Bundle Council of Governors 24 February 2026

Royal United Hospitals Bath
NHS Foundation Trust

Public Meeting of the Council of Governors of the Royal United Hospitals Bath NHS Foundation Trust

Tuesday 24th February 2026, 15:00 – 17:00

Venue: Room T0.24, Bath Spa University Sion Hill Campus, Sion Hill, Bath, BA1 5SF

No	Item	Presenter	Action	Time	Enc.
Governor Networking Session: 14:30 – 15:00					
Opening Business					
1.	Welcome, Introduction and Apologies: Cara Charles-Barks, Deborah Wilson, Ian Thorn, Paul Newman	Liam Coleman, Interim Chair	-	15:00	-
2.	Declarations of Interest		To note		-
3.	Minutes of the Council of Governors Meeting held on • 15th December 2025 • 3rd February 2026		For approval		Enc.
4.	Action List and Matters Arising		For approval		Enc.
Local Care Organisation Update					
5.	Update from the Chief Executive and Managing Director • Group Update • Operational Performance • Financial Position	John Palmer, Managing Director	For info	15:10	Enc.
6.	RUH Strategic and Business Plan Update • 2026/27 Strategic Plans and A3s	Rhi Hills, Director of Transformation	For info	15:40	Enc.
Governance					
7.	Item withdrawn				
8.	NED Feedback and Governor Assurance Questions • No new questions raised since the Council met in December 2025. There are no open questions	Non-Executive Directors / Governors	For disc.	16:10	Verbal
9.	Appointment of Deputy Lead Governor	Roxy Milbourne, Interim Head of Corporate Governance	For approval	16:20	Enc.
10.	Working Group Proposal	Kate Cozens, Lead Governor / Roxy Milbourne, Interim Head of Corporate Governance	For approval	16:25	Enc.

Governor Updates					
11.	Lead Governor Report	Kate Cozens, Lead Governor	For info	16:35	Verbal
12.	Joint Councils of Governors Nomination and Remuneration Committee Update	Kate Cozens, Lead Governor	For info	16:45	Verbal
13.	Stakeholder Governor Feedback	All Stakeholder Governors	To note	16:50	Verbal
Closing Business					
14.	Items for Future Work Plan / AOB	Liam Coleman, Interim Chair	For disc.	16:55	Verbal
Date of Next Meeting: 10th June 2026, 14:00 – 17:00 **Venue:** To be confirmed					

Key:
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

Minutes of the Public Meeting of the Council of Governors of the Royal United Hospitals Bath NHS Foundation Trust
Monday 15th December 2025, 15:00 – 17:00
Microsoft Teams

Present:
Liam Coleman, Interim Chair

Public Governors	Staff Governors	Stakeholder Governors
Anne-Marie Walker	Craig Jones	Cllr Ian Thorn *(until 16:00)*
Paul Newman	Anthony Green	
Rachel Walker	Fi Abbey	
Ming Keng Teoh		
Vic Pritchard		
Kate Cozens		
Chris Leadbeater		
Anna Beria		

In attendance:
Roxy Milbourne, Interim Head of Corporate Governance
Cara Charles-Barks, Chief Executive
John Palmer, Managing Director
Sumita Hutchison, Interim Vice-Chair
Paul Fairhurst, Non-Executive Director
Simon Harrod, Non-Executive Director
Joy Luxford, Non-Executive Director
Antony Durbacz, Non-Executive Director
Abby Strange, Corporate Governance Manager *(minute taker)*

CG/25/12/01 Chair's welcome, introduction and apologies
The Chair welcomed everyone to the meeting. Apologies had been received from Hannah Morley, Non-Executive Director, and the following Governors:

Public Governors	Staff Governors	Stakeholder Governors
Ian Lafferty	Gary Chamberlain	Alison Born
Adam Cooksey	Craig Sanders	Lucy Baker
Nick Craw		Deborah Wilson

CG/25/12/02 Declarations of Interest relevant to items on the agenda
The Interim Chair noted that Kate Cozens had a conflict of interest in terms of agenda item 10 but determined that it was not necessary for her to step out of the meeting. No other declarations of interest were raised.

CG/25/12/03 Approval of the minutes of the Council of Governors meeting held in public on 11th September 2025

The minutes of the meeting held on 11th September 2025 were approved as a true and accurate record of the meeting.

CG/25/12/04 Action List and Matters Arising

The action list was reviewed and the actions presented for closure were approved.

CG/25/12/05 Update from the Chief Executive and Managing Director

The Chief Executive reported that the key focus across the Group was performance and financial recovery. A notable amount of work had taken place around the financial recovery to stabilise the position but significantly more needed to be done before year end. A Turnaround Team was now in place at the RUH to support the delivery of its agreed £17m year end deficit and this work would be extrapolated across to Great Western Hospitals (GWH) and Salisbury Foundation Trust (SFT) who were experiencing similar pressures. Urgent and Emergency Care (UEC) remained challenged and a UEC reset month has been launched with local authority and community partners working on site to support the reduction of Non-Criteria to Reside (NCTR) and to ensure ambulance colleagues were supporting patients to access appropriate care. The Q2 national ratings had been released and the RUH position had improved from 112 and 105. The Trust remained in National Oversight Framework 4 but continued to improve.

The Managing Director reported that there had been an exponential growth in demand in UEC at the Trust and a significant increase in flu, which was likely to peak in January. The British Medical Association had announced that resident doctor strike action would go ahead on 17th December 2025, and preparatory meetings were taking place. A winter plan was in place and there had been good support from the Integrated Care Board, with additional spend being made available for the overnight workforce in ED and virtual ward beds and steps being taken to operationalise ward 4 at St Martins Hospital. There was a significant level of demand on staff and a call to action had been launched to enable them to focus on delivering on key performance metrics while maintaining safety. This was having a considerable impact with 4 hour performance at 64% despite the increase in demand in UEC, continued improvement in the deficit position, diagnostics below 30% and under 100 patients now waiting over 65 weeks. Cancer 28 day performance had also improved to 65% and the Equality and Quality Impact Assessment process was being embedded across the organisation to maintain safety.

Vic Pritchard sought clarity on what could be done to reduce NCTR to 9% in a safe way and how the RUH compared to GWH and SFT. The Chief Executive advised that the UEC reset was the system equivalent of the RUH call to action and required a commitment from all partner organisations to create a step change. This would provide clarity around what was needed and would enable timelier escalation of issues to generate a system based response. It was difficult to compare the 3 organisations within the Group in that they each experienced different challenges, but GWH and the RUH were under significant pressure in terms of volume and overcrowding.

Fi Abbey indicated that she had received positive feedback around the Managing Directors' Leadership approach but observed that the call to action did not account for staff wellbeing. She emphasised the need to ensure that the focus on improving performance metrics was not to the detriment of staff. The Managing Director agreed that staff wellbeing was a priority and advised that the next call to action session would focus on this in response to recent feedback. The Chief Executive added that it was important to achieve a balance in terms of taking challenging decisions with humanity and that it was essential to communicate with staff in an honest way so that they could understand the context around this.

Ming Keng Teoh sought clarity around the underlying deficit. The Chief Executive confirmed that the Group had a £100m underlying deficit and needed to collectively resolve this pressure, particularly given that deficit support funding would be removed over the next 2 years.

The Council of Governors noted the report.

CG/25/12/06 RUH Strategic and Business Plan Update

The Interim Chair welcomed the Director of Transformation to the meeting who provided an update on the business planning process for 26/27 and progress to date. She outlined the planning context and challenges, the strategic planning timeline and A3 refresh, and the 26/27 operational planning timeline and approach. The first draft submission was due to be submitted to NHS England on 17th December 2025 and was based on a top down approach. The final submission was due to be submitted on 12th February 2026 and would overlay the top down approach with bottom up planning to strengthen plans and support assessment of deliverability and key risks.

Fi Abbey sought clarity on when the Group strategy would be developed. The Chief Executive confirmed that work would commence post April 2026 to enable the organisations to focus on recovery.

Rachel Walker sought clarity on the purpose of the strategic A3s. The Director of Transformation explained that they were designed to be a structured problem solving exercise involving various steps to review the vision, the current position, and the issues that needed to be resolved. It also contained different assessments to identify ideas and tools to deliver the change that was required.

Anna Beria asked how staff were engaged in the planning process. The Director of Transformation indicated that this could be challenging but deep dives supported staff input and priorities were identified and communicated to support teams in understanding how they could contribute to delivering an improvement. Teams were also supported to review data to determine what their own priorities should be.

The Council of Governors noted the planning approach and the timeline for full plan submission.

CG/25/12/07 NED Feedback including Governor Log of Assurance Questions

Sumita Hutchison and Paul Fairhurst provided an overview of the question NOV25 and the feedback that had been received in relation to the corporate services redesign and the communication around this. They advised that they had met with the Staff Governors for an honest and productive discussion and the feedback had been shared with the Board. The Chief People Officer had since held an open staff forum to provide greater clarity around the corporate services redesign and monthly meetings had been set up between the Non-Executive Directors and Staff Governors to ensure that they could share insights on a regular basis. The Staff Governors were thanked for raising this issue.

The Council of Governors noted the report and closed assurance question NOV25.

CG/25/12/08 Election Results

The Interim Head of Corporate Governance reported that the process to elect new Governors began on 8th September 2025 and Civica Engagement Services had acted as the Trust's Returning Officer, distributing and receiving all election material. All eligible members were able to put themselves forward and the successful candidates who were detailed in the report, began their terms on 3rd November 2025.

The Corporate Governance Team had not heard from the successful candidate for Mendip despite reaching out via email and phone and would attempt to contact them via post. If contact could not be made, the Constitution enabled contact to be made with the next highest polling candidate. Similarly, one of the Staff Governors had left the Trust and the next highest polling candidate from the most recent elections would be approached in line with the Constitution.

The Council of Governors noted the election results.

CG/25/12/09 Annual Declarations of Interest

The Interim Head of Corporate Governance reported that the Trust's Constitution required Governors to declare interests that could conflict with the impartial discharge of their duties and presented the Register of Governor Interests for information, advising that the Council was responsible for noting this on an annual basis.

The Council of Governors noted the Register of Governor Interests.

CG/25/12/10 Appointment of Lead and Deputy Lead Governor

The Interim Head of Corporate Governance reported that the previous Lead and Deputy Lead Governors had chosen not to stand for re-election during the 2025 constituency-wide elections and an election had recently been held to elect a new Lead and Deputy Lead Governor. The agreed process was followed, and Kate Cozens and Ian Lafferty had put themselves forward for the role of Lead Governor, with no expressions of interest received for the role of Deputy Lead Governor. Kate Cozens received the highest number of votes and Ian Lafferty was subsequently invited to take on the role of Deputy Lead Governor but declined to do so. Two expressions of interest had since

been received for the role of Deputy Lead Governor, and to give all Governors an opportunity to express interest, the Corporate Governance Team would write to all Governors following the meeting to ensure they had the opportunity to put themselves forward.

The Council of Governors approved the appointment of Kate Cozens, Public Governor, Mendip as Lead Governor and noted that the same appointment process would be followed to appoint a Deputy Lead Governor.

CG/25/12/11 Working Group Proposal

The Interim Head of Corporate Governance provided an overview of work that had been undertaken in 2024 to review the working group structure. This had been led by a Task and Finish Group which had been established by the Council of Governors in response to feedback from NHS Providers and Governors around the number of working groups, adequate Governor representation, and the need to identify a sustainable model. This culminated in the Council of Governors approving a proposal to continue with the existing structure and to try and make it more effective and efficient. The agreement was to review the situation in June 2025 but following the subsequent departure of colleagues from the Corporate Governance Team and the limited availability of some Governors, no working groups had been convened since May 2025.

Following the recent Governor election and the intake of new Governors, it was proposed that the Council of Governors and Corporate Governance Team worked together to create a sustainable way forward, recognising the core statutory responsibilities, Governor availability, the support that the Corporate Governance Team could provide, and longer term changes that were likely to take place as part of the establishment of BSW Hospitals Group. It was suggested that a new Task and Finish Group was formed and led by the Lead Governor in the new year to agree a way forward.

