

Bundle Council of Governors 10 September 2026

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

Thursday 10th September 2026, 09:15 – 12:00

Venue: Room C, Education Centre (E7), RUH, Bath, BA1 3NG

No	Item	Presenter	Action	Time	Enc.
Opening Business					
1.	Welcome, Introduction and Apologies: Anthony Green, Paul Newman	Paul von der Heyde, Chair	-	09:15	-
2.	Declarations of Interest		To note		-
3.	Minutes of the Council of Governors meeting held on 10 th June 2026		For approval		Enc.
4.	Action List and Matters Arising		For approval		Enc.
Strategic Update					
5.	Update from the Chief Executive and Managing Director	Cara Charles-Barks, Chief Executive / John Palmer, Managing Director	For info	09:20	Enc.
6.	Digital Transformation and EPR	Jonathan Hinchliffe, Group Chief Digital and Information Officer	For info	09:40	Enc.
7.	Strategy and Business Planning Update	Fiona Bird, Deputy Director of Strategy	For info	09:50	Enc.
Governance					
8.	Presentation of External Audit Letter	Eddie Bell, Deloitte	For info	10:00	Enc.
9.	Vice-Chair and Senior Independent Director Appointments Update	Paul von der Heyde, Chair	To note	10:05	Verbal
10.	Governor Participation and Attendance		To note	10:10	Verbal
11.	Election Update and Timeline	Roxy Milbourne, Interim Head of Corporate Governance	To note	10:15	Enc.
12.	Annual General Meeting and Annual Members' Meeting Update		To note	10:20	Verbal
Governor Updates					
13.	Membership and Outreach Working Group Update	Ian Lafferty, Public Governor	To note	10:25	Verbal
14.	Lead Governor Report	Kate Cozens, Lead Governor	To note	10:30	Verbal
Comfort Break: 10:35 – 10:50					
Governor and Non-Executive Director Forum					

15.	NED Activities and Insights from the Last Quarter	All NEDs	For disc.	10:50	Verbal
16.	Governor Feedback and Assurance Questions for NEDs	All Governors	For disc	11:00	Verbal
Closing Business					
17.	Items for Future Work Plan / AOB	Paul von der Heyde, Chair	For disc.	11:55	Verbal
Date of Next Meeting: 7th December 2026, 09:00 – 12:00 Venue: Room C, Education Centre (E7), RUH, Bath, BA1 3NG					

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
Wednesday 10th June 2026, 15:00 – 17:00
Room T0.24, Bath Spa University Sion Hill Campus, Sion Hill, Bath, BA1 5SF**

Present:

Paul von der Heyde, Chair, BSW Hospitals Group

Public Governors

Ian Lafferty
Kate Cozens
Anna Beria
Chris Leadbeater
Rachel Walker
Ming Keng Teoh
Vic Pritchard

Staff Governors

Gary Chamberlain
Fi Abbey
Craig Jones

Stakeholder Governors

Alison Born

In attendance:

Cara Charles-Barks, Chief Executive Officer (via Microsoft Teams until item 6)
John Palmer, Managing Director
Paul Fairhurst, Non-Executive Director
Joy Luxford, Non-Executive Director
Antony Durbacz, Non-Executive Director
Jude Gray, Chief People Officer (item 7)
Eugenie Mellon, Group Associate Director for HR Operations (item 7)
Rhiannon Hills, Director of Transformation (item 8)
Roxy Milbourne, Interim Head of Corporate Governance

CG/26/06/01 Chair's welcome, introduction and apologies

The Chair welcomed everyone to the meeting. Apologies had been received from Simon Harrod and Sumita Hutchison, Non-Executive Directors, and the following Governors:

Public Governors

Adam Cooksey
Anne-Marie Walker
Paul Newman

Staff Governors

Anthony Green
Fiona Marfleet

Stakeholder Governors

Deborah Wilson
Cllr Ian Thorn
Lucy Baker

CG/26/06/02 Declarations of Interest relevant to items on the agenda

The Council of Governors confirmed that there were no declarations of interest relevant to the items on the agenda.

CG/26/06/03 Approval of the minutes of the Council of Governors meetings held in public on 24th February 2026 and 16th March 2026

The minutes of the meetings held in public on 24th February 2026, and 16th March 2026 were approved as a true and accurate record of the meetings.

CG/26/06/04 Action List and Matters Arising

The Council of Governors reviewed the action list and noted that there were no open actions.

CG/26/06/05 Update from the Council of Governors meeting in private

The Chair provided a verbal update from the Council of Governors meeting held in private. The Council noted that the proposed appointments of ten Non-Executive Directors to support the BSW Hospitals Group governance arrangements had been approved. The Council also recorded its thanks to Antony Durbacz and Sumita Hutchison for their support and contribution as Non-Executive Directors over their terms of office.

CG/26/06/06 Update from the Chief Executive and Managing Director

The Managing Director presented a summary of the RUH year-end position, and the progress made during 2025/26. He reminded Governors that the Trust had entered national tiering in September 2025 across key performance domains and had been placed in segment 4 of the NHS Oversight Framework. He reported that significant improvement had been delivered during the second half of the year through the Trust-wide Call to Action, with improvements across elective recovery, diagnostics, cancer faster diagnosis and urgent and emergency care, although urgent and emergency care and the 62-day cancer standard remained areas requiring further improvement.

The Council noted that the RUH had developed a three-year plan and that this had been signed off with conditions, which had subsequently been addressed. The Managing Director highlighted that the Trust was now operating from a stronger platform than at the mid-year point, but that complacency must be avoided given the continued scale of operational and financial challenge.

The Chief Executive joined remotely and thanked colleagues for the improvement work delivered during the year. She emphasised that the Electronic Patient Record programme should be understood as a transformation tool rather than solely a digital implementation, with opportunities to support clinical pathway redesign and strengthen care across hospital and community settings. She also updated the Council on the development of the BSW Hospitals Group strategy, noting that engagement with Governors would be sought as part of that process.

The Council discussed urgent and emergency care pressures, including the need to understand demand across the full patient pathway and not only within the hospital. Governors challenged whether additional urgent treatment centre capacity would resolve flow pressures if demand into hospital and discharge delays remained high. The Managing Director acknowledged the point and explained that work was underway with the Integrated Care Board, local authorities and community providers to develop a more complete shared dataset covering primary care, hospital flow and social care capacity.

Governors also sought clarity on missing data in the pathway information and asked whether analysis was being undertaken to identify patients attending the Emergency Department because they had been unable to access services in the community. The

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Managing Director confirmed that this analysis was being developed and would inform wider Group and system discussions.

The Council of Governors noted the Chief Executive and Managing Director's report.

