purpose includes overseeing the integrity of financial statements, ensuring the effectiveness of the internal audit function, monitoring compliance with legal and regulatory requirements, and assessing the independence and performance of external auditors. By scrutinizing financial reporting processes, internal controls, and the

management of financial and operational risks, the Audit Committee helps to ensure that the Trust operates in a transparent, efficient, and accountable manner, thereby contributing to the Trust's overall integrity and public confidence in its operations.

3. Membership and attendance

3.1 The Committee shall be composed of a minimum of:-

- Four Non-Executive Directors of the Trust with the exception of the Trust Chair.
- At least one of the members should have recent and relevant financial experience and should be appointed Chair of the Committee by the Board.
- The Deputy Chair of the Trust and the Senior Independent Director (SID) will not Chair the Committee.

3.2 The composition of the Committee should be given in the Trust's Annual Report.

3.3 The Chair of the Trust shall not be a member of the Committee.

3.4 A quorum will be two members.

3.5 The following are required to attend meetings of the Audit Committee in a non-voting capacity:

- Chief Financial Officer
- Head of Internal Audit
- Representatives of the External Auditors
- Anti-Fraud Specialist
- Company Secretary
- The Chief Executive Officer*

3.6 *Compulsory attendance* - The Chief Financial Officer (or in their absence their deputy and another Executive Director) is expected to attend regularly. The External and Internal Auditors shall normally attend as agreed by the Chair of the Committee. The Counter Fraud Specialist shall attend at least 2 meetings each year as agreed by the Chair of the Committee.

*The Chief Executive, as Accounting Officer, shall be invited to attend meetings and should discuss at least annually with the Committee, the process for assurance that supports the annual governance statement. The Chief Executive should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

3.7 Other Executive Directors or relevant members of staff may be co-opted or requested to attend for specific agenda items as necessary by invitation of the Audit Committee Chair.

3.8 *Substitutes/Deputies* - Where a member of the Committee is unable to attend a nominated representative may attend in their absence on approval of the Chair. A nominated representative will contribute towards quoracy.

- 3.9 *Voting* - Only the Non-Executive Directors who are members of the Committee may vote. When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.
- 3.10 *Additional meetings* – The External Auditor, the Head of Internal Audit and Counter Fraud Specialist have a right of direct access to the Chair. The Accounting Officer, external auditors, or Head of Internal Audit may request a meeting of the Committee if they consider that this is necessary. At least once each year the Committee will meet privately with the internal and external auditors.
- 3.11 *Frequency* - Meetings of the Committee shall take place at the frequency and timing necessary to enable discharge of its responsibilities and the Committee will routinely meet on a quarterly basis. Responsibility for calling meetings of the Committee shall rest with the Committee Chair.
- 3.12 Virtual meetings, subject to minimum quoracy requirements, will have full authority to take decisions; meetings will be recorded, and Minutes/Action Logs produced, in the normal way.

4. Duties

The Committee is responsible for:

4.1 Governance, risk management and internal control

- The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them.
- In particular, the Committee will review the adequacy of:
 - All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance to external bodies), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
 - The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
 - The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
 - The Trust's standing orders, standing financial instructions and scheme of delegation.

- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State directions and as required by the NHS Counter Fraud Authority.
- The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
- In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

4.2 **Internal Audit**

The Committee will ensure that there is an effective internal audit function established by management that meets mandatory government and Public Sector Internal Auditing Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- Reviewing the internal audit programme, considering the major findings of internal audit investigations (and management's response), and ensuring coordination between internal and external auditors
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- Annual review of the effectiveness of internal audit.

4.3 External Audit

The Committee shall review the independence, objectivity and work of the external auditor appointed by the Council of Governors and consider the implications and management's response to this work. This will be achieved by:

- Consideration of the appointment and performance of the external auditor, including making recommendations to the Council of Governors regarding the former.
- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure coordination with internal auditors and with other external auditors
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any audit work performed outside the annual audit plan, together with the appropriateness of management's response
- Recommending to the Council of Governors the engagement of the external auditor in respect of non-audit work, taking into account relevant ethical guidance regarding the provision of such services
- Annual review of the effectiveness of external audit.

4.4 Other assurance functions

- The Committee will review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to, reviews and reports by the Department of Health and Social Care, arm's length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Resolution, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc) or the Local Anti-Fraud Specialist.
- The Committee will receive the Clinical Audit Annual Plan on an annual basis, together with an update on progress of the plan at the mid-year point. The Annual Plan should be presented to the Committee alongside the Internal Audit Annual Plan to ensure a cross-referencing of items. The Committee's remit in receiving the plan will be to ensure transparency and accountability. The Committee will ensure appropriate consideration is given to alignment with relevant Group priorities and assurance plans.
- The Committee will provide oversight and monitor the effectiveness of the processes in place for delivery of the plan.
- The Committee will also review all suspensions of standing orders and variation or amendment to standing orders.
- The Audit Committee will report to the Board and to the Council of Governors any matters in respect of which it considers action or improvement is needed.