Paul Newman observed that the existing structure aligned with the Board sub-Committees and suggested that this should be considered when developing the new proposal. He asked whether SFT and GWH could share any learning. The Interim Head of Corporate Governance indicated that SFT and GWH had similar structures and were looking to simplify for the same reasons as the RUH. She added that their Governors did not observe board sub-committees

The Council of Governors discussed the proposal and welcomed a reduction in working groups with improved communication and methods of working to minimise the demand on Governor time. They agreed that the Lead Governor and Interim Head of Corporate Governance would form a small Task and Finish Group in January 2026 with a view to bringing a proposal to the Council in March 2026. The Interim Head of Corporate Governance advised that expressions of interest would be sought from all Governors via email.

Action: Interim Head of Corporate Governance / Lead Governor

CG/25/12/12 Stakeholder Governor Feedback

The Interim Head of Corporate Governance advised that Cllr Ian Thorn had left the meeting early and any feedback would be circulated via email.

CG/25/12/13 Items for Future Work Plan / Any Other Business

Kate Cozens and Paul Newman provided an update on the progress of the Group Council of Governors Nomination and Remuneration Committee to appoint the substantive Group Chair.

No additional items were identified for the future work plan.

The meeting closed at: 16:30

Royal United Hospitals Bath
NHS Foundation Trust

Minutes of the Extraordinary Council of Governors of the Royal United Hospitals Bath NHS Foundation Trust
Tuesday 3rd February 2026, 13:45-13:50
First Floor, Beacon House, Devizes, SN10 2EY

Present:
Liam Coleman, Interim Chair

Public Governors	Staff Governors	Stakeholder Governors
Paul Newman	Craig Jones	Deborah Wilson
Anna Beria	Gary Chamberlain	
Ian Lafferty	Fi Abbey	
Kate Cozens		

In attendance:
Roxy Milbourne, Interim Head of Corporate Governance

CG/26/02/01 Welcome, Introduction and Apologies
The Chair welcomed everyone to the meeting and confirmed that the meeting was quorate. He noted apologies had been received from those listed below:

Public Governors	Staff Governors	Stakeholder Governors
Adam Cooksey	Anthony Green	Lucy Baker
Chris Leadbeater	Fiona Marfleet	Alison Born
Vic Pritchard		Ian Thorn
Ming-Keng Teoh		
Anne- Marie Walker		
Rachel Walker		

CG/26/02/02 Proposal Regarding Interim Group Chair Arrangements
The Chair confirmed that the Council of Governors of the RUH, Salisbury NHS Foundation Trust and Great Western Hospital NHS Foundation Trust had met in common to receive an overview of the proposal regarding the Interim Group Chair arrangements.

It was confirmed that the extraordinary Joint Council of Governors Nominations & Remuneration Committee had met on Wednesday 28 January and agreed to pause the substantive Group Chair recruitment process as only one candidate remained. The panel concluded that proceeding with only one candidate would not provide an appropriate level of competition for such a significant appointment. It was therefore recommended to the Councils of Governors that the Group appoint an Interim Group Chair for an 18-month term.

The Council of Governors:
1. Approved the appointment of an Interim Group Chair for an 18-month term.

2. Approved the inclusion of the proposed amendments to the job description to ensure suitability for an interim appointment.

It was noted that the Interim Group Chair appointment would progress on behalf of the three Councils of Governors via the Joint Council of Governors Nominations & Remuneration Committee.

The meeting closed at 13:50

Agenda Item: 4.0

Action list of the Council of Governors of the Royal United Hospitals Bath NHS Foundation Trust following the meeting held on 15th December 2025 and 3rd February 2026

Action No	Details	Agenda Item Number	First Raised	Action by	Progress Update & Status	Lead
CG283	**Working Group Proposal** Interim Head of Corporate Governance and Lead Governor to seek expressions of interest from Governors to form a small Working Group Task and Finish Group.	**CG/25/12/11**	Dec 2025	Feb 2026	Complete. Expressions of interest initially sought via the January Monthly Governor Round-Up email. A follow up email was sent on 13th January 2026. **To close**	Interim Head of Corporate Governance / Lead Governor

Matters arising:

1. Key Headlines for Public Awareness

- The Council of Governors met extraordinarily on 3rd February 2026 to consider urgent proposals relating to the Interim Group Chair arrangements across the RUH, Salisbury NHS FT and Great Western Hospitals NHS FT.
- The meeting was quorate, and apologies were noted from a wide range of public, staff, and stakeholder governors.
- The Joint Council of Governors Nominations & Remuneration Committee had reviewed the Group Chair recruitment process and advised that, due to only one candidate remaining, the substantive recruitment should be paused.

2. Decisions Taken or Escalations

Decisions:

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

Escalations / Follow-On Governance Route:

- The appointment process for the Interim Group Chair will now proceed via the Joint Council of Governors Nominations & Remuneration Committee on behalf of all three Councils of Governors.

Report to:	**Council of Governors**	**Agenda item:**	**5**
Date of Meeting:	**24 February 2026**		
Title of Report:	**Chief Executive & Managing Directors Report**		
Status:	**For Information**		
Board Sponsor:	**Cara Charles-Barks, Chief Executive Officer & John Palmer, Managing Director**		
Author:	**Helen Perkins, Senior Executive Assistant to Chief Executive and Roxy Milbourne, Interim Head of Corporate Governance**		
Appendices	**None**		

1. Executive Summary of the Report

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

Chief Executive's Report

- Risks including financial position and performance pressures

Group

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

National update

- Resident Doctors Industrial Action
- NHS Oversight Framework

Managing Director's Report

- Local (RUH)
  - Operational
  - Finance
  - Turnaround update
  - Medium term financial plan
  - Quality
  - Call to action
  - Consultant Appointments
  - RUH In the News – a selection of news stories from the past two months

2.	Recommendations (Note, Approve, Discuss)
The Council 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 Council of Governors meeting.	

8.	Freedom of Information
Public	

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

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

Group Chief Executive and Managing Director Report

GROUP CHIEF EXECUTIVE'S REPORT

Risks

Financial Position & Recovery

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

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

Urgent & Emergency Care (UEC) Update

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

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

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

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

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

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

Elective

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

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

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

National Update

Resident Doctors Industrial Action

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

NHS Oversight Framework – NHS Trust Performance League Tables

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

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

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

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

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

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

Group Development

Joint Committee

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

Leadership Team

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

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

Group Governance and Assurance Arrangements and Transition Roadmap

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

Group Priorities and Prioritisation Approach.

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

1. Recovery (Performance & Finance)

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

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

EPR Deployment Options Appraisal

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

Clinical Transformation Programme.

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

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

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

Corporate Services Programme

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

Group Board-to-Board Development Days.

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

Councils of Governors Workshop

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

MANAGING DIRECTOR'S REPORT

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

Key improvements include zero 65 week waiters as of 31st December 2025, an improved ranking on the 4-hour standard (for all types performance) with the RUH improving from 113/123 in October to 110/123 in November, and we have seen a step increase in our Cancer 28 day faster diagnosis from 52.9% in September 2025 to 75.3% in December 2025 (+22.4%). Further details on all operational performance and financial recovery are provided below.

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

1. Operational

Urgent and Emergency Care

4-hour performance has improved, with type 1 performance improving from 56.63% in October to 57.70% in November, and all types performance improving from 65.3% in October to 66.90% in November. The average ambulance handover time has improved further to 31.6 minutes against a target of 33 minutes. RUH has commenced with a UEC reset plan which will focus on refreshing internal professional standards, improving board/ward rounds, redesign of escalation processes and streaming within ED Majors and UTC.

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

Referral to Treatment

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

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

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

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

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

As we look forward to Q4, we will continue to rely on insourcing activity for a small number of our specialities and as part of our planning for 26/27 we will be exploring all opportunities to remove our reliance on insourcing through improved productivity and efficiency and by right sizing our capacity to meet our demand.

Cancer
Performance improved in October against all three of the standards but remained under the national target. The most notable improvements were in Breast and Skin.
However, 62 day performance will deteriorate from November to January due to recovery of the Skin Minor Ops (MOPS) backlog with more breach patients being treated. An executive decision was made to work through all of the backlog using all additional capacity and modelling has identified that we will achieve this by the end of January. We would then expect us to achieve our planned end of March position. We are in contact with our regional and national cancer colleagues and our Chief Operating Officer is providing an enhanced level of scrutiny and leadership to the cancer PTL meetings.

Diagnostics
In November, 71.05% of patients received their diagnostic within the 6-weeks against the 71.60% target. 102 additional diagnostic tests were delivered in month, compared to October.

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

2. Finance

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

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

The drivers of variance to trajectory in month are:

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

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

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

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

Divisional Position against total trajectory

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

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

3. Turnaround update – Programme summary

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

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

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

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

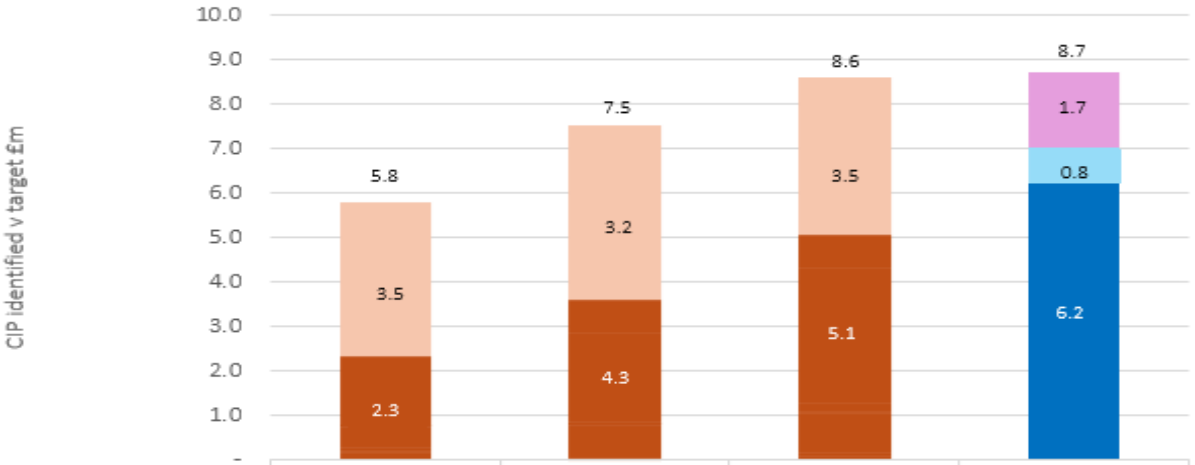
- Sickness policy revision to reduce sickness rates which have arisen in recent months; and
- High-cost drugs funding shortfall discussion with Commissioners raised with group CFO.