CG/26/06/07 Temporary Staffing Briefing

The Chief People Officer presented the Temporary Staffing Briefing, which informed the Council of the decision to create a single BSW Hospitals Group Bank service provided by Bank Partners. The paper explained that the new model would consolidate the three existing Bank services into a single Group-wide service, supported by centralised workforce management and a single digital platform for shift access and booking.

The Chief People Officer explained that the proposal had been developed as part of the wider corporate shared services work across the Group. She advised that the existing temporary staffing arrangements were fragile and that the proposal was intended to improve service quality, resilience, fill rates and return on investment. The Council noted that the current average fill rate was approximately 80%, with the new contractual performance standard set at 85%.

The Council discussed whether the new arrangement constituted agency staffing. The Chief People Officer clarified that the arrangement would continue to operate as a worker agreement rather than an agency route, with no obligation on the Trust to offer work and no obligation on workers to accept shifts. She confirmed that pay rates, unsocial hours arrangements, shift release and related operational decisions would remain controlled by the Group.

The Council raised concerns around the use of a private provider, the redirection of public money, the impact on bank-only workers and pension arrangements, and whether the arrangement would deliver the savings and service improvements anticipated. The Chief People Officer advised that bank-only workers would no longer be eligible for the NHS Pension Scheme through the bank arrangement but would be offered access to an alternative pension provision, and that substantive NHS staff undertaking bank shifts would retain their NHS pension through their substantive employment.

Governors challenged whether staff would realistically work across the three Trust sites given the geography of the Group. The Chief People Officer explained that the model would make cross-site working easier for those who wished to do so, but that no worker would be required to work at another site. The Council noted that some workers might already hold multiple bank agreements and that the new model would create a single process for accessing shifts across the Group.

The Council sought clarity on why medical staff were not included. It was explained that medical staffing was subject to existing Locums Nest and direct engagement arrangements, and that medical and dental fill rates were performing well under the current arrangements.

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Governors also raised concerns about communication, particularly that Staff Governors had first become aware of the issue through external and union communications rather than through an earlier Governor briefing. The Chief People Officer acknowledged that although engagement with staff side and affected workers had been prioritised, there had been a missed opportunity to engage Governors earlier, and she apologised for that learning point.

The Council noted that the go-live date was 1 August 2026 and that a call-in request had been made through the Bath and North East Somerset Health and Scrutiny Committee. It was explained that the Trust's view was that the change did not constitute a reconfiguration of NHS services, as clinical services were not changing, and that implementation was not expected to be delayed.

A Non-Executive Director confirmed that Governor questions on temporary staffing had been seen in advance of the meeting and that Non-Executive Directors had received assurance through Committee, Trust Board and Joint Committee discussions.

The Council of Governors noted the Temporary Staffing Briefing.

CG/26/06/08 Business Planning Update: Strategic Objectives

The Director of Transformation presented the Business Planning Update and provided an overview of the Medium-Term Plan for 2026/27 to 2028/29, including the delivery framework, strategic initiatives, breakthrough objectives and corporate projects. The Council noted that the Plan had been developed collaboratively across the BSW Hospitals Group and had now moved into the delivery phase.

During discussion, Governors raised concerns regarding the development of commercial opportunities and private patient activity, including whether this could create a two-tier service. The Managing Director advised that the emerging commercial strategy would be supported by an ethical framework and that Governors would have an opportunity to scrutinise the proposals as they developed. He also confirmed that income generated through Sulis Hospital was reinvested in support of the wider organisation and its financial sustainability.

The Council requested a future discussion on Sulis Hospital and the wider commercial strategy, which the Interim Head of Corporate Governance confirmed would be incorporated into the forward work programme.

Action: Interim Head of Corporate Governance

The Council of Governors noted the Business Planning Update and the Strategic Initiatives, Breakthrough Objectives and Corporate Projects for 2026/27.

CG/26/06/09 Approval of Constitution

The Interim Head of Corporate Governance presented the paper seeking Governor approval of procedural amendments to the Trust Constitution to support the introduction of the BSW Hospitals Group Board. She explained that the amendments followed

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approval by the Board of Directors on 7 May 2026 and were now presented to the Council of Governors in accordance with the statutory framework.

The Council noted that the RUH was working with Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust under a formal Partnership Agreement to strengthen collaborative working. This included the establishment of a Group Board operating as a General-Purpose Joint Committee. The Interim Head of Corporate Governance emphasised that the amendments were procedural only and did not change the statutory role, powers or accountabilities of the Trust or the Council of Governors.

The proposed changes focused on how governance processes would operate in practice, including alignment of meeting and notice periods, updated voting and quorum arrangements, and clarification of decision-making thresholds. In particular, the Council noted that quorum would move to at least half of voting members, decisions would be clarified as being taken by simple majority, and some procedural timelines would be shortened to support more responsive decision-making across the Group. The Council noted that the revised Standing Orders were provided at Appendix 1 for completeness and set out how the Board conducts its business, provided a consistent framework across the three Trusts, and confirmed that each Trust remains a separate statutory organisation retaining its own functions. Governors were not asked to approve the Standing Orders directly, but approval of the constitutional amendments would give them effect.

The Interim Head of Corporate Governance advised that the proposed approach was compliant with the NHS Act 2006 and relevant governance guidance and was supported by external legal advice confirming that the arrangements were within the Trust's powers and maintained accountability. The Council noted that the Trust would remain sovereign and accountable for its own decisions and that the arrangements did not dilute accountability or transfer authority away from the Board or Council.

The Council also noted that there would be no change to the role of Governors, including holding Non-Executive Directors to account, approving constitutional amendments and exercising existing statutory functions. The amendments were intended to ensure that governance arrangements remained robust, aligned across the Group and fit for joint decision-making in practice.

The Chair invited questions. There were no substantive questions raised and the Council of Governors approved the proposed amendments.

CG/26/06/10 NED Feedback and Governor Assurance Questions

The Council noted that Governor assurance questions had been discussed as part of the earlier agenda items, particularly in relation to temporary staffing. The Council discussed how Governor questions would be routed under the new Group governance arrangements. It was confirmed that Governors should continue to send questions through the Corporate Governance route and that the questions would then be directed to the appropriate person to respond. It was noted that responses would continue to be

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received by Governors, with the governance and record-keeping route reflecting the new Group arrangements where appropriate.

CG/26/06/11 Membership and Outreach Working Group Update

The Council received an update from the Membership and Outreach Working Group, noting the development of a digital newsletter for members and discussions regarding membership recruitment in light of uncertainty surrounding the Health Bill.

The Council of Governors noted the Membership and Outreach Working Group update.