4.5 Counter fraud

The Audit Committee will satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the appointment of the Local Anti-Fraud Specialist. The Committee will review the outcomes of counter fraud work.

4.6 Group / System Collaboration

The Committee will consider the implications of Group and system working on the Trust's governance, risk and control environment and provide assurance to the Board as required.

In order to ensure an integrated approach and carry out the above duties effectively, the Committee will have effective relationships with all Board committees so that it understands processes and linkages and seeks assurance on their work.

The Committee may request specific reports from individual functions within the organisation in pursuance of its duties.

4.7 Financial reporting

- The Audit Committee shall monitor the integrity of the Annual financial statements of the Trust.
- The Audit Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.
- The Audit Committee will review the Trust's annual report and financial statements before submission to the Board, focusing particularly on:
 - The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
 - Changes in, and compliance with, accounting policies and practices
 - Unadjusted misstatements in the financial statements
 - Major judgmental areas, and
 - Significant adjustments resulting from the audit
 - Letter of representation
 - Qualitative aspects of financial reporting.

4.8 Systems for raising concerns

The committee shall review the effectiveness of the arrangements in place to allow staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

5. Conflicts of interest

If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, they will declare that interest as early as possible and act in accordance with the Trust's Conflicts of Interests

Policy. The Chair of the meeting will determine how a conflict of interest should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

6. Reporting

- 6.1 The Audit Committee will report to the Board of Directors.
- 6.2 A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members.
- 6.3 The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide commentary in support of the Annual Governance Statement (AGS), specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts.
- 6.4 Trust standing orders and standing financial instructions apply to the operation of the Audit Committee.

7. Administration of meetings

- 7.1 The Company Secretary will plan to ensure that the Committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chair and members.
- 7.2 Agendas and papers will be circulated at least five working days in advance of the meeting.
- 7.3 Minutes will be circulated to members as soon as is reasonably practicable.
- 7.4 A forward planner of agenda items shall be determined by the Chair.

8. Review

The Terms of Reference of the Audit Committee shall be reviewed and submitted for approval to the Board of Directors at least annually.

Approved by: [Trust Board]

Date of Approval: [Date]

Review Date: [Date - annually]

Version: Draft v0.5

Remuneration Committee

Terms of Reference

Remuneration Committee (RemCo) – provides independent and objective oversight of executive remuneration, senior appointments and workforce reward policy; is authorised to obtain information and independent professional advice; and focuses on fair, transparent and merit-based remuneration arrangements, recruitment processes, and alignment with NHS frameworks, organisational performance and good governance standards.

It is proposed that for the BSW Group the three Remuneration Committees will meet in common.

1. Authority

- 1.1 The Committee is established by the Board of Directors and will be known as the Remuneration Committee (the Committee). The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.
- 1.2 The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.
- 1.3 The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.
- 1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. Purpose

- 2.1 The Committee's primary responsibilities include overseeing the processes for recruiting and appointing senior leadership positions within the Trust, and ensuring there is a transparent and merit-based selection process. Additionally, the Committee is tasked with developing and reviewing policies related to the remuneration, incentives and terms of service for the Executive Directors, ensuring these are fair, competitive, and capable of attracting and retaining high-calibre talent necessary for the Trust's success.
- 2.2 The Committee will recommend and monitor the structure of remuneration including setting pay ranges and receiving relevant reports (at least annually) for the layer of management under the Executive Director not covered under Agenda for Change (AfC).

3. Duties

The Committee shall:

- 3.1 Coordinate the recruitment and appointment process for Executive Director roles.