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

The following observations are made:

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

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

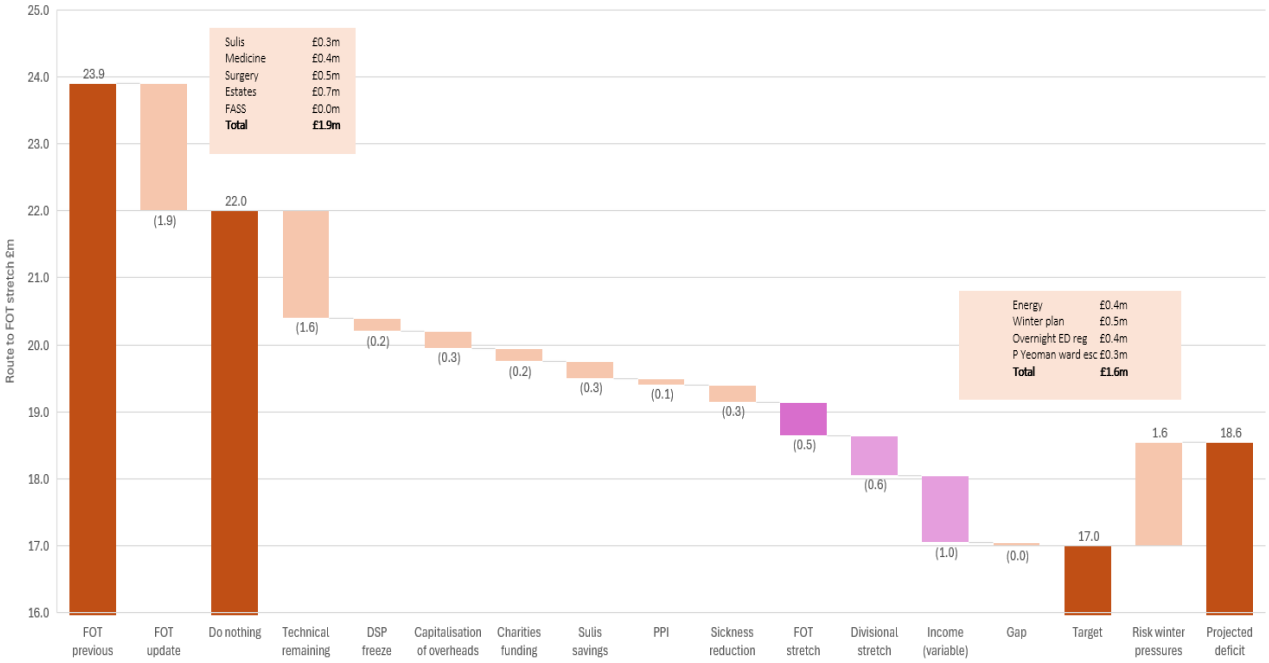


	W3	W4	W5	Target
Stretch	3.5	3.9	3.5	
Target group				1.7
Target RUH M8 uplift				0.8
Target RUH baseline				6.2
Sulis		0.8	0.8	
Technical	1.5	2.0	3.0	
Corporate	0.0	0.1	0.2	
HR	0.0	0.0	0.0	
E&F	0.5	0.7	0.9	
Surgery	0.1	0.0	0.1	
Medicine	0.1	0.0	0.1	
FASS	0.2	0.0	0.0	
Total	5.8	7.5	8.6	8.7

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

Indicative opportunities – Route to Control total £17m Deficit

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



4. Medium Term Financial Plan

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

The headlines are:

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

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

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

Current position versus NHSE expectation(5.12.2025)

	Metric	Latest RUH position (Oct '25)	RUH plan Mar '26	26/27 NHSE Instruction	26/27 RUH Plan	27/28 NHSE Instruction	27/28 RUH Plan	28/29 NHSE Instruction	28/29 RUH Plan
UEC	4-hour ED performance RUH and MIU Footprint	65.3%	78%	82% by Mar '27	75.3%	83%	76.1%	85%	TBC
	12-hour ED performance	9.1%	4.9%	3.9%	7.0%	Year on year reduction	6.9%	Year on year reduction	TBC
	Ambulance handover	37 mins	33 mins	Reduce toward 15 mins	31 mins	Further improvement	31 mins	15 mins	TBC
Elective & Diagnostic	18w RTT Performance	60.7%	67.7%	74.7% for RUH *(65% or 7% improvement, whichever is higher.)*	74.7%	To bridge the ask between74.7% and 92% constitutional standard	78.9%	92%	TBC
	DM01	70.5%	83.9%	86.9% for RUH *(3% improvement)*	12.5%	To bridge the ask between 86.9% and 99%	9.0%	99%	TBC
Cancer	28d FDS	53.7% (Sep '25)	80.2%	80%	76.1%	80%	76.1%	80%	TBC
	31d	91% (Sep '25)	93.7%	94%	94.7%	96%	96.1%	96%	TBC
	62d RTT	58.3% (Sep '25)	75.3%	80%	70.0%	82.5%	70.0%	85%	TBC
Workforce	30% Reduction in agency use	13.6 WTE	5.0 WTE	*30% improvement relative to M6*	5 WTE	Improvement	4 WTE	Zero agency spend	TBC
	10% reduction in bank spend	268.8 WTE	261 WTE	*10% reduction relative to M6*	-11 WTE	Improvement	-6 WTE	30% reduction relative to 25/26	-6 WTE
	Sickness rate (rolling 12 month average)	4.97% (Sep '25)	5.3%	Improvement	4.8%	Improvement	4.6%	4.1%	4.4%
Finance	2% productivity improvement	2.4%	6.7%	% for RUH *(2% improvement)*	2%		2%	"Sustained improvement"	2%
	Savings Plan		15.0m (29.7m)		36.1m		10.0m		8.6m
	Balanced or surplus financial position	-£14.1m	-£17m	Balance or surplus	-1.6m		0.0m	Balance or surplus	10.9m

RUH 3 year financial plan

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

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

5. Quality

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

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

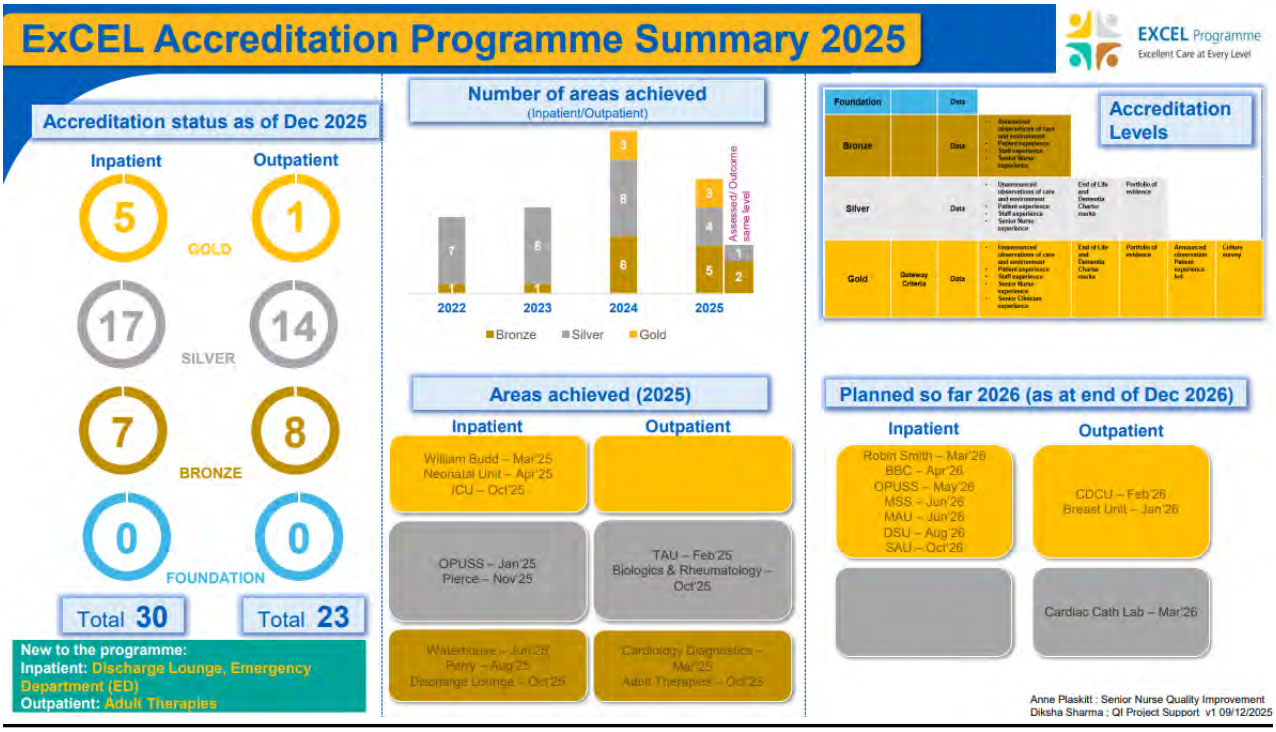
Following immediate feedback the Trust has made improvements to three key areas:

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

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

Accreditation

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



6. Use of Trust Seal

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

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

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

7. Membership

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

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

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

8. Consultant Appointments

The following Consultant appointments were made since the last report:

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

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

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

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

Birth registration services available at the RUH

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

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

Local GP shares pancreatic cancer experience to urge early detection

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

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

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

RUH Bath maternity team praised in latest national CQC survey

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

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

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

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

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

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

RUH's Musician in Residence spreads festive cheer at Christmas

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

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

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

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Council of Governors**	**Agenda item:**	**6**
Date of Meeting:	**24 February 2026**		

Title of Report:	**RUH Strategic Business Planning**
Status:	**For Information and discussion**
Board Sponsor:	**Rhiannon Hills, Director of Transformation**
Author:	**Lisa Lewis, Head of Coach House**
Appendices	**Appendix 1: Strategic Business Planning Update** **Appendix A: Strategic A3's**

1. Executive Summary of the Report

This paper provides a summary of the Strategic Business Planning process and the proposed RUH care organisation priorities for 2026/27.

Strategic A3 Annual Refresh

As part of the annual business planning process, the organisation undertakes a refresh of its strategic objectives, Vision Metrics, to help steer the priorities for the coming year based on the most pressing areas where it is believed the biggest collective improvements can be made.

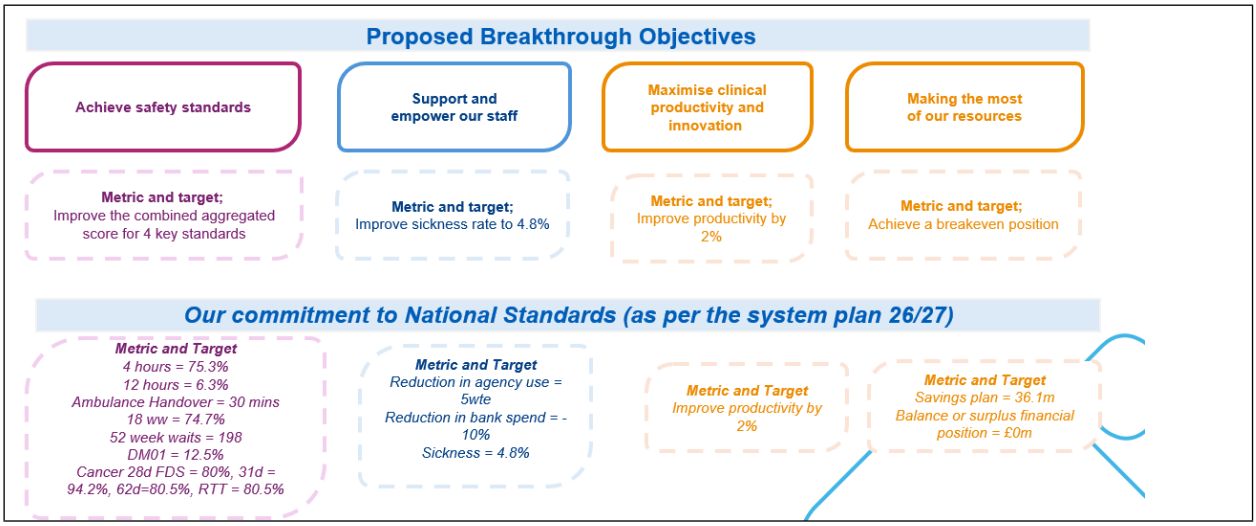
For 2026/27, the strategic A3s focused on the most pressing operational challenges for the organisation, reflecting the fact that the Group Strategy and its future strategic pillars are in development. However, the process has ensured close aligned to the Group's Vision Metrics and Corporate Projects to ensure synergies across Group and Care Organisation priorities.

The level of ambition across the Strategic A3s needs to be carefully balanced with the realities of the financial environment, the evolving Group strategy, the organisation's cultural maturity, and the capacity of staff to deliver change. The proposed breakthrough objectives and corporate projects aim to continue the focus on our key operational and financial challenges in line with our current Call to Action on six key priorities alongside the deliverables of our Medium Term Financial Plan (MTFP).

What are breakthrough objectives and why do they matter?