CG/26/06/12 Governor and NED Forum Update

The Lead Governor provided feedback following the first Governor and NED Forum, which had taken place earlier that day. The Council noted that the Forum had generated constructive discussion but that more time would be needed for future meetings. The Council discussed the need to develop the right mechanism for Governor and Non-Executive Director engagement as the organisation moved into Group governance arrangements. It was suggested that future meetings could consider rotating focus across committee areas rather than attempting to cover all committees at each meeting.

The Council of Governors noted the Governor and NED Forum update.

CG/26/06/13 Lead Governor Report

Kate Cozens, Lead Governor welcomed Paul von der Heyde as Chair and noted the breadth of skills, life experience and commitment within the Council of Governors. She observed that the Council recognised the need for change and was keen to work productively and effectively under the new arrangements.

She reflected on the Council of Governors workshop held on 30 April 2026 in Devizes and noted that there had been good Governor attendance and that Governors had met the majority of the Group Non-Executive Directors who would take up their roles from 1 July 2026. She reported that the workshop had included useful discussion on the different communities across the Group, health inequalities, access barriers and approaches to membership and public engagement.

The Lead Governor reported that Governors had been disappointed not to have been briefed earlier on the temporary staffing proposals before the issue was raised externally by local union communications. She noted that although the topic had been referenced at the earlier away day, this had not been sufficiently clear for Governors to understand the nature of the proposal.

The Council noted that an introductory session on the Ward Accreditation Scheme was being organised for Governors, with existing Governors encouraged to participate given the value of the scheme in supporting understanding of ward-level improvement and assurance.

The Lead Governor also highlighted the need for succession planning, noting that seven Governors would complete their three-year terms of office in October 2026. The Council

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noted that both the Lead Governor and Deputy Lead Governor would also complete their terms and Governors were asked to consider whether they wished to seek re-election or put themselves forward for Lead Governor or Deputy Lead Governor roles.

The Council formally recorded its thanks to Sumita Hutchison, Antony Durbacz and Liam Coleman for their support and contribution to the Council of Governors and noted the report.

CG/26/06/14 Stakeholder Governor Feedback

The Council received stakeholder feedback from Alison Born. She reported that Bath and North East Somerset Council continued to work with the RUH and HCRG Care Group to support hospital flow. She advised that routine delay numbers were lower than other areas across BSW, although they were slightly higher than usual and represented around 12% of delays across BSW beds. She explained that some delays were outside the direct control of the local authority, including family and deputyship issues. The Council also noted that a new permanent social work team manager had started in the hospital discharge service and that additional locum capacity had been put in place.

The Managing Director noted the importance of learning from good practice in Bath and North East Somerset and applying this to wider work with Wiltshire and HCRG Care Group where appropriate.

The Council noted the Stakeholder Governor feedback.

CG/26/06/15 Items for Future Work Plan / Any Other Business

The Chair noted that the forward work programme would be developed with the Lead Governor.

A Non-Executive Director asked how Governor assurance questions would be reported under the new governance arrangements. It was confirmed that Governor questions and responses would be reported through the Public BSW Hospitals Group Board.

The Chair thanked Governors for their support during a period of significant change and noted that future Council meetings should focus less on constitutional and structural matters and more on the substantive issues where Governors could add value, particularly integration and service improvement.

The meeting closed at: 17:15

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Action list of the Council of Governors of the Royal United Hospitals Bath NHS Foundation Trust following the meeting held on 10th June 2026

Action No	Details	Agenda Item Number	First Raised	Action by	Progress Update & Status	Lead
CG284	Business Planning Update: Strategic Objectives Interim Head of Corporate Governance to incorporate a future discussion on Sulis Hospital and the wider commercial strategy into the forward work programme.	CG/26/06/08	June 2026	Sept 2026	Complete, Sulis Hospital and the wider commercial strategy incorporated into the future work programme. To close	Interim Head of Corporate Governance

Public Council of Governors

Agenda item	5.1
Report title	CEO Report
Date of meeting	3 September 2026
Sponsor	Cara Charles-Barks, Chief Executive Officer
Prepared by	Ben Irvine, Programme Director, BSW Hospitals Group Helen Perkins, Senior Executive Assistant to the Chief Executive
Approval Process: (where has this paper been reviewed and approved)	CEO Approved
☒ FOR ASSURANCE	☐ FOR DECISION ☒ FOR INFORMATION

STRATEGIC ALIGNMENT (Tick all priorities that this paper materially supports)

☒ Developing an engaged workforce	☒ Making our teams diverse and inclusive
☒ Making our services safer	☒ Improving timely access to our services
☒ Improving the experience of those who use our services	☒ Improving our financial sustainability
☒ Improving health equity	

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
R1	Becoming an Effective Group
R3	Delivering Digital Maturity
R4	Transforming Models of Care
R5	Increasing Financial Sustainability
R6	Reducing Waits

KEY MESSAGES

Following the last public board meeting the group has been undertaking a range of activities.

For the three Care Organisations, June was a particularly busy month with a continued focus on elective, diagnostic and cancer recovery. This was delivered alongside significant urgent and emergency care, flow, workforce and financial challenges.

Recovery of our financial position and long-term financial sustainability remain a priority across the group. Finance capacity and capability, grip and control, forecasting and recovery delivery are being strengthened ahead of approval and submission of the revised group recovery plan.

The executive team remains focused on recovery over the next six months to support a return to the operational and financial plan.

The Group's risk and assurance arrangements continue to mature. The report presents three key risks for each Care Organisation, with actions and updates from the August Group Risk Register and latest Managing Directors' reports.

RECOMMENDATION

The Council of Governors is asked to note the report.

APPENDICES

None

Introduction

This report aims to provide the Board with both an update on our strategic context and cover the most significant developments across BSW Hospitals Group. It will also highlight matters for board attention and oversight.

Strategic initiatives and priority activities for the Group

Our five Group strategic initiatives remain central to recovery of today but also the transformation that we need for the future. As a reminder our areas of focus are transforming models of care, our people, increasing sustainability, delivering digital maturity and developing our Group. As each of the programs has matured, the interdependence of each program is becoming more apparent. Financial recovery depends on clinical and corporate transformation, workforce availability and productivity; operational recovery depends on system flow and discharge; and implementation of transformational change depends on digital, estates and leadership capacity and capability.

Operational performance and recovery

Quality, safety and maternity

The Managing Directors' reports highlight a number of areas that require continued oversight. Actions being taken to manage and mitigate these risks will be covered in the Managing Directors update to Board. Issues highlighted are:

- GWH: Operational pressure, corridor care, maternity triage estate constraints and neonatal staffing.
- RUH: Infection prevention and control, corridor-care exposure, End of Life Care capacity and maternity safety.
- SFT: The Care Quality Commission's surgical-services findings have been met with an improvement response and continued inspection readiness.
- Maternity and neonatal safety remains a Board-level priority across the Group.