- 3.2 Align job descriptions, person specifications and remuneration benchmarks.
- 3.3 Consider and discuss proposals for appointment and remuneration packages.
- 3.4 Review the structure, size and composition of the Board and make recommendations where appropriate.
- 3.5 It is for the Non-Executive Directors to appoint and remove the Chief Executive. The appointment of a Chief Executive requires the approval of the Council of Governors.
- 3.6 Both the appointment and removal of the Company Secretary should be a matter for the whole Board of Directors.
- 3.7 Ensure that the contractual terms of severance payments on termination of office for the CEO/Executive Directors are fair to the individual/organisation and in line with associated national guidance.
- 3.8 To ensure compliance with the requirement that the performance of Directors is reviewed annually through appraisal

4. Membership and Attendance

- 4.1 The members of the Committee shall be:
 - The Chair of the Trust
 - The Non-Executive Directors of the Trust.
- 4.2 The Committee will be chaired by the Chair of the Trust. In the absence of the Chair, the Vice-Chair or Senior Independent Director will chair the meeting.
- 4.3 In addition to members of the Committee, the following are required to attend and participate in the meetings of the Committee in a non-voting capacity except on those occasions when discussions or decisions relate to their own remuneration or terms of office:
 - Group Chief Executive Officer
 - Group Chief People Officer
 - Director of Corporate Governance / Company Secretary
- 4.4 Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations, at the discretion of the Chair.

Quorum

- 4.6 The quorum for meetings and necessary for the transaction of business is a minimum of 3 Non-Executive Directors (including the Chair or deputy Chair).

5. Conduct of Business

- 5.1 In conducting its business, the Committee will at all times seek to promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users including those who have protected characteristics and vulnerable members of our community.

Administration

- 5.2 The Company Secretary or their nominee will act as secretary to the Committee. The secretary will minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance.
- 5.3 Any member of the Committee can ask for an extraordinary meeting to be convened to meet business needs.

Notice of meetings

- 5.4 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be available to each member of the Committee and where appropriate, other persons required to attend, no later than five working days before the date of the meeting.

Reporting

- 5.5 The minutes of all meetings of the Committee shall be formally recorded and submitted to the next meeting for approval. An assurance report shall be available to the Board of Directors on request. Identified risks are to be escalated to the Board of Directors in accordance with the agreed assurance and escalation procedure.
- 5.6 The Committee will report annually to the Board of Directors in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.

6. Review

- 6.1 These Terms of Reference will be subject to an annual review or following any significant changes in the governance or legal frameworks.

Approved:

Version:

Date:

Report to:	Public Board of Directors	Agenda item:	19
Date of Meeting:	3 June 2026		

Title of Report:	Annual Review of Directors' Fit and Proper Persons Test
Status:	For noting
Board Sponsor:	Paul von der Heyde, Interim Group Chair
Author:	Roxy Milbourne, Interim Head of Corporate Governance Abby Strange, Corporate Governance Manager
Appendices	None

1. Executive Summary of the Report

In September 2023, NHS England launched the national Fit and Proper Person Test (FPPT) Framework guidance which takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles. The Framework sits in the wider context of good governance, leadership and Board development, and is intended to strengthen individual accountability for Board members, thus enhancing the quality of leadership within the NHS.

There is an ongoing requirement for individual assessments to be completed on currently serving Board members each year and as such the Board of Directors undertakes an annual review and declaration that Board members continue to meet the requirements of the FPPT framework.

This report provides confirmation to the Board that all necessary individual annual checks have been completed, and the evidence reviewed confirms that all serving members of the Board are fit and proper. All Board members have completed and signed their self-declarations confirming that they continue to meet the requirements of the Test. The requirements for the annual FPPT assessment have therefore been fully satisfied, and an overall summary submitted to the NHSE Team confirming compliance with the framework within the required deadline of 30 June 2026.

All FPPT checks have been undertaken in line with the Trust's Fit and Proper Person Policy.

2. Recommendations

The Board of Directors is asked to:

1. Note that the annual FPPT has been conducted for the period 2025/26 and that all current Board members satisfy the requirements.

3. Legal / Regulatory Implications

The requirements of the Fit and Proper Persons Test for Executive and Non-Executive Directors are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

NHS England developed the FPPT Framework to strengthen/reinforce individual accountability and transparency for board members, this came into effect in September 2023.

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

The CQC has the power to take enforcement action against the Trust if it considers that requirements of FPPR have not been complied with.

5. Resources Implications (Financial / staffing)

None

6. Equality and Diversity

All Board members, regardless of their voting rights are required to undertake fit and proper persons checks.

7. References to previous reports

This is an annual report presented to the Board of Directors.

8. Freedom of Information

This is a public Board paper.

9. Sustainability

The annual FPPT processes has been digitalised and all records are stored digitally.

10. Digital

The annual FPPT processes has been digitalised and all records are stored digitally.

Annual Fit and Proper Persons Test

1. Introduction

The Fit and Proper Person Regulation (FPPR) came into force for all NHS Trusts in November 2014 and requires all organisations to seek assurance that all Directors are fit to undertake the responsibilities of their role.

In September 2023, NHS England (NHSE) developed a Fit and Proper Person Test (FPPT) Framework in response to the recommendations made by the Kark Review in 2019. This was commissioned to establish why the FPPT was not being applied effectively and consistently and built upon the Francis Report which called for better regulation of NHS Board level Directors.