- Breakthrough objectives are our annual focus on a small number of measures that we believe will significantly help us in achieving our Trust Vision.
- We aim to improve the most pressing operational issues, and we ask every member of staff to support with these.
- The areas are identified by reviewing our progress against our Vision Metrics via Strategic A3 refresh
- It is a data driven and evidence-based process
- We expect to see a 20-30% improvement within 12-18 months as we are all working on the same problem together

A summary of our proposed Breakthrough Objectives for 2026/27 are below.



2.	Recommendations (Note, Approve, Discuss)
Council of Governors is asked to discuss the proposed breakthrough objectives and critical projects for 2026/27 and provide any comments on the areas identified.	

3.	Legal / Regulatory Implications
No direct legal or regularity changes arising from the proposed priorities. However, several programmes particularly Cancer, UEC, Outpatients and Diagnostics are essential to maintaining compliance with national access standards. Any future changes arising from the Group Strategy may require updates to programme scope.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
The priorities for 2026/27 carry several operational and strategic risks, many of which are already reflected within the strategic A3's. Key risks include workforce shortages, aging estate, digital maturity, fragile financial recovery that limits investment capacity. These risks directly impact the deliverability of the breakthrough objectives and corporate projects.	

5.	Resources Implications (Financial / staffing)
The proposed corporate projects require co-ordinated allocation of resources, capital and digital investment. Significant resource requirements including expanding diagnostic capacity, supporting UEC re-design, enabling outpatient transformation and delivering workforce programmes focused on requirement, retention and role design.	

6.	Equality and Diversity
Each of the breakthrough objectives has implications for patients, staff and communities from an equality and inclusion perspective. Improving access to core services supports equitable patient outcomes, particularly for groups disproportionately affected by delays. An EQIA will accompany the full programme to ensure impacts on diverse patient groups and the workforce are fully understood.	

7.	References to previous reports/Next steps
This report links to previous Business Planning papers to Council of Governors.	

8.	Freedom of Information
Public	

9.	Sustainability
The proposed priorities for 2026/27 have several sustainability implications, particularly relating to the ageing estate, backlog maintenance, and the need for safer, compliant, and energy-efficient infrastructure. Estate constraints highlighted across the Strategic A3s - such as ageing engineering systems, limited clinical space, and power availability – which present both risk and opportunity in relation to the Trust's net-zero commitments. Modernisation activity within diagnostics, UEC redesign, and outpatient transformation may require capital investment but also has the potential to reduce environmental impact through more efficient patient flow, reduced repeat visits, and better utilisation of clinical space.	

10.	Digital
Although Digital was intentionally excluded from the 2026/27 A3s pending the emerging Group digital plan, the summary strongly reinforces the importance of digital transformation as a core enabler for almost every breakthrough objective and corporate project. The paper therefore provides a clear strategic rationale for prioritising digital investment, even while awaiting the Group's emerging digital plan, and reinforces that digital is a critical dependency for achieving the 2026/27 breakthrough objectives.	

Royal United Hospitals Bath
NHS Foundation Trust

Strategic Business Planning Update

2026-27

Council of Governors

24th February 2026

The RUH, where you matter

Introduction & Contents

The purpose of this document is to provide an update on the Trust's Strategic A3 annual refresh to inform our plans for 2026/27

Contents

Royal United Hospitals Bath
NHS Foundation Trust

Strategic A3s Annual Refresh

2026/27

The RUH, where you matter

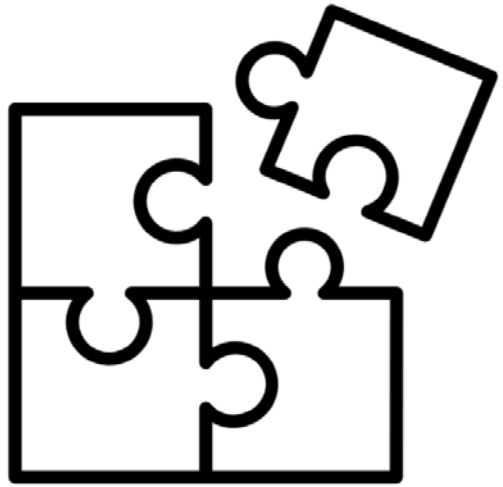
Strategic A3s Annual Refresh

Strategic A3s play a vital role in shaping our Trust's priorities for the year ahead.

They define our Breakthrough Objectives and identify the strategic projects that require dedicated resources and oversight.

Strategic A3s have been developed across seven key areas:

- Urgent and Emergency Care (UEC)
- Outpatients
- Diagnostics (All demand for MRI, CT, and Ultrasound)
- Cancer
- Estates
- People
- Finance



The following slides highlight the key opportunities, challenges and interdependencies across these areas, along with the proposed breakthrough objectives and critical projects emerging from the refresh.

Opportunities highlighted across the A3's

Patient centred care: more personalised, accessible, and seamless pathways across all settings.

Digital first models: improved interoperability, real-time tracking, and use of AI to enhance productivity and decision making *(limited opportunity in yr 1 due to EPR, plan for yrs 2,3)*

Right care, right place, right time: strengthened flow across diagnostics, outpatients, UEC, and cancer pathways.

Workforce sustainability: capability led staffing models, consistent expectations for line management, and more effective multidisciplinary teamworking.

Resilient infrastructure: a compliant, safe, and flexible estate supported by data driven asset and equipment management.

Population aligned care: reducing inequalities and enabling more care to be delivered closer to home.

Common challenges across the A3's

Workforce availability remains the primary bottleneck to progress, with recruitment difficulties in areas such as radiology, ED middle grades, sonography, and oncology.

Digital maturity is a foundational requirement for all clinical transformation, underpinning scheduling reform, pathway tracking, AI-enabled optimisation and patient communication.

Estate constraints, particularly ageing engineering systems and limited clinical space, increase risk and limit transformation. Power availability and backlog risk directly affect diagnostic expansion, ED re-design, and outpatient modernisation.

Financial recovery remains fragile and requires clear benefit realisation plans linked to each transformation programme.

Proposed Breakthrough Objectives

The four proposed breakthrough objectives ensure patients receive the right care in the right place at the right time, build a sustainable and capable workforce, set our intention to boost productivity and innovation and make best use of our resources. They also closely align with the commitment set out in our system plan.

Proposed Breakthrough Objectives

Achieve safety standards	Support and empower our staff	Maximise clinical productivity and innovation	Making the most of our resources
Metric and target; Improve the combined aggregated score for 4 key standards	**Metric and target;** Improve sickness rate to 4.8%	**Metric and target;** Improve productivity by 2%	**Metric and target;** Achieve a breakeven position

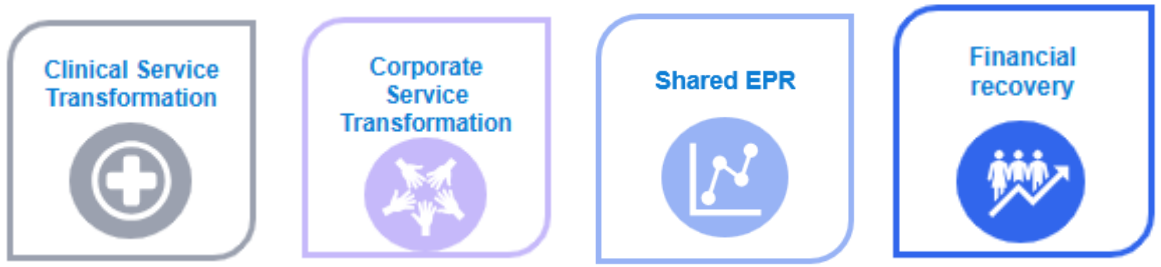
Our commitment to National Standards (as per the system plan 26/27)

Metric and Target *4 hours = 75.3%* *12 hours = 6.3%* *Ambulance Handover = 30 mins* *18 ww = 74.7%* *52 week waits = 198* *DM01 = 12.5%* *Cancer 28d FDS = 80%, 31d = 94.2%, 62d=80.5%, RTT = 80.5%*	***Metric and Target*** *Reduction in agency use = 5wte* *Reduction in bank spend = -10%* *Sickness = 4.8%*	***Metric and Target*** *Improve productivity by 2%*	***Metric and Target*** *Savings plan = 36.1m* *Balance or surplus financial position = £0m*

Proposed Critical Projects

The proposed critical projects enable delivery of our Breakthrough Objectives by driving clinical transformation, addressing our major constraints – workforce and financial recovery – and ensuring we can successfully deliver key group programmes such as the Shared EPR.

Group Critical Projects



RUH Care Organisation Critical Projects

Strategic Planning Timeline – Next Steps

December 2025

High-level strategic A3 reviews at SEF

January 2026

Proposed breakthrough objectives for 2026/27 shared for comment

Trust priorities for 2026/27 agreed by MEC

February 2026

Exec to Division Objective Dialogue

Trust priorities for 2026/27 agreed by BoD

Divisional Scorecard updated

March 2026

Division to Specialty Objective Dialogue

Specialty Scorecard updated

April 2026

Division to Frontline Objective Dialogue

Performance Boards updated

Royal United Hospitals Bath
NHS Foundation Trust

Appendix A: Strategic A3s

2026/27

The RUH, where you matter

Cancer A3

Strategic A3 Title: Cancer
Contributors: Meggan Jarvis, Ed Nicolle, Dr Rebecca Bowen, Ros Helps, Jess Taylor, Sufi Hussain, Lisa Tolson, Nyasha Manomano

Problem Statement: RUH is falling short of key cancer standards, with around 70% of patients receiving a diagnosis within 28 days (against an 80% target) and 52% at early stages (1&2). These gaps delay timely treatment and reduce chances for better outcomes. Patients face prolonged uncertainty and fragmented care pathways, while staff morale declines under persistent backlogs. Additionally, there are challenges in the increasing 62-day target as well our provision for cancer patients presenting in urgent and emergency care, creating further risk of compromised care quality.

Current State / Top Contributors/ Analysis

Diagnostic pathway changes in last 12 months:
•Breast, Myeloma and Lymphoma one stops went live
•Nurse led IDA first appointment
•Straight to test improvements for urology in development
•Ringfencing endoscopy capacity
Increased cancer demand, notably:
•FOT 20% increase in breast cancer diagnoses 25/26 vs 24/25
•Oncology & haematology – treatment advances
•Record skin cancer demand
Quality / Experience impacts;
•Acute oncology service – 2 PSII's
•Access to psychology – demand increasing, lack of wrap around care impacts demand on consultant time
•Pt experience – meds not delivered in a timely manner, increase in prescriptions
•Cohorts we're not supporting as no capacity for clinical nurse specialist (CNSs)

Vision: Our cancer pathways are efficient, and patient focused to ensure that every patient is diagnosed as early as possible, communicated with clearly, and with onward treatment commenced as set out within national standards
Goal for 26/27: As per national targets for cancer. Goal around pt experience / or reducing themes that come up in complaints?