Urgent and emergency care, patient flow and winter planning

Urgent and emergency care remains the most pressured operational area across the Group.

- GWH reported sustained emergency demand, high occupancy, repeated critical incident status and incidence of corridor care.
- RUH continues to face rising demand, delayed discharge, incidence of corridor care and a risk regarding available capacity for winter.
- SFT reports high occupancy, patients no longer meeting the criteria to reside and ambulance handover delays as key constraints.
- The common issue across the group is end-to-end flow which requires stronger internal control and improved out-of-hospital and system capacity.

Winter planning is well underway. As a reminder, our plan, which we are developing with BSW system partners, must be submitted to NHSE by the Board at the end of September.

At both public board and private board today, we will be reviewing the recovery actions for UEC in each organisation and across the system, as we remain committed to continuing to improve access and experience of all our urgent care services.

Referral to treatment and elective recovery

We are seeing good recovery of our elective care position across the group. Both RUH and SFT show sustained control of very long waits and performance above trajectory. GWH continues to require enhanced focus on RTT recovery and validation. GWH have shown sustained week-on-week improvement and are now meeting their recovery trajectory. Across the Group we are actively sharing best practice and insight to ensure that we can recover to the planned levels of performance as quickly as possible.

Cancer and diagnostics

Cancer recovery is improving but remains inconsistent, with a number of pathway-specific pressures across the three organisations. Across the group there are recovery plans in place to respond to these pressures, but we are seeing a significant increase in demand which we are discussing with commissioning colleagues to ensure that we can respond and right size our service delivery as appropriate.

Diagnostic performance is similarly challenged in places across the group. RUH remains ahead of trajectory, SFT is below plan in a small number of areas, and GWH continues to perform strongly whilst

addressing capacity and access issues. Mutual aid, pathway redesign and specific workforce actions remain important Group strategies for managing performance.

Financial sustainability

Financial sustainability is the most significant shared challenge across the group. The common risks are the scale and pace of savings required. In particular, ensuring identified opportunities are delivered, cash position is managed and we have the capacity to deliver transformation while managing day-to-day operational pressure. The Group has taken action to strengthen finance team capacity and capability and improve senior turnaround leadership. This has been necessary to ensure that we have the appropriate level of grip and control, consistency of reporting and forecasting, and the pace needed to ensure delivery of our recovery plan. This is intended to complement, not replace, the accountability of Group leaders and the Care Organisation, importantly it is designed to build sustainable in-house capability.

The revised recovery plan will be reviewed through the Financial Sustainability Committee and is due for submission to NHS England on 10 September 2026. An extraordinary Group Board is proposed for 9 September 2026 to approve the plan before submission. The plan will also form a central part of preparation for the Board-to-Board session on 5 October 2026.

Weekly executive recovery meetings have been established to support delivery and to drive the pace of recovery needed.

Workforce and culture

There are several areas of focus across the group pertaining to workforce and overarching culture. Workforce availability, sickness absence, use of temporary staffing and the capacity to deliver change remain key constraints. There are a number of established priorities across the group designed to ensure they address the key pressure points as they differ in each of the organisations. SFT continues to focus on staff unavailability as a breakthrough objective; RUH is progressing its Healthier Workforce Programme and targeted recruitment; and GWH is addressing safer staffing, sickness, temporary staffing and clinical leadership capacity.

As we focus on recovery of the financial position and responding to operational pressure, workforce usage and planning are areas of increased oversight and scrutiny across the Group.

Main capital schemes

We have a number of large capital schemes underway across the group.

- At SFT, the DASH program is intended to replace our aging day-surgery and diagnostic infrastructure. The business case has identified a £6m capital gap, with further redesign and alternative funding routes being explored. SFT's Urgent Treatment Centre remains on track for opening in the autumn and is central to its front-door redesign and reducing crowding in the emergency department.
- At RUH, the modular Urgent Treatment Centre supports the UEC 100-day program and reconfiguration of urgent pathways.

Delivery of all of these programs requires continued oversight of affordability, mitigation of any construction risk and ensuring that cost remains within the allocated capital envelope.

Risks across the Care Organisations and BSW system

The risks listed below are the three key risks reported for each Care Organisation. These and the subsequent mitigations are covered in each of the care organization reports which we will discuss in detail later in the meeting.

Great Western Hospitals

Key risk	Why it is being escalated
Patient flow and high bed occupancy	This remains the most significant operational risk at GWH. June was characterised by sustained emergency demand, high occupancy, critical incident escalation and corridor care. It continues to require Board visibility because of its direct effect on patient safety, privacy, dignity and access, and its dependencies on discharge capacity and wider system flow.
Financial sustainability and delivery of the savings programme	Delivery of the financial plan remains challenging because of the scale of recurrent saving required and the need to deliver transformation alongside operational pressure. Governance and recovery controls are in place, but delivery remains dependent on scheme maturity, recurrent benefit and sufficient organisational capacity.
Elective access and RTT recovery	RTT recovery remains an area of enhanced visibility. GWH continues to experience pressure on waiting times and elective performance, requiring sustained operational focus, reliable validation and performance information, and continued use of Group improvement approaches.

Royal United Hospitals Bath

Key risk	Why it is being escalated
Urgent and emergency care performance and flow	Flow and capacity remain the most significant operational challenge at RUH. Rising demand, discharge constraints, corridor-care exposure and the projected winter bed-capacity gap create material risks to performance, quality and patient experience. Several mitigations remain dependent on commissioner and system-partner action.
Delivery of the financial plan and savings programme	Financial recovery and cash sustainability remain the organisation's highest strategic concern. The position is materially adverse to plan and requires sustained savings delivery, productivity improvement and tighter recovery trajectories. Cash resilience continues to require active executive and Group oversight.
Ageing estate, backlog maintenance and fire safety compliance	The RUH estate continues to present strategic and operational challenges, including infrastructure capacity, backlog maintenance, fire-safety compliance and the ability to support

	future development. Its scale, compliance implications and capital requirements cannot be managed solely through routine controls.
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Salisbury

Key risk	Why it is being escalated
Financial recovery and delivery of the savings programme	Delivery of the break-even plan remains dependent on a sizeable savings and transformation programme, productivity gains and active management of cash-flow pressures. It remains the principal organisational risk because delivery risk increases through the year and several dependencies sit beyond the Care Organisation.
Urgent care flow and discharge	High occupancy, delayed discharge and patients who no longer meet the criteria to reside continue to constrain performance. This remains the principal operational challenge, with improvement dependent on both internal flow actions and a step-change in out-of-hospital and system capacity.
Workforce availability	Workforce availability remains a breakthrough objective and a critical enabler of performance, productivity, resilience and financial recovery. Staff unavailability remains materially above target and continues to affect temporary staffing expenditure and delivery capacity.