The FPPT framework came into effect from 30 September 2023, and it is a requirement that FPPT checks are undertaken annually. The next annual submission is required by 30 June 2026. The framework applies to all Executive and Non-Executive Board members, regardless of voting rights or whether an individual is permanent or interim.

2. Fit and Proper Person checks: New Appointment and Annual Assurance Checks

2.1 New Appointments

During the Financial year, new FPPT checks have been undertaken for the following Board members:

- Jonathan Hinchliffe, Group Chief Digital and Information Officer (Interim)
- Bernie Bluhm, Chief Operating Officer
- John Palmer, Managing Director

Where Group Executive and Non-Executive Directors have been appointed as part of the formation of BSW Hospitals Group, the employing Trust has undertaken responsibility for completion of FPPT checks. Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust are responsible for completing checks for the following Board members:

Great Western Hospitals NHS Foundation Trust

- Jude Gray, Group Chief People Officer
- Simon Wade, Group Chief Finance Officer
- Paul von der Heyde, Group Chair (Interim)

Salisbury NHS Foundation Trust

- Judy Dyos, Group Chief Strategic Officer (Interim)
- Mark Ellis, Group Chief Risk Officer

2.2 Existing Directors Annual Review Process

As part of the annual review process, all current Directors have been subject to the following checks.

- Satisfactory completion of the self-declaration

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- Search of insolvency and bankruptcy register.
- Search of Companies House register to ensure that no board member is disqualified as a director.
- Search of the Charity Commission's Register of Removed Trustees
- Web/social media search.

The Chair is accountable for ensuring the FPPT process is effective and that the desired culture of the Trust is maintained to support an effective regime. The Interim Head of Corporate Governance supports the Chair in ensuring that the appropriate processes are followed.

The annual FPPT processes at the Trust are aligned with NHSE recommendations as well as broader HR processes. They are well documented and are completed on an annual basis, and a Fit and Proper Persons Policy was implemented following the annual checks for 2024/25 to make the process more robust.

3. Outcome of the 2026 Annual FPPT checks and submission

All Board members have completed and signed their self-declarations confirming that they continue to meet the requirements of the Test. All necessary individual annual checks have been completed and the outcome of the FPPTs have been saved on each personal file and uploaded onto ESR.

All serving members of the Board continue to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test. An overall summary will be submitted to the regional NHSE Team to confirm compliance with the framework within the required deadline of 30 June 2026.

Between annual checks, each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and for bringing these issues to the attention of the Interim Head of Corporate Governance or Chair.

4. Recommendations

The Board is asked to:

- a) note that the FPPT has been conducted for the period 2025/26 and that all Board members satisfy the requirements.

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Report to:	Public Board of Directors	Agenda item:	20
Date of Meeting:	3 June 2026		

Title of Report:	Annual Review of Directors' Interests
Status:	For Approval
Board Sponsor:	Paul von der Heyde, Interim Group Chair
Author:	Roxy Milbourne, Interim Head of Corporate Governance
Appendices	Appendix 1: Directors Declarations of Interest

1. Executive Summary of the Report

The Trust's Managing Conflicts of Interest Policy requires all staff to declare relevant interests which are recorded on a central register of interest.

All "Decision Making" staff (which includes Directors, all staff at band 8D and above and those with substantial budgetary responsibility) are required to make an annual declaration of interests, which are published on the Trust website.

It is good practice for the Board of Directors to receive and review the interests declared by its members at least once a year for approval, and these are included at appendix 1.

The Board is also reminded of the requirement to declare interests at meetings when matters in which there is an interest are being considered and the requirement to withdraw from the meeting during their consideration.

2. Recommendations

The Board of Directors is asked to approve the Register of Directors' Interests as at 3 June 2026 and highlight any anomalies.

3. Legal / Regulatory Implications

All NHS Directors are legally required to declare their interests. This requirement is outlined in the Code of Governance for NHS Provider Trusts.

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

The consequences of not dealing with a conflict of interest can be significant. It can result in reputational risk, a failure to act in the best interest of the RUH, and poor governance.

5. Resources Implications (Financial / staffing)

None

6. Equality and Diversity

All Board members are required to declare interests as they arise.

7. References to previous reports

This is an annual report presented to the Board of Directors.

8.	Freedom of Information
This is a public Board paper.	

9.	Sustainability
The Declarations of Interest processes has been digitalised and all records are stored digitally.	

10.	Digital
The Declarations of Interest processes has been digitalised and all records are stored digitally.	

Annual Review of Directors' Interests

Introduction

The Trust's Managing Conflicts of Interest Policy requires all staff to declare relevant interests which are recorded on a central register of interest. Additionally, all "Decision Making" staff (which includes Directors, all staff at band 8D and above and those with substantial budgetary responsibility) are required to make an annual declaration of interests, which are published on the Trust website.