Future State – Design Principles
- Personalised patient care (what matters to me)
- Workforce will be capability led rather than historic configurations
- Care closer to home
- Utilisation technology/innovation to drive safety and efficiency
- Capacity planning (transformation) at pathway level (design the beginning with the end in mind)
- Future services designed around meeting the patient and population needs and addressing health inequalities

Dependencies (be specific)
- Intelligence – data and insight to inform decision making (triangulation of performance, outcomes and experience)
- Diagnostics – desire to have same day planning and staging scans during OP appointment
- Pathology -
- Workforce -
- Estate – Maximising Frome and scoping opportunities at Sulis
- Finance –
- Pharmacy – A pharmacy structure that supports future needs e.g. virtual appointments need pharmacy infrastructure

Key Risks:
- Recruitment and retention; staff wellbeing/burnout
- Reliance on temporary capacity (insourcing/locums)

Countermeasures	Owner	To be implemented by	Benefit realised by
Skillmix and workforce sustainability project - feed into training needs analysis / growth case		Y1	Yr2
eProms (surveillance) - pending SWAG bid outcome		Yr 0 (25/26)	Y0 (25/26)
Expand remote monitoring		Yr 1 (26/27)	
Scope expand community hubs/ utilise Sulis incl. Dispensing, and wrap around services		Yr 2 (27/28)	
Same day staging and planning scans (diagnostics dependency)		Yr 1 scoping with diagnostics	Yr 2
Skillmix and workforce sustainability project - feed into training needs analysis / growth case			Yr2

Outpatients A3

Strategic A3 Title: Outpatient Transformation | Contributors: Ian Kerslake, Rhiannon Hills, Louise Pisani, Dr Ed Jefferies, Dr Mark Atkin, Simon Andrews, Mandy Rumble, Dr Moya O'Doherty, Jess Taylor, Karen Rye, Laura Davies, Dr Matt Lawrence, Carley Goodwin, Helen Back, Reshmi Ravi, Spencer Thorn, Alex Bushell, Katie Windrum, Lisa Lewis

Problem Statement:
Outpatient services at the RUH are constrained by traditional models, fragmented pathways and under-resourced clinical admin, creating variation, backlogs & long waits. Demand now exceeds clinical capacity, leaving us unable to modernise at pace driving a 6% gap in meeting key access targets.

Current State / Top Contributors/ Analysis

- Long waits & RTT underperformance, Currently underperforming wait to-first appt target by 7.3%
  - High number of patients waiting 52 & 65 weeks with little headroom to absorb further demand
- Outdated Operating Model: Predominantly consultant led 1:1 appointments
  - Decentralised village model with limited centralised scheduling or pooled capacity
  - Legacy commissioning structures restrict pathway modernisation & flexibility
- Limited integration with Primary Care
  - Inconsistent collaboration leads to fragmented patient journeys & duplication / Gaps in effort
- Demand Exceed Clinical Capacity
  - Post Covid increased demand & Rising complexity, increased Follow UP need
- Variation in Clinical productivity
  - Unwarranted variation in templates, job plans, utilisation & how clinics operate across specialities
  - Lack of standardised/modern models of care impacting throughput & efficiency
- Under resourced Clinical Administration
  - Insufficient admin capacity to manage demand, leading to Backlogs in booking, triage & correspondence & Insufficient scheduling practices
- Patient Safety & Experience Impact
  - Approx 8% of patients on RTT pathway get admitted to ED while they wait for their appt
  - Poor communication and limited choice of appointment type/delivery model
  - Increased patient frustration & reduced perception of trust/service reliability

Countermeasures (Draft)	Owner	Timeframe
• Advice and Guidance - Single point of access • Standardisation of Clinical Templates across OP specialities • Expansion of Cleo • Continuation / Expansion of Ambient AI • Group clinic Pilot Implementation • E-rs > Pas conversion & Check in Kiosks implementation • Expansion/Delivery of 'Spoke' model with Primary Care & wider system • Further Faster (FF) Collaborative with GIRFT (Urology, Gynae, ENT, Gastro, T&O, Spines) • Digital Pathway integration pilots in FF cohorts • STT modelling & expansion	*Ownership to be confirmed*	**Yr 1** (Stabilise & Foundation work)

Vision: Equitable, high-quality care delivered at the right time in the right way by expert teams, ensuring a seamless, end-to-end patient experience

Goal(s) for 26/27:

- Achieve 71.7% wait to first performance target March 27
- Improve OP productivity to GIRFT-aligned standards by 26/27, reducing unwarranted variation across all major specialities
- Deliver a transformed OP operating model by 2027, shifting X% of activity to modern, digital, group-based models of care

Future State – Design Principles (Full description on slide 4)

- Accessible & Personal, Patient Centred and Seamless
- Care Closer to Home
- Digital First
- Right Care, Right Time, Right Place
- Empowered, Expert MDT Teams

Dependencies (be specific)

Digital: Robust Population health analytics to understand need & design pathways
  - Consistent, patient friendly digital information & diagnostic access
  - Interoperable systems between primary & secondary care
  - Digital communication tools for two-way messaging, referrals & test results
  - Unified PAS across GP & Secondary care
  - Patient tracking & assurance Tools (Portals, Notifications (DrDr), tracking "like a parcel")

Estates: Centralised OP dept (where appropriate)
  - Dedicated spaces & flexible rooms to support future models of care

Workforce: Upskilling programmes for GPs & community clinicians
  - Dedicated time (in Job plans) for proactive planning, not reactive crisis working
  - Navigator roles working across secondary & primary care to support access to community services

Diagnostics (radiology/Pathology): Turnaround times & capacity to support new models (STT, One Stop)
Finance: Investment (Digital, Estates) sustainability & commissioning alignment
Information to support decision making: D&C modelling, speciality real-time dashboards, data linkage with primary care, IG for new models.

Key Risks:

- Workforce & Capacity : *Insufficient clinical time to release staff Under resourced clinical admin*
- Operational pressure : *RTT recovery pressures and rising demand reducing headroom & impacting capacity*
- Financial & commissioning: *Legacy structures may not support modernised pathways*
- Estates & Space constraints *may not support new models*
- Programme Delivery: I*nsufficient project/prgm mgt*

Diagnostics A3

Strategic A3 Title: Diagnostics (all demand for radiology imaging for CT, MRI and Ultrasound)
Contributors; Gary Cross, Nuno Aguiar, Simon Sethi, Calum Macgregor, Sadie Pyecroft, Morag Callow, Paige Carney

Problem Statement: Radiology imaging services for CT, MRI, and Ultrasound are under increasing pressure to meet growing demand (increased by 8%) while maintaining a safe, high-quality service that improves patient outcomes and reduces harm.

Current delivery models face significant cost challenges, including reliance on mobile units, outsourcing, and workforce constraints, which impact sustainability and efficiency.

In addition, implementing specialty specific GIRFT recommendations requires substantial service redesign and operational change, adding complexity to an already stretched system. Without a coordinated approach, these issues risk compromising performance, patient experience and financial viability.

Current State / Top Contributors/ Analysis

- **Demand:** If the past 4 years' growth rates continue, expect an additional +3.5k **Ultrasound** referrals each year. Ultrasound referrals are growing ahead of activity (RUH and Sulis). An additional +2.3k **MRI** referrals each year and an additional +6k CT Referrals each year

- **Activity: ultrasound** has turned around in the last 2 years with Sulis adding +1k exams on top of +2.1k **(total of 48k)**. **MRI** activity has increased by 4.3k on top of sulis 1.3k **(total 25k)** and **CT** is at max capacity up by 3k for each of the last two years (total **60k)**

Top contributors to current position;
•**Demand management** - Planned referrals for repeat scans are increasing. GP referrals remain high, and RUH is an outlier for accepting cases other Trusts decline. Out-of-area patients (e.g., Swindon) are being referred to RUH—partly due to patient choice and partly because GWH and SFT do not provide these services. 40% of patients choose RUH over Sulis, with parking issues at Sulis being a factor. Radiology was not consulted when new GIRFT standards were introduced by specialties, and these specialty-specific standards are significantly impacting overall demand.

Productivity - Ultrasound capacity is underutilised due to difficulties recruiting sonographers. Radiologists are covering gaps to maintain service delivery. Increasing requests for part-time hours among radiologists are reducing overall availability. Current MDT commitments are unmanageable within existing job plans.

Capacity: Sulis cannot manage complex patients, perform cannulation, or report its own activity. Reporting is redirected to RUH, requiring outsourcing or weekend work (WLI), with costs recharged to Sulis. RUH cannot add additional scanners due to power limitations and lack of suitable space.

Vision: To deliver a sustainable, patient-centered radiology service for CT, MRI, and Ultrasound that consistently meets growing demand while ensuring the highest standards of safety, quality, and efficiency. The future service will leverage innovation to optimise workflows, reduce reliance on mobile units and outsourcing, and strengthen workforce planning.
Goals:

Future State – Design Principles

- No decision about diagnostics without radiology input
- Right test, right time, first time (deliver the most appropriate imaging at the earliest opportunity)
- Sustainable workforce with continuous development (build and maintain a resilient and skilled workforce)
- Efficiency through technology and innovation (leverage digital tools and AI to optimise workflow and capacity)
- Patient centred experience and communication (make patient experience seamless and transparent.

Dependencies

- Digital – AI and integration across RUH and Sulis
- Pathology – what other diagnostics are available alternative to an image?
- Estate – we can't have another scanner on site without more power
- Finance – A budget that allows for headroom

Key Risks:

- Previous attempts to manage demand has been met with resistance from GPs and Specialities
- Recruitment – finding the right people and time to recruit
- Unknown unplanned demand
- Equipment failure
- Unknown future costs e.g. wages, equipment, consumables

Countermeasures	Owner	Implement by	Benefit realised by
Expand CT/MRI Availability (12/7) Secure additional staffing and allocate resources to enable extended service hours.	Simon Sethi	Yr 1	Yr 2?
Optimise Medical Workforce Spend Review current expenditure, reduce outsourcing, and prioritize permanent recruitment for better value.	Nuno Aguiar	Yr 1	Yr1

Cross-A3 Strategic Themes (Cancer, OP, Diagnostics)

Cross-cutting themes across Cancer, Outpatients and Diagnostics

1. Demand outstripping capacity
2. Desire to modernise across patient pathways (beginning with the end in mind)
3. Workforce constraints and non-medical job planning
4. Significant digital and data enablers
5. Estates and physical capacity constraints
6. Patient experience and communication
7. Financial sustainability and commissioning alignment
8. Governance, performance management and risk

Cross A3 strategic actions

1. Implement a demand governance framework (sign off for pathway changes that impact enabling teams)
2. Accelerate joint job planning and define MDT time explicitly
3. Digital quick wins – voice recognition, eProms, DrDoctor
4. Primary – Secondary care integration pilots
5. Increasing capacity road map
6. Reduce outsourcing reliance and value for money tracking
7. Unified patient communication standards

Shared enablers to align early

1. Digital and data (EPR readiness, analytics, AI)
2. Workforce (capability led roles)
3. Estates (power, space, CDC, OP hub and spoke model)
4. Finance and Commissioning (investment and alignment to modernise pathways)

Estates A3

Strategic A3 Title: Backlog Maintenance & Critical Infrastructure
Contributors: Jamie Caulfield, Martin Duggan, Mandy Rumble, Neil Flint, Paul Jenkins

Problem Statement:
RUH has a £73.8m backlog maintenance risk, including £33.6m of high/significant critical infrastructure risk. Ageing engineering systems and deteriorating environments are driving increasing failures, compliance pressure and operational disruption. These risks affect safety, experience, carbon performance, and continuity of care, limiting the Trust's ability to deliver on its priorities and the BSW Group Operating Model. A coordinated, multi-year estates, capital and workforce programme is required to prevent escalation.

Current State / Top Contributors/ Analysis
RUH's estate is increasingly fragile, with rising failures, reactive demand and limited assurance across key engineering and environmental domains. Estate condition is impacting patient safety, staff experience, infection control, carbon performance and operational resilience. Capacity, capital and data constraints limit the Trust's ability to reduce risk at scale.

Key Points
- £73.8m backlog risk; £33.6m high/significant (ERIC).
- Ageing engineering systems with increasing failures and emergency callouts.
- Compliance pressure: PAM Safety SAQs, repeated AE findings, PPM displacement.
- Poor/very poor Six-Facet and PLACE condition.
- Reactive demand > planned capacity, reducing resilience.
- Digital/data gaps in CAFM and asset intelligence.
- Workforce capacity and skills constraints in key engineering roles.
- Capital insufficiency to address lifecycle risks at the required scale.

Vision: A safe, resilient and future-ready estate that enables high-quality care, supports our people and provides the infrastructure needed to deliver the RUH vision and the BSW Group Operating Model.

Goal for 26/27: Strengthen critical infrastructure by reducing the highest-risk backlog, improving compliance assurance and enhancing the resilience of priority engineering systems to reduce failures and operational disruption.