Group and system risks

As detailed in my Group Executive Committee report there are several risks across the group. These include capacity to deliver the scale of recovery and transformation needed at this time, financial sustainability and cash position; UEC flow, occupancy and discharge; workforce availability and use of temporary staffing; estates and capital affordability; digital and EPR readiness; and capacity to deliver multiple transformation programs at the pace needed.

To support mitigation and management of these challenges we are in the process of establishing a delivery approach that ensures the right level of daily and weekly focus on immediate recovery and a more integrated and ambitious approach to longer-term transformation.

Group strategy and Board development

Board strategy development workshop

The Board strategy development workshop brought together feedback from staff, volunteer, governor, partner and community engagement and enabled the Board to clarify the ambition of the proposed Group vision and strategic priorities.

The meeting was positive and clearly set out a shared ambition for the future. It also provided the board with the opportunity to ensure that we all progress with the same level of clarity.

We will continue to develop this over coming months to align the delivery of the strategy and our longer-term recovery plan.

Board development programme

The Group will participate in the first wave of NHS England's Board Development Program. It is a requirement that all boards undertake this program over the next 4 years. Initial engagement and baseline activity are underway and will also be aligned to the Group's development priorities. The program will provide an opportunity to strengthen collective leadership, clarify how the Group Board leads to serve our collective population and build the assurance and governance disciplines needed to ensure successful delivery of our ambition and strategy.

Recovery, oversight and external engagement

Forthcoming Board-to-Board session

NHS England has scheduled a Board-to-Board session for 5 October 2026. At this meeting we will focus on the revised recovery plan, which includes both operational and financial delivery plans. We will also share how the Group model is being used to accelerate improvement. The recovery plan is due to be submitted to NHS England on 10 September, following the proposed extraordinary Group Board on 9 September.

Leadership team

Rebecca Maxwell joined RUH in August as Chief Medical Officer. Rebecca is joining us at an important point in our clinical transformation program and EPR delivery. Rebecca is also taking a lead role in supporting our preparations for winter. I would also like to thank Emma-Kate Reed for her contribution and support to the organisation and colleagues over the past six months as acting CMO at RUH. In July we also welcomed Angie Ansell as interim Chief Nursing Officer in SFT.

Chief Executive external meetings

Since my last public report, I have continued to engage with local Members of Parliament, national NHS leadership teams and the NHS England South West regional team. The principal themes included access and operational performance, financial sustainability and recovery, winter readiness, maternity and neonatal assurance, provider oversight and the ongoing development of the BSW Hospitals Group.

Conclusion

It remains a very busy time for the Group, and I would like to thank both the executive team and our wider staff for their continued passion and commitment to deliver services of high standard. As a Group we have shown genuine improvement in a number of areas. Having said that there are several risks including UEC flow, finance, workforce, estates and transformation capacity that require ongoing oversight and mitigation. Over the last two months the Group has continued to mature in its way of working, which will translate into sustained delivery supported by a credible recovery plan focused on improving services and experience for patients and staff.

Royal United Hospitals Bath

Managing Director's Report:

RUH Care Organisation assurance, risk and delivery position

Report Title:	Managing Director's Report: RUH Care Organisation Assurance, Risk and Delivery Position
Date of meeting:	3 September 2026
MD / Lead:	John Palmer, Managing Director
Purpose:	☒ FOR ASSURANCE ☐ FOR DECISION ☒ FOR STRATEGIC STEER

At a glance

This report provides assurance on the first full cycle of the RUH Care Organisation governance structure (June (M3) data), supplemented by the latest Finance & Performance and Quality & Safety Committee evidence (July (M4) data). It highlights where Board attention is required to convert visibility into grip. The overall judgement is one of limited assurance at this stage of the financial and operational year. There is evidence of control in diagnostics, RTT, productivity and governance implementation, but a smaller group of high-impact risks remains across financial recovery, system demand, UEC flow, corridor care, winter capacity, quality, workforce and EPR delivery. Several cannot be resolved by RUH alone and require explicit Group, commissioner and wider system action.

- Financial recovery and cash sustainability:** the £10.6m year-to-date deficit is £5.6m adverse to plan, with no evidenced route to break-even. **Active mitigations** are the working-capital application, refreshed divisional recovery plans, FIPB assurance points on 11 and 15 September, a Medicine deep dive, and tighter bank, agency and waiting-list initiative controls. **Remaining test:** recurrent cash-releasing savings and sustained monthly improvement sufficient to reduce the forecast deficit and cash exposure.
- System demand, UEC flow and winter resilience:** attendances are approximately 9% higher over two years, ambulance conveyance and lower-acuity Type 1 activity are increasing, NCTR is materially off plan, 602 patients experienced more than 45 minutes of corridor care in July and modelling indicates a potential 72-bed peak deficit. **Active mitigations** are joint RUH and SWASFT analysis of the displacement hypothesis, review of alternative-pathway reliability, a strengthened clinically led Care Coordination model, the UEC 100-day programme, UTC reconfiguration, Hospital at Home (service consolidation and ICB escalation) and targeted NCTR reduction. **Remaining dependency:** commissioner funding, community-provider delivery and measurable system impact on demand, conveyance, discharge and bed use.
- Quality and regulatory risk:** IPC outlier status, corridor-care exposure, End of Life Care capacity and maternity safety require continued oversight. **Active mitigations** are external IPC review and ICB support, a pre-winter stocktake of CQC UEC actions, maternity recruitment and escalation arrangements, diagnostic-results assurance and explicit inclusion of IPC in winter planning. The HTA inspection provides positive assurance on licensing, patient care and dignity; the identified procedural findings are being managed through the agreed improvement plan. **Remaining test:** sustained improvement in outcomes and closure of overdue actions.
- EPR and transformation readiness:** outpatient templates, migration-critical data quality, CNIO and CSO capacity, training backfill and cutover resilience remain exposed within a digital portfolio of more than 700 programmes. **Active mitigations** are the RUH CCIO appointment, confirmed anaesthetic-monitor funding, identification

of 60% of training-facility requirements, specialty template work and post-cutover activity planning through the Business Planning Working Group. **Remaining dependency:** protected clinical-safety and operational capacity, quantified recovery trajectories and safe exception handling before Trial Load and cutover.

- **Workforce resilience and delivery capacity:** sickness absence, appraisal performance, temporary staffing and high-risk service gaps continue to affect quality, finance and operational resilience. **Active mitigations** are the Healthier Workforce Programme, bank-partner implementation, divisional recovery action, maternity and Medlock recruitment, and targeted skill-mix changes. **Remaining test:** measurable reductions in absence and temporary staffing, improved appraisal compliance and evidence that workforce actions are releasing capacity for recovery and transformation.
- **Overall assurance requirement:** the next cycle will aim to pair each material risk with a named owner, funded or agreed mitigation, quantified trajectory and explicit Group or system decision where RUH cannot deliver the control alone.