It is good practice for the Board of Directors to receive and review the interests declared by its members at least once a year for approval, and these are presented overleaf.

The Board is also reminded of the requirement to declare interests at meetings when matters in which there is an interest are being considered and the requirement to withdraw from the meeting during their consideration.

Board of Directors Declared Interests

The interests documented overleaf have been declared by the members of the Board of Directors, and they have been approved by the Chief Executive, Interim Managing Director, or Chair, or in the case of the Chair's interests, by the Senior Independent Director.

The interests that have been marked as 'ceased' will remain on the register for 6 months in line with the Managing Conflicts of Interest Policy.

Recommendations

The Board of Directors is asked to approve the Register of Directors' Interests as at 3 June 2026 and highlight any anomalies.

Surname	First Name	Role	Declared Interest
Bavalia	Kheelna	Chief Medical Officer (Interim)	• Trustee of Shooting Star Children's Hospices.
Bluhm	Bernie	Chief Operating Officer	• Nil.
Charles-Barks	Cara	Chief Executive	• Group CEO for Royal United Hospitals, Great Western Hospitals and Salisbury Foundation Trust. • Appointed Honorary Colonel of 243 Multi-role Medical Regiment, part of the Army Reserve Medical Services. • Director of Chatham Row Management Company Ltd, a residents property management company. • Visiting Professor in the Faculty of Health and Applied Sciences at the University of the West of England.
Coleman	Liam	Non-Executive Director	• Interim Chair of the Financial Ombudsman Service. • Group Chair of the London and Quadrant Housing Trust.
Durbacz	Antony	Non-Executive Director	• Independent Governor at Bath Spa University. • Daughter is on rotation as a registrar in Obstetrics and Gynaecology in the Severn region. • Trustee at Wessex Learning Trust.
Dyos	Judy	Group Chief Strategic Officer (Interim)	• Nil.
Ellis	Mark	Group Chief Risk Officer	• Director of STL, a wholly owned subsidiary of Salisbury NHS Foundation Trust.

Surname	First Name	Role	Declared Interest
Fairhurst	Paul	Non-Executive Director	• Trustee of Designability (UK Charity). • Trustee of Back-Up (UK Charity).
Gray	Jude	Group Chief People Officer	• Trustee of ICP Support, a charity supporting women and their families who experience ICP in pregnancy. • Trustee of Gympanzees, a charity providing fun and fitness for disabled children and young people. • Son is a senior manager at Deloitte (ceased 11/01/26).
Harrod	Simon	Non-Executive Director	• Trustee of Amesbury History Centre.
Hinchliffe	Jonathan	Group Chief Digital and Information Officer (Interim)	• Delivery Director at St Vincents Consultancy, a company that provides interim roles and consultancy support to the NHS. Employed as Interim Group Chief Digital and Information Officer for BSW Hospitals Group via St Vincents Consultancy.
Hollowood	Andrew	Group Clinical Strategic Transformation Director	• Wife is a General Practitioner at Hartcliffe Surgery, Bristol.
Hutchison	Sumita	Non-Executive Director	• Volunteer for the Save the Soil movement. • Non-Executive Director at Gloucestershire Health and Care NHS Foundation Trust (ceased 18/01/26). • Chair of West of England Nature Partnership. • Trustee of Avon Wildlife Trust. • Governor of Bristol Grammar School. Professional association with Ian Chesham, RUH Charity Investment Manager, who also sits on the school Board of Governors. • On the Board of Office for Students.

Surname	First Name	Role	Declared Interest
Luxford	Joy	Non-Executive Director	• Husband runs an IT Cyber Security Business that the Trust contacted in May 2025 to raise an order for services. This was done on normal business terms without any awareness or influence from either party. • Director of Iconoclast Global Limited (ceased April 2026). • Non-Executive Director of Alliance Homes and Chair of their Audit and Risk Committee. • Member of ICAEW, a chartered accounting body. • Co-Chair of Pride in Place, a government back initiative in Twerton under B&NES.
Lynch	Antonia	Chief Nursing Officer	• Spouse is a Matron at Great Western Hospitals NHS Foundation Trust.
Palmer	John	Managing Director	• Nil.
Von der Heyde	Paul	Group Chair (Interim)	• Paul was appointed on 1 April, and we are awaiting this information.
Wade	Simon	Group Chief Finance Officer	• Nil.