NHS Foundation Trust

Future State – Design Principles
Safety and compliance first
Infrastructure will consistently meet statutory, regulatory and HTM requirements.
Resilience by design
Systems and environments will minimise single points of failure and protect continuity of care.
Digital-first and data-driven estate
Infrastructure will support digital care, real-time monitoring and integrated asset intelligence.
Flexible, standardised and future-ready design
Spaces will be adaptable, standardised where appropriate and capable of supporting future models of care.
Environmentally sustainable solutions
Design choices will support carbon reduction, energy efficiency and lifecycle sustainability.
Patient- and population-centred environments
Environments will be accessible, modern and designed to improve experience and reduce inequalities.
Value-driven and workforce-enabling estate
The investment will maximise value, improve productivity, and support safe, efficient working environments for staff.

Dependencies
Clinical Access & Decant Capacity
Intrusive works depend on access to clinical areas and decant space, which is limited by high bed occupancy.
Capital & Revenue Funding
Delivering critical infrastructure improvements requires sustained multi-year capital and adequate revenue support.
Technical / Estates Workforce Capacity
Progress depends on sufficient technical capacity, skills and protected time to deliver planned maintenance and compliance.
Digital Estate Systems & Data Intelligence
Real-time monitoring and effective prioritisation require integrated digital estate systems and reliable asset data.
Governance, Approvals & Sequencing
Timely approvals and alignment with clinical service plans are needed to schedule and deliver intrusive works safely.
Integrated System Working
Delivery depends on coordination with ICS capital planning, local authorities and wider system partners.
Procurement, Supply Chain & Contractors
Access to specialist contractors and long-lead equipment is essential for timely delivery.
Utilities & Infrastructure Capacity
Upgrades require sufficient power, ventilation, cooling and other core utilities.

Estates A3 Continued

DRAFT

Royal United Hospitals Bath NHS Foundation Trust

Theme	Countermeasures	Owner	To be implemented by	Benefit realised by
Capital & Investment	• Develop multi-year risk-based capital plan; build full-costed business cases (fees, prelims, OB, decant); establish a Critical Systems Replacement Plan.	Jamie Caulfield Deputy Director of Estates & Facilities	Year 2	Year 3
Safety & Compliance	• Implement a Compliance Improvement Programme (water, fire, ventilation, electrical); protect PPM schedule; deploy compliance dashboard; prioritise replacement of non-compliant systems.	Jamie Caulfield Deputy Director of Estates & Facilities	Year 1	Year 3
Workforce & Capacity	• Create workforce plan; strengthen recruitment/retention; define capacity model; implement HTM competency framework; reduce contractor dependency	Jamie Caulfield Deputy Director of Estates & Facilities	Year 1	Year 3
Digital & Data	• Modernise CAFM; refresh Six-Facet and asset register; expand BMS/metering; build digital estates dashboard; agree digital estates roadmap.	Jamie Caulfield Deputy Director of Estates & Facilities	Year 2	Year 3
Planning & Delivery	• Strengthen integrated planning and make more effective use of existing governance and operational forums to make decisions, unblock delays, coordinate procurement and sequencing, and ensure Estates requirements are identified early for the timely delivery of infrastructure works.	Jamie Caulfield Deputy Director of Estates & Facilities	Year 1	Year 3
Estate Condition	• Deliver a targeted estate modernisation and refurbishment programme that renews deteriorated engineering systems, upgrades poor-condition clinical environments, and redesigns outdated ward and outpatient layouts to ensure safe, resilient and fit-for-purpose spaces aligned to modern models of care.	Jamie Caulfield Deputy Director of Estates & Facilities	Year 2	Year 3

Key Risks

- Remaining level of risk exposure
- Ongoing estate fragility due to scale and age of infrastructure
- Limited capital availability at Trust, ICS and national level
- National technical workforce shortages
- Operational pressures limiting access to clinical spaces
- Inflation and supply chain volatility in construction and engineering
- System-wide pressures and competing priorities

People A3

Strategic A3 Title: Our People – our workforce

Problem Statement:

Delivery of quality, safe and efficient patient care is reliant on our RUH colleagues, both professional and non-professional. Currently we have areas where we are unable to **recruit** key staff to roles, areas that are finding it hard to **retain** their staff (staff development and appraisal quality are inconsistent, limiting retention and internal progression and also workload and staffing pressures persist in several services, leading to additional unpaid hours and difficulty meeting conflicting demands) and we have services where due to changes in pathways, introduction of new technology or shortage of qualified staff we need to **reform/redesign** the workforce mod

A number of clinical areas struggle to **recruit** to key posts, which results in reduced productivity and high agency costs, with increased pressure on substantive colleagues.

- Medical Consultants posts in national hard to recruit specialist areas remains a driver in our reliance for high costs agency provision primarily in H&O and Dermatology.
- Nursing agency provision within in-patient areas is very low. However high-cost agency provision in specialist areas such Emergency Medicine and NICU is evident and reflective of vacancies and winter pressures.

There is generally low levels of turnover at the RUH (Support to Clinical and Non-Clinical roles are the exception) but some areas have high levels of new hire attrition and are unable to **retain staff.** With generally low turnover, sickness levels are very high in some clinical teams and support functions, sitting above the national and regional trends (Nationally approximately 5.2%, Regionally approximately 4.9%) with staff reporting workplace pressures and operational/finance challenges. Leadership training is currently not mandated or targeted; attendance is by choice for those who wish to develop and is not aligned to a training needs analysis of roles.

Where key roles are hard to fill due to national shortages, we lack the capacity and capability to support colleagues through workforce **redesign/reform.** This will become an increasing issue with the Government White paper changes on Immigration and VISA's – which accounts for 14% of our current workforce.

Sickness absence at the RUH continues to increase above National levels, the cause of

Vision: The RUH will attract, develop, and retain a diverse workforce—ensuring the right people, with the right skills, are available at the right time. Through purposeful workforce redesign, strong leadership, learning, and a focus on wellbeing, we will create sustainable roles and ways of working that enable our staff to thrive and deliver safe, effective, efficient and person-centred care."

Goal for 2026/27: The RUH will stabilise its workforce by reduce critical vacancies, reduce turnover (in key areas), improve employee well-being, improve recruitment speed and pathways and pilot redesigned workforce models in priority services.

Future State (Design Principles):

- Employer Value Proposition – recruitment marketing becomes a strategic branding function, not a HR activity alone and is based around candidate experience.
- Diverse and non-traditional talent pipelines – design multiple entry points rather than one hiring gateway (apprenticeships, careers transition, RTW, internal movement)
- Continuous learning – this becomes a core offer to all staff not a benefit
- Wellbeing, flexibility, trust, leadership and belonging – recognising retention is driven by more than compensation alone
- Agile and adaptive work structures – technology needs to be viewed as a tool to redesign workforce not and IT issue. Workforce strategy becomes a continuous forward looking discipline.

Dependencies:

- **Clear governance and decision-making structures** (transparency and clear escalation)
- **Performance and recognition frameworks** (improving together and comms)
- **Leadership behaviour framework** (capability and accountability for our behaviours)
- **Wellbeing incl Safe and Inclusive Environment** (colleagues have access to a safe, inclusive and supportive working environment)
- **Digital infrastructure** (tools and spaces that enable collaboration and inclusion)
- **Physical infrastructure** (estates strategy that reflects staff wellbeing)
- **FTSU & Patient Safety** (addressing feedback about learning)
- **e Rostering & Job Planning** (addressing workload)

Countermeasures	Owner	Timeframe
Recruit: Implement a consistent, values-driven and efficient recruitment approach across all roles and senior appointments'		
Retain: Leadership development programme – based on TNA		
Retain: Workforce wellbeing – breakthrough objective		
Redesign/reform: digitisation of workflows		
Redesign/reform: Programme to support local workforce transformation (aligned to clinical strategy)		

Key risks to delivery:

Organisational Capacity and capability: to support WF transform

Digital: capacity of IT to support ambitions around technology

Operational: Our continued operational context will create continued pressure on staff, requiring constant review of wellbeing programme.

Immigration and visa changes: government white paper. 14% of workforce of VISA's

UEC A3 2025/26

Strategic A3 Title: UEC 4-hour performance

Problem Statement: Our patients are experiencing long waits at many points along their journey through our hospital. This is culminating in long waits in ED and slow ambulance handover

Vision: To deliver the 4-hour 95% ED standard
Goal for 26/27: By 31 March 2026 we will deliver the following targets: 33 minutes ambulance handover, 72% type 1 against 4-hour ED standard, maximum 40 NCTR patients

Current State / Top Contributors/ Analysis.

	Last Complete (Nov)	Previous month (Oct)	YTD Apr-Nov
Ambulance Handover	31.6min	36.9min	56.4min
4-hour performance (All Sites)	66.90%	65.27%	68.10%
12 hours	8.7%	9.1%	8.1%
NCTR	92.5	88.8	83.2
LoS emergency, 2+ days – MH)	8.5days	8.1days	8.6days

Top contributors are demand, internal processes and slow discharging to the community for P1 – 3 pathways due to community capacity.

Future State – Design Principles

The underlying systems and processes within the hospital should be effective in delivering the flow required to deliver the 4-hour ED standard without management intervention.

Dependencies

- Digital systems supporting the changes required to smooth and speed up patient flow
- Radiology and pathology – response times are in keeping with the IPS
- Workforce – to support the Teams to enable the changes – Change Team
- Estate – to redesign and build the new UTC area and redesign the area to be repurposed for ED
- Finance – to support the changes and provide advice to keep within budget and release savings as the become possible.
- Information to support decision making – to produce BI reports and Dashboards
- Coach house to provide hands on improvement support
- Improvement Team to provide project management support

Countermeasures	Owner	To be implemented by	Benefit realised by
Move UTC	Medicine Tri	End of April 26	Yr 1
Redesign ED observation area	Medicine Tri	TBC	
Reg and Middle grade substantive recruitment (10.2wte)	Medicine Tri	End of May 26	Mid Yr 1
ED footprint change (12 extra spaces in majors)	Medicine Tri	TBC	
Operational Countermeasures Redesigned escalation processes so there is a step change in flow and increase in bed capacity when in higher levels of escalation.	Deputy COO UEC	TBC	
Specialties take ownership of the Internal Professional Standards (IPS)	Specialty Tri	End of May 26	
Deliver best practice on board rounds/ward rounds	Deputy CMO	End of May 26	

Key Risks:
Winter demand is high leading to inability to sustain flow and focus on improvements leading to delayed delivery of targets.

The changes required need significant engagement from a large number of staff so this may be difficult to achieve within the time frame as it's difficult to change behaviours quickly leading to delay in delivering targets.

Significant flu season will impact flow leading to delay in delivering targets

Finance A3

Title of A3; Finance - 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.

A3 Lead; Jon Lund

Step 1: Problem Statement

The Trust expects to enter 26/27 with an underlying financial deficit of £47.3m; and is entering a 3year Medium Term Plan where additional 2% efficiency savings are required each year to stand still. The Trust has identified the need to make £55m of recurrent saving over next 3 years to reach a 1% surplus.