The risk visual in **Section 4** maps principal risks by residual exposure and strength of control, with the “Executive grip zone” highlighting issues where exposure is high and mitigations remain least secure.

Section 1: Executive Summary

1.1 Alert | Advise | Assure

ALERT: Draw attention to matters requiring the Board's awareness or action.

Financial recovery and cash require immediate Group oversight. The year-to-date deficit is £10.6m, £5.6m adverse to plan, and the medium forecast of £19.9m still requires approximately £1.5m monthly improvement with no evidenced route to break-even. Cash support is likely to be required. Active mitigations are the working-capital application, FIPB assurance points on 11 and 15 September, refreshed divisional plans, a Medicine deep dive and tighter temporary staffing and waiting-list expenditure controls. The Board test is whether these actions generate recurrent, cash-releasing improvement at the required pace.

System demand, flow and winter capacity now form one strategic risk. Attendances are approximately 9% higher over two years, ambulance conveyance and lower-acuity Type 1 activity are increasing, NCTR remains materially off plan and modelling indicates a potential peak-period adult bed deficit of approximately 72 beds. Improved handovers and same-day emergency care are positive, but unreliable alternatives and constrained discharge capacity risk shifting queueing and clinical exposure into Pitstop, corridors and waiting areas. RUH and SWASFT are jointly testing this displacement hypothesis, reviewing alternative pathways and strengthening clinically led Care Coordination, alongside the UEC 100-day programme, UTC changes, Hospital at Home work and targeted NCTR reduction. Delivery remains dependent on commissioner and community-provider action.

Quality, regulatory and workforce risks remain under active management. In July, 602 patients—6.5% of attendances—spent more than 45 minutes in an ED corridor. IPC outlier status, End of Life Care capacity, maternity workforce and safety, and cancer performance also require oversight. Mitigations include external IPC review, a pre-winter stocktake of CQC UEC actions, maternity recruitment and escalation arrangements, diagnostic-results assurance and targeted cancer recovery. The HTA inspection provides positive assurance on continued licensing, patient care and dignity, with procedural findings managed through an agreed improvement plan.

EPR readiness remains a major organisational delivery risk, with tangible progress but material dependencies. Anaesthetic-monitor funding, CCIO appointment, identification of 60% of training-facility requirements and structured post-cutover planning strengthen readiness. Executive grip is still required on outpatient schedules, migration-critical data quality, CNIO and CSO capacity, training backfill and safe exception handling ahead of Trial Load and cutover.

The immediate Board task is to convert these mitigations into accountable delivery. Each material risk now requires a named owner, funded or agreed action, quantified trajectory and time-bound assurance point, with explicit Group or system decisions where RUH cannot deliver the control alone. Detailed committee evidence and trajectories are set out later in the report.

ADVISE: Provide the context, analysis or recommendation the Board needs to understand the issue.

The first cycle of the Care Organisation assurance framework has demonstrated the value of triangulating quality, performance, finance and workforce intelligence. The key management insight is that several material risks are cross-cutting and cannot be fully understood through a single committee lens.

The Board is advised that some risks are currently more visible through assurance discussion than through the formal risk register, particularly EPR readiness, NCTR, maternity workforce, winter bed capacity, cancer performance and financial sustainability. The next cycle will therefore need to test whether there is sufficient capacity, capability, resource and executive ownership to deliver the proposed mitigations, particularly where delivery depends on staff release, clinical leadership, data quality remediation, programme backfill or system partner action.

The focus must now be on strengthening triangulation across quality, performance, workforce and finance, supported by rescoring the register using the Group 5+5+5 methodology and progressing risk housekeeping in line with agreed KPIs. This will be underpinned by risk education for staff and senior leaders, strengthened governance reporting and improved register quality, so that future escalation is based on clearer evidence, professional judgement and a more robust formal risk position.

ASSURE: Provide evidence (not assertions) that systems and controls are working as intended.

There is assurance that the new committee structure is operating as intended, with Quality & Safety, Finance & Performance and People & Culture Committees now feeding structured Alert, Advise and Assure reports into COMC. The first cycle has improved visibility of escalation matters and cross-domain risks, including Hospital at Home, IPC, EPR readiness, workforce resilience and financial recovery.

Specific evidence of controls operating includes diagnostic and RTT performance remaining above trajectory, with zero patients waiting over 65 weeks; productivity improving by 4.9% year on year, placing RUH in the top national quartile; establishment of a refreshed UEC leadership architecture; and active implementation of the 5+5+5 risk methodology. The unannounced HTA inspection confirmed that the mortuary remains suitable to be licensed, most standards were met and no significant patient care or dignity concerns were identified. The ten findings are procedural and are being managed through an agreed improvement plan: five actions are complete, four are due by October 2026 and the Estates flooring action has an agreed extension to August 2027. This supports placement of HTA assurance in the green assurance zone while retaining oversight of action completion. Across the wider risk portfolio, assurance remains developing and the next cycle must evidence impact and delivery trajectories.

1.2 Key Achievements and Good News

- Diagnostic performance remains ahead of trajectory, with 88.2% of patients receiving diagnostics within six weeks and continued reduction in breaches.
- Referral to Treatment (RTT) performance remains above trajectory and the organisation has sustained zero patients waiting over 65 weeks.
- The unannounced Human Tissue Authority inspection confirmed that the mortuary remains suitable for continued licensing and identified no significant patient care or dignity concerns. An improvement plan is in place for the ten inspection shortfalls, including five repeat findings.
- The annual staff flu campaign achieved 63.6% frontline vaccination uptake, ranking RUH second in the South West and sixth nationally.
- The revised assurance framework has been successfully implemented, establishing clearer governance, escalation and assurance arrangements across the Care Organisation.
- The RUH Intensive Care Unit (ICU) has received a highly positive external peer review from the South West Critical Care Network. The review described the unit as a high-performing service with clear evidence of progress since its previous assessment, recognising the team's work in addressing key risks and service pressures and highlighting strong plans for future development.
- The significant improvement in breast cancer performance at RUH has been recognised nationally, with the Trust cited as an exemplar on a recent national performance call. This reflects the breast team's work to implement a one-stop model and create sufficient capacity to support sustained improvement, with a positive impact on wider Trust cancer performance. This should be viewed in context: breast cancer performance has since dipped temporarily, largely due to sickness absence, and recovery may take time given the volumes involved.

Figure 1: Integrated Performance Report (IPR) Executive Summary

Executive Summary

Performance is moving in the right direction; demand, finance and sickness remain the constraints.

MOMENTUM

20-place rise

SOF 4 → SOF 3 | 11th most improved trust nationally at the end of 2025/26

- Largest Q4 improvement in NOF score across the [South West](#)
- RTT and diagnostics recovery continues
- June brought better 4-hour performance, fewer ambulance handover delays and fewer patients experiencing corridor care

CRITICAL PRESSURES

£7.6m deficit

Year to date; £2.8m adverse to plan. Cash balances remain a risk

- GP referrals and emergency demand are above plan at month 3
- 28- and 62-day cancer standards remain below target
- Savings plans cover 101% of the requirement, but only 60% (£25.1m) is green versus the 80% target
- Sickness is 5.6%; bank staffing remains above plan

NEXT 90 DAYS

UEC 100-day challenge

Mobilised across non-elective pathways; UTC relocation planning is under way for Q3

- Reduce urgent demand and NC2R delays, prioritising P0 delays over 24 hours and P2 length of stay
- Strengthen front-door safety, pressure-injury prevention and infection control
- Sustain RTT, cancer and diagnostics recovery; address challenged specialties
- Use Healthier Workforce workstreams to reduce absence, improve retention and strengthen wellbeing

Section 2: Performance Triangulation

2.1 SPC Variation

Figure 2: Operational Performance Alerting Watch Metrics

Watch Metrics - Performance - Alerting										
Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	% Discharged by Midday		45.0%		Jun-26	21.1%	X			Common Cause Variation
People we care for	% of patients waiting <12hrs in ED		93.7%		Jun-26	88.7%	X			Special Cause Concerning - Two Out of Three Low
People we care for	Adult % G&A bed occupancy		92.0%		Jun-26	96.0%	X			Common Cause Variation
People we care for	Mean time in ED - >75y				Jun-26	549				Special Cause Concerning - Two Out of Three High
People we care for	Mean time in ED - Mental health				Jun-26	629				Special Cause Concerning - Run Above Mean
People we care for	Non Elective Length of Stay		8.4		Jun-26	9.2	X			Common Cause Variation

Figure 3: Quality Alerting Watch Metrics

Watch Metrics - Quality - Alerting										
Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	% complaints responded to within agreed timescales with the complainant		90.0%		Jun-26	68.0%	X			Common Cause Variation
People we care for	% of ED admissions <60mins from CRTp		80.0%	80.0%	Jun-26	70.6%	X			Common Cause Variation
People we care for	Medication Incidents per 1000 bed days		7.0		Jun-26	8.2	X			Common Cause Variation
People we care for	Never events		0		Jun-26	1	X			Common Cause Variation
People we care for	Number of complaints received		30		Jun-26	35	X			Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 2		5		Jun-26	8	X			Special Cause Concerning - Two Out of Three High
People in our community	% Difference in DNA rates between IMD 1-2 and IMD 9-10		0.0%		Jun-26	5.2%	X			Common Cause Variation
People in our community	% Difference in RTT performance between IMD 1-2 and IMD 9-10		0.0%		Jun-26	-3.2%	X			Common Cause Variation

Alerting Watch Metric Commentary: Medication Incidents per 1000 bed day

Total medication incidents per 1,000 bed days increased to 7.61, against a local year-end target of 7. This remains below the April 2026 high of 9.73.

Incident reporting should continue to be encouraged, with attention given to trends, themes and levels of harm, rather than overall numbers in isolation. Increased reporting is not, in itself, a cause for concern.

Most incidents were low or no harm, with one incident graded as severe harm and one as moderate harm. The ratio of harm to no-harm events has reduced from the April high. Where incidents meet the criteria for a learning response, they are managed through the Patient Safety Team. The Medicines Safety Group reviews initial Datix reports as a cohort to identify themes and trends, and receives updates on final reports when available.

Similar to previous months, administration and prescribing incidents were the most common incident types reported. High throughput areas including ED and pharmacy reported the highest number of incidents.

The Medicines Safety Group will continue to review this metric, alongside themes and trends, to identify areas for improvement.

Figure 4: Medication Incidents by Subcategory

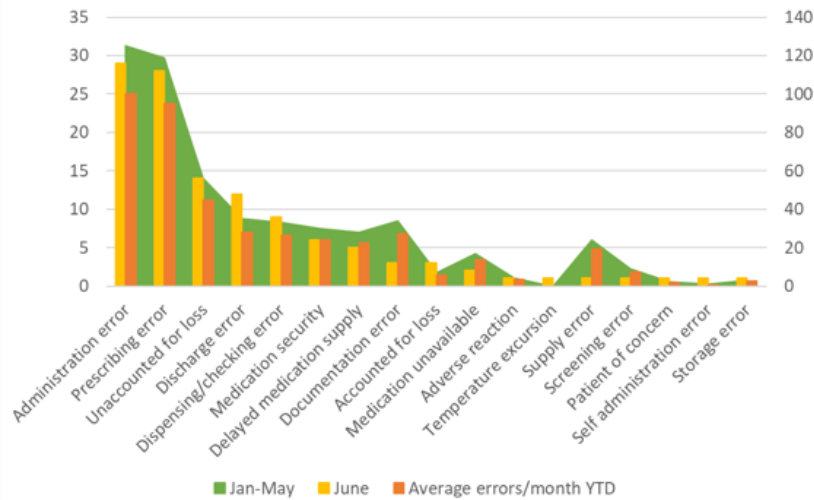
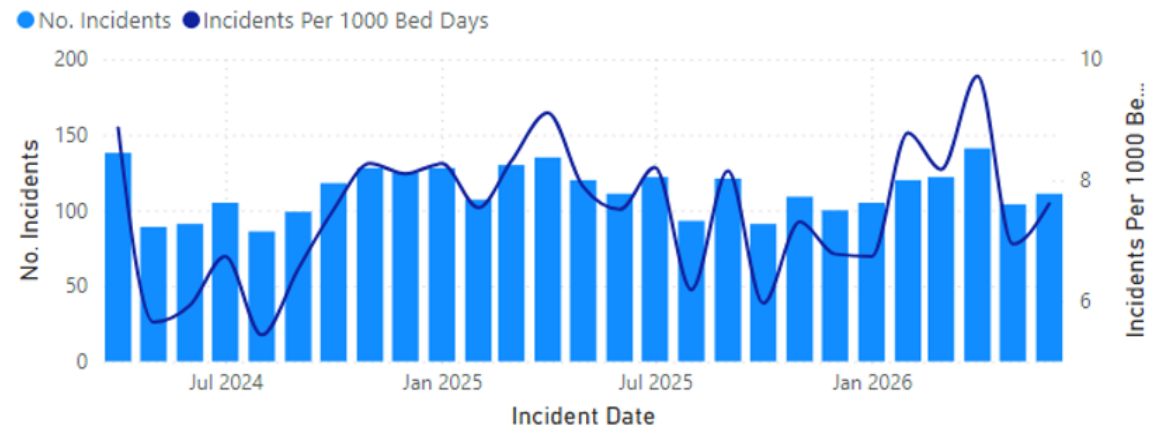


Figure 5: Total Incidents & Incidents Per 1000 Bed Days



2.2 Cross-Domain Analysis

Quality & Safety

Operational pressures continue to affect quality. The Trust is an IPC outlier for *C. difficile* and *E. coli*, with regional and ICB support reviewing drivers and strengthening improvement actions. Pressure-ulcer themes include acuity, prolonged ED stays, skin checks, repositioning and escalation. Further assurance work covers infection prevention, pressure-ulcer prevention, Hospital at Home and End of Life Care.