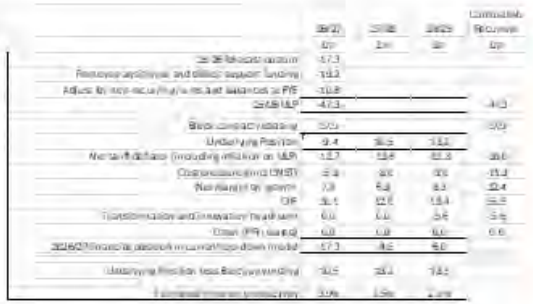
£30.1m of savings are required in 2026/27

Step 2: Current Situation

• In year Deficit 2025/26	£17.3m	2.9%
• Underlying deficit	£47.3m	7.9%
• Block contract rebasing	(£37.9m)	(6.4%)
• Opening Baseline	£9.4m	1.6%

of which,(£1.5m) surplus Sulis and £10.6m deficit RUH

- Key Drivers of the Deficit:
  - £4.0m UEC demand growth
  - £1.5m Outpatient Care Model
  - £0.8m Delays in Group Corporate Services Savings
  - £1.5m Medical Staffing budget pressures
  - £3.0m Non Recurrent / Unidentified Savings
  - (£1.5m) Sulis surplus



Step 3: Vision/Goals

RUH productivity and efficiency levels are in the national upper quartile

RUH has an I&E budget that is sufficient to invest in Strategic Priorities by 28/29, defined by Access, Quality and Performance delivery; measured as 1% invested non recurrent each year in Transformation and 1% I&E surplus to generate cash flow for strategic investment and contingency

RUH has a financial position each year that would place Trust is NOF1 or NOF2 rating and has autonomy to act without regulator intervention; and within an Integrated Care System that also is SOF1 or SOF2 and has autonomy to act without regulator intervention – this will include BSW Hospitals Group

Underlying deficit position as at November 2025 £47.3m, caused by:

-external factors: including pandemic disruption, growing demand for acute services, cost inflation, labour market pressures, underfunding of block services, including high cost drugs and urgent & emergency care; immature collaboration with key external partners incl ICB, HCRG, Primary Care, Social Care commissioners & providers and SWAST; Commissioner affordability challenge for key performance leading to non recurrent and premium cost solutions

•internal factors: - including lowered organisational resilience; infrastructure deficits – estate, IT, medical; underfunded growth in resident doctor workforce; equipment; sub-optimal & un-modernised operating& workforce model; weak financial accountability culture; internal transformation capacity & capability: various specialist services running without sustainable funding or cost effective operating model; shortfall of benefits realisation from major investment programmes incl Dyson, CDC, EPR; recruitment challenges in core services incl oncology & haematology; pathology & radiology

Step 5: Counter Measures and Future State

Step 6: Actions and Risks

1. Annual Business/Operational Plan and Annual Financial Plan / Budget that is fully delegated to budget holders
2. Divisional financial reporting and Performance Review Meetings that monitors the delivery of the financial plan.
3. Vacancy Control process that acts as an authorisation process for all posts that are being vacant.
4. Controls to manage discretionary expenditure
5. Strict adherence to the purchase order process
6. Scheme of delegation and standing financial instructions provides guidance on who and what can be purchased or funding committed.
7. Coding & Capture of activity that drives the accurate recording of expenditure that can be charged to ICBs and NHSE.
8. Collaborative working with ICB, overseen by BSW Recovery Board
9. Collaborative working with BSW Hospitals Group Partners overseen by Joint Committee
10. External support and challenge – NHSE SW Region, External financial advisors for in year and future years planning, Turnaround Team
11. Enhanced organisation Comms and Engagement through Call to Action and All Staff comms channels; and Divisional Accountability Letters
12. Maximise benefits from Capital Investment

Risks and Issues

1. Continued development of capacity and capability to deliver scale of savings
2. Full identification of medium term financial plan and 25/26 savings programme has yet to be completed
3. Contract terms with BSW ICB leading to financial risk transfer from ICB to Trust

Step 7: Cost/Benefit

Report to:	Council of Governors	Agenda item:	9
Date of Meeting:	24 February 2026		

Title of Report:	**Appointment of Deputy Lead Governor**
Status:	**For approval and discussion**
Board Sponsor:	**Liam Coleman, Interim Chair**
Author:	**Roxy Milbourne, Interim Head of Corporate Governance**
Appendices	**Appendix 1: Lead & Deputy Lead Governor Role & Responsibilities**

1. Executive Summary of the Report

The purpose of this paper is to update the Council of Governors on the process undertaken to appoint a new Deputy Lead Governor following the end of the previous postholder's term of office, and to present the outcome for formal noting.

2. Recommendations (Note, Approve, Discuss etc)

The Council of Governors is asked to:

1. Note the completion of the agreed selection process for the Deputy Lead Governor role.
2. Formally endorse the appointment of Craig Jones as Deputy Lead Governor.
3. Confirm that the approved selection process continues to reflect the Council's expectations for future appointments.

3. Legal / Regulatory Implications (NHSLA / Value for Money Conclusion etc)

NHS England's Code of Governance requires each NHS Foundation Trust to appoint or elect a Governor as Lead Governor.

4. Risk (Threats or opportunities link to risk on register etc)

None

5. Resources Implications (Financial / staffing)

None

6. Equality and Diversity

All Governors were invited to express an interest in the roles of Lead and Deputy Lead Governor.

7. References to previous reports

Process for Electing a Lead Governor – January 2021.
Lead Governor Appointment and Deputy Lead Governor Role – December 2022.
Process for Electing a Lead Governor – December 2025.

8. Freedom of Information

Public.

9.	Digital
An online voting system was used for this process.	

10.	Sustainability
This process took place virtually.	

1. Purpose of the Paper

The purpose of this paper is to update the Council of Governors on the process undertaken to appoint a new Deputy Lead Governor following the end of the previous postholder's term of office, and to present the outcome for formal noting.

2. Background

The terms of office for the previous Lead and Deputy Lead Governors ended in October 2025. In line with the agreed selection process, the Corporate Governance Team initiated the procedure to appoint successors.

Two expressions of interest were initially received for the Lead Governor role from Kate Cozens and Ian Lafferty. No expressions of interest were received for the Deputy Lead Governor role at that time. Following an election, Kate Cozens was appointed as Lead Governor. Ian Lafferty was invited to take on the role of Deputy Lead Governor but declined.

At the Council of Governors meeting in December 2025, Governors were informed that expressions of interest for the Deputy Lead Governor role had subsequently been received from:

- Paul Newman, Public Governor
- Craig Jones, Staff Governor

To ensure fairness and allow all Governors the chance to express interest, the Corporate Governance Team wrote to all Governors on 7 January to invite further nominations. No additional expressions of interest were received.

3. Summary of the Agreed Selection Process

As previously approved by the Council of Governors, the process for appointing a Lead or Deputy Lead Governor is:

1. The Membership Office seeks expressions of interest.
2. All candidates (including unopposed ones) provide a short personal statement.
3. Statements are circulated to all Governors.
4. Voting
    - If one nomination is received: Governors endorse or abstain.
    - If more than one nomination is received: an election is held via electronic survey.
    - If no nominations are received: the Trust Chair, in consultation with the Nominations & Remuneration Committee, appoints a candidate.
5. The Council has previously agreed that a Deputy Lead Governor should be appointed to support resilience and ensure continuity should the sitting Lead Governor not be re-elected.

4. Appointment Process

An electronic survey including statements from both candidates was circulated on 15 January. Governors were asked to vote by 18 January.

A total of 12 Governors voted, and the outcome was as follows:

- Craig Jones, Staff Governor – *successfully elected as Deputy Lead Governor*
- No further ties or concerns were recorded

5. Outcome

Following the completion of the approved selection process, Craig Jones has been elected as the Deputy Lead Governor.

His appointment ensures continuity and provides succession resilience in line with the Council's agreed approach.

The Lead & Deputy Lead Governor roles & responsibilities are detailed at appendix 1.

6. Recommendations

The Council of Governors is asked to:

1. Note the completion of the agreed selection process for the Deputy Lead Governor role.
2. Formally endorse the appointment of Craig Jones as Deputy Lead Governor.
3. Confirm that the approved selection process continues to reflect the Council's expectations for future appointments.

Appendix 1: Lead & Deputy Lead Governor Role & Responsibilities

Role: Lead or Deputy Lead Governor of the Council of Governors
Accountable to: Council of Governors
Period of Office: Subject to annual reappointment (limit of 2 years in office)

Lead Governor Responsibilities:

1. Assist the Trust Chair to organise the business of the Council. In particular to support the Chair to set the agenda for the Council meetings and to advise the Chair on the process for consulting the Council on any matters between meetings. Encouraging all Governors to take part in Governor Working Groups.

2. Assist the Chair to promote amongst Governors a constructive, patient-focussed culture, and generally to further a good relationship with the Board of Directors.

3. Assist the Chair to develop and implement a programme of development for the Council.

4. Act as a point of contact for any Governor wishing to raise matters with the Chair, in the event that a Governor may not wish to do so directly.

5. In the absence of the Chair or any Non-Executive Director, chair any meeting of the Council of Governors.

6. In the event that NHS Improvement wishes to contact the Council directly, or the Council decides to exercise its powers to contact NHS Improvement in line with the Trust's Constitution, act as the point of contact between the Regulator and the Council. This will include any referral by the Council to the Panel established by NHS Improvement to advise the Council.

7. Carry out the role described in Appendix B of NHS Improvement's FT Code of Governance 2010 (as amended from time-to-time) – see Appendix 1.

Deputy Lead Governor Responsibilities:

1. Act as Deputy in the absence of the Lead Governor.
2. To support the resilience of the Council of Governors by working with the Lead Governor to gain experience and knowledge.
3. To succeed the Lead Governor providing they are still an elected Governor and this is supported by a majority on the Council of Governors.
4. In the permanent absence of the Lead Governor, the Deputy Lead Governor would be required to act as Lead Governor until further elections are held.

Appointment:

The Lead Governor shall be appointed by the Council of Governors. All candidates for appointment/re-appointment must submit a supporting statement, and a decision will be taken at a meeting of the Council of Governors by secret ballot.

The Deputy Lead Governor appointment shall follow the same process.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Council of Governors**	**Agenda item:**	**10**
Date of Meeting:	**24 February 2026**		

Title of Report:	**Working Group Proposal**
Status:	**For Approval**
Board Sponsor:	**Liam Coleman, Interim Chair**
Author:	**Abby Strange, Corporate Governance Manager** **Roxy Milbourne, Interim Head of Corporate Governance**
Appendices:	**Appendix 1: Draft Governor and NED Forum Terms of Reference** **Appendix 2: Draft Council of Governors Meeting Structure**

1. Executive Summary of the Report

This paper presents the outcome of the Council of Governors Task and Finish Group, established following the December 2025 Council meeting, to develop a more sustainable and effective working group structure.

The current working group model has not functioned since May 2025 due to significant Corporate Governance resourcing constraints and limited Governor availability. As a result, Governors have had reduced opportunity to fulfil key statutory responsibilities, including holding Non-Executive Directors to account and representing the interests of members and the public.

The Task and Finish Group has reviewed alternative approaches and recommends adopting a streamlined, NHS-recommended model comprising:

- The statutory Nominations and Remuneration Committee,
- The Membership and Outreach Working Group, and
- A new Governor and Non-Executive Director Forum, designed to strengthen accountability, assurance, and dialogue between Governors and NEDs.

Draft Terms of Reference and a revised working group structure are presented for approval.

2. Recommendations (Note, Approve, Discuss)

The Council of Governors is asked to:

1. Approve the dissolution of the following working groups:
    - Strategy and Business Planning Working Group
    - People Working Group
    - Quality Working Group

2. Approve the establishment of a quarterly Governor and Non-Executive Director Forum.

3. Approve the draft Terms of Reference for the Governor and NED Forum (Appendix 1).

4. Approve the proposed Council of Governors meeting structure (Appendix 2).

3.	Legal / Regulatory Implications

Foundation Trusts are required to:

- Convene a Council of Governors a minimum of four times per year, and
- Maintain a Nominations and Remuneration Committee to oversee NED and Chair appointments.

The proposed model remains compliant with all statutory duties and follows NHS England recommended governance practice.

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

The Council of Governors must be able to:

- Hold the NEDs to account for the performance of the Board, and
- Represent the interests of members and the public.

The current non-functioning working groups present a governance risk.

The new structure mitigates this risk by providing a sustainable mechanism for assurance, scrutiny, and engagement.

5.	Resources Implications (Financial / staffing)

The existing working group model is not sustainable given:

- Governor availability, and
- Limited Corporate Governance Team capacity to administer multiple groups.

The proposed model is proportionate, efficient, and reduces administrative overhead.

6.	Equality and Diversity

There are no specific equality or diversity implications arising from this proposal.

7.	References to previous reports/Next steps

Outcome of the Working Group Task and Finish Group – September 2024
Working Group Task and Finish Group – December 2024
Working Group Proposal – December 2025

8.	Freedom of Information

Public

9.	Sustainability

Not applicable

10.	Digital

Not applicable

Council of Governors Working Group Proposal

1. Background and introduction

In 2024 the Council of Governors reviewed its working group structure and agreed to retain the existing model with a further assessment planned for June 2025. However, no working groups have been convened since May 2025 due to staff departures within the Corporate Governance Team and challenges with Governor availability.

At the December 2025 Council meeting, Governors were asked to work with the Corporate Governance Team to identify a sustainable approach that:

- Supports the Council's statutory responsibilities,
- Reflects the capacity of both Governors and the Corporate Governance Team,
- Reduces duplication and operational focus, and
- Aligns with future BSW Hospitals Group governance arrangements.

The Council agreed that a Task and Finish Group should be formed to develop a proposal for consideration at the February 2026 meeting.

2. Task and Finish Group Overview

Expressions of interest were invited from all Governors following the December 2025 meeting. Two meetings of the Group were held in January and February 2026.

The Group agreed that any new structure must:

- Strengthen Governor–NED engagement and create meaningful opportunities for scrutiny.
- Support Governors to hold the NEDs to account, in line with statutory duties.
- Improve communication and information flow, enabling Governors to represent members and the public.
- Provide clarity of purpose, avoid operational diversion, and ensure Governor time is used effectively.
- Be deliverable within the available Corporate Governance resource.

Having considered several options, the Group concluded that the optimal model is one aligned with national NHS Provider recommendations. This model retains only the groups essential to statutory functions and introduces a new Governor and NED Forum to enhance accountability, triangulate assurance from Board committees, and strengthen Governor effectiveness.

The Group also considered the forthcoming BSW Hospitals Group operating model and ensured the proposed structure can adapt to Group-level governance arrangements once established.

3. Proposed Working Group Structure

The recommended model consists of:

3.1 Statutory Committee

- **Nominations and Remuneration Committee**
  Required by legislation and retained without change.
  (Remit unchanged; supports appointments of Chair and NEDs.)
  - To note: Chair appointment delegated to a Joint Nominations and Remuneration Committee with Governors from Salisbury NHS Foundation Trust and Great Western NHS Foundation Trust

3.2 Working Group

- **Membership and Outreach Working Group**
  Continues to support Governor engagement and statutory duties relating to representing the interests of members and the public.

3.3 New Forum

- **Governor and Non-Executive Director Forum (Quarterly)**
  A private, structured forum enabling:
  - Direct engagement and open dialogue with NEDs,
  - Scrutiny of Board performance using upward committee reports and performance data,
  - Feedback loops between Governors, NEDs, and the wider Board,
  - Discussion of constituent insights and assurance needs,
  - Identification of training and development requirements.
  - Detailed Terms of Reference are provided in Appendix 1.

This structure removes unnecessary meetings, reduces operational burden, and focuses activity on the areas of highest governance value.

4. Recommendations

The Council of Governors is asked to:

1. Approve the dissolution of the following working groups:
   - Strategy and Business Planning Working Group
   - People Working Group
   - Quality Working Group

2. Approve the establishment of a quarterly Governor and Non-Executive Director Forum.

3. Approve the draft Terms of Reference for the Governor and NED Forum (Appendix 1).

4. Approve the proposed Council of Governors meeting structure (Appendix 2).

Appendix 1:

Royal United Hospitals Bath NHS Foundation Trust Governor and Non-Executive Director Forum Terms of Reference

1. Constitution of the Forum

1.1. The Council of Governors hereby resolves to establish a Governor and Non-Executive Director Forum (referred to as 'the Forum' below). The Forum is authorised to act in accordance with its terms of reference.

2. Purpose

2.1. The principal purpose of the Forum is to support the fulfilment of the Council of Governor's statutory role in holding the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors. This will include, but is not limited to, seeking assurance on behalf of the Council of Governors that the Trust is addressing all matters relating to:

- Progress against strategic goals and objectives.
- Quality, safety, and patient experience.
- Financial performance and sustainability.
- Operational performance.
- People related matters.
- Digital and information governance.
- Partnership working within the wider health and social care economy.
- Regulatory and statutory compliance.
- Trust achievements and best practice.

3. Roles and Responsibilities

The Forum will:

3.1. Develop an understanding of the strategic direction of the Trust.

3.2. Receive reports from Non-Executive Director led Board sub-Committees and seek assurance on the Board's delivery of its strategic goals, and that appropriate and effective decision-making is in place.

3.3. Provide feedback on the views of the Trust membership and members of the public and explore whether the Board is operating in the best interests of its workforce, service users, and the community it serves.

3.4. Agree items for escalation and identify any Governor training and development needs in relation to these.

3.5. Review the action list and matters arising and ensure that items are addressed and closed.

3.6. Give progress reports and report the views of the Forum to the Council of Governors at full meetings of the Council.

4. Membership

4.1. The Forum membership is as follows:

- All public, staff, and stakeholder Governors.
- All Non-Executive Directors.

4.2. The Forum will be chaired by a nominated Governor.

4.3. In the absence of the nominated Chair, another Governor will perform this role.

4.4. The Forum will co-opt additional members to attend as and when required, but this will routinely include a representative of the Membership Office.

4.5. The Forum may request the attendance of individuals with relevant experience and expertise if it considers this necessary to assist in holding the Non-Executive Directors to account for the performance of the Board.

5. Quorum

5.1. The Forum membership will be open to all public, staff, and stakeholder Governors but will, as a minimum, need to comprise of a core membership of:

- Four elected Public Governors.
- One Staff Governor.
- Two Non-Executive Directors.

5.2. The core membership will be reviewed each year to account for changes to the Council of Governors arising from the annual election process.

6. Frequency

6.1. It is expected that the Forum shall meet a minimum of four times per year to fulfil its remit.

6.2. Extraordinary meetings or workshops may be held as required.

7. Accountability

7.1. The Forum is accountable to the Council of Governors.

8. Other Matters

8.1. No formal minutes will be recorded; however, the Membership Office will be responsible for providing administrative and governance support to the Forum, including:

- Agreement of the agenda with the Forum Chair.
- Collation of the papers which will be disseminated five working days in advance of the meeting.
- Maintenance of a record of matters arising and issues to be carried forward.

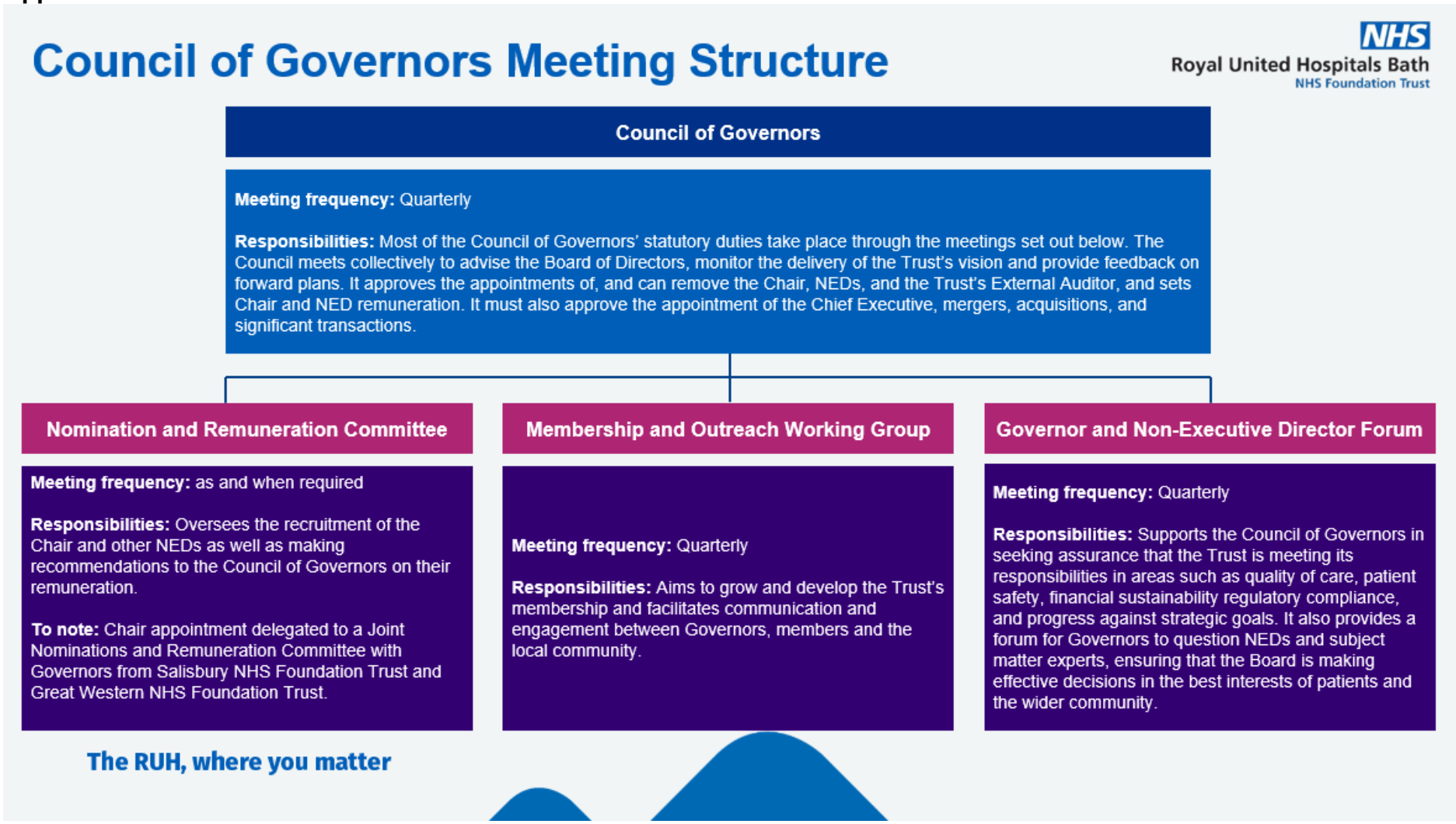
8.2. The Forum will undertake an annual review of its performance against the Terms of Reference to evaluate the achievement of its objectives. The outcome of this review will be reported to the Council of Governors.

8.3. These Terms of Reference will be reviewed annually as part of the process of monitoring the Forum's effectiveness.

Ratified by the Council of Governors on:

Date of Review:

Appendix 2:


Council of Governors Meeting Structure
NHS
Royal United Hospitals Bath
NHS Foundation Trust
Council of Governors
Meeting frequency: Quarterly
Responsibilities: Most of the Council of Governors' statutory duties take place through the meetings set out below. The Council meets collectively to advise the Board of Directors, monitor the delivery of the Trust's vision and provide feedback on forward plans. It approves the appointments of, and can remove the Chair, NEDs, and the Trust's External Auditor, and sets Chair and NED remuneration. It must also approve the appointment of the Chief Executive, mergers, acquisitions, and significant transactions.
Nomination and Remuneration Committee
Meeting frequency: as and when required
Responsibilities: Oversees the recruitment of the Chair and other NEDs as well as making recommendations to the Council of Governors on their remuneration.
To note: Chair appointment delegated to a Joint Nominations and Remuneration Committee with Governors from Salisbury NHS Foundation Trust and Great Western NHS Foundation Trust.
Membership and Outreach Working Group
Meeting frequency: Quarterly
Responsibilities: Aims to grow and develop the Trust's membership and facilitates communication and engagement between Governors, members and the local community.
Governor and Non-Executive Director Forum
Meeting frequency: Quarterly
Responsibilities: Supports the Council of Governors in seeking assurance that the Trust is meeting its responsibilities in areas such as quality of care, patient safety, financial sustainability regulatory compliance, and progress against strategic goals. It also provides a forum for Governors to question NEDs and subject matter experts, ensuring that the Board is making effective decisions in the best interests of patients and the wider community.
The RUH, where you matter