End of Life Care requires fuller context within the unmitigated quality and safety position. Although rated outstanding by CQC three years ago, this reflected a small team delivering high-quality care rather than a sustainable capacity model. Demand now exceeds capacity and performance is materially off benchmark. COMC concluded that a clear investment case is needed to demonstrate workforce resilience and service sustainability ahead of future CQC scrutiny.

Workforce & Finance

Workforce and financial performance remain closely linked. Sickness absence remains above trajectory and appraisal compliance is close to 80%, below the 90% organisational target. Temporary staffing remains elevated, and several high-scoring workforce risks continue to require oversight. Workforce resilience and financial sustainability should therefore be managed as a single strategic delivery risk.

Access & Operational Delivery

Performance remains mixed. Diagnostics and RTT are ahead of trajectory, while UEC and cancer remain challenged by demand and capacity. Cancer performance was 75.1% against the 80% 28-day Faster Diagnosis standard, driven principally by Breast and Skin; Skin received more than 300 additional referrals compared with June 2025 and experienced short-term locum disruption. The 31-day standard was achieved at 94.4%, but 62-day performance remained below target at 68.6%, with Urology and Upper GI contributing most to the deterioration. Recovery actions include weekend lists, insourcing, pathway redesign, diagnostic-capacity review and targeted consultant recruitment, although demand growth, workforce resilience and reliance on waiting-list initiatives, locums and outsourcing remain key risks.

Urgent and emergency care remains under significant pressure. Four-hour performance improved to 57.75% in June from 56.55% in May, with improvement across admitted and non-admitted pathways. It remains materially below the 72% trajectory because of exit block, ED crowding, constrained downstream flow, delayed senior decision-making and inconsistent UTC streaming. The UEC 100-day programme, ED/UTC reconfiguration and planned Q3 UTC relocation remain the principal mitigations.

Figure 6: IPR Executive Summary

Business Plan | Performance detail

CURRENT POSITION		QUARTER 2 FOCUS
PERFORMANCE	Largest improvement in NOF scores across the <i>South West</i> in Q4, national ranking up by 20 places, moving from SOF 4 to SOF 3 and 11th most improved trust nationally at the end of 2025/26.	Sustaining improvement in elective operational standards (RTT, Cancer, Diagnostics) and addressing delivery risks within challenged specialities;
	Continue to operate in a highly pressurised environment with both GP referrals and emergency demand exceeding plan. Improved 4-hour and a reduction in ambulance handover delays and patients experiencing corridor care in month.	Improved partnership working to reduce urgent demand and non-criteria to reside (NC2R) discharge delays - discharged home (P0) & discharged to a community setting (P2).
	Demonstrate good progress in our elective recovery plans for referral to treatment and diagnostics but cancer wait times for 28 day and 62 day remain below target.	UEC 100-day challenge to support improvements across non-elective pathways and planning for relocation of the Urgent Treatment Centre by Q3.
FINANCE	Year-to-date financial performance is £7.6m deficit which is £2.8m adverse to plan, driven by £0.3m Industrial Action, £1.1m structural issues arising from final contract settlement, SOC £1.1m adverse to plan and critical incident escalation £0.6m. Cash balances remain a risk.	Whilst strong progress on maturity of the savings plan has been made over quarter 1, the plan condition that 80% of savings were Green by end of June has not been met.
	101% of Savings plans identified, of which 60% (£25.1m) are assessed as Green in delivery or fully developed. £3.1m of savings have been delivered after 3 months, and £2.4m of income has been re-phased to achieve £5.5m overall delivery .15% CIP delivery in Q1 has been delivered.	Priority during quarte 2 is to shift opportunities and plans in progress into green schemes and achieve the 25% CIP target for quarter 2
QUALITY	Urgent and emergency care front-door environments; pressure-injury prevention; and infection control focused on E. coli and C. difficile remain the key quality and safety concerns. Priority clinical areas are receiving enhanced support in addition to Trust-wide quality improvement programmes.	Targeted improvement activity is focused on urgent and emergency care front-door clinical environments, alongside strengthening pressure injury prevention and infection prevention and control, with particular emphasis on reducing E. coli and C. difficile infections.
WORKFORCE	Workforce stability is evident through low turnover, manageable vacancies and mandatory training compliance.	The Healthier Workforce Programme is focused on reducing absence, improving retention and strengthening wellbeing through five targeted workstreams, with success measured through attendance, staff experience, leadership capability and culture.
	Bank staffing remains above plan, with agency spend on target but recent increased temporary staffing reliance due to hospital pressures.	
	Sickness absence remains the key concern at 5.6%, above the trajectory required for the March 2027 target, with stress, anxiety and depression continuing to affect capacity and operational performance	This will be further strengthened by the building of our People Plan that will enhance in year actions as well as ensure we have the right workforce for the future.

Figure 7: IPR Performance and Assurance Overview

Business Plan | Performance Metrics

July 2026		Performance against trajectory (in year)						3 Year Plan Profile		
Domain	Metric	26/27 NHSE Instruction	Current Month Trajectory	Apr-26	May-26	Jun-26	Jul-26	Year End 26/27 RUH Plan	Year End 27/28 RUH Plan	Year End 28/29 RUH Plan
UEC	ED Attendance Growth YTD	<i>Versus 25/26 actual</i>	-0.5%	3.6%	3.0%	4.2%	3.9%	-0.5%		
	NEL Admission Growth YTD	<i>Versus 25/26 actual</i>	-4.8%	12.4%	5.5%	5.6%	5.6%	-4.6%		
	Eliminating Corridor Care	<i>0> 45mins by Nov '26</i>	0	556 (15%)	683 (15%)	587 (6.5%)	602 (6.5%)	0	0	0
	4-hour ED performance (type 1)	<i>66.9% by Mar '27</i>	59.9%	61.2%	56.6%	57.8%	56.2%	77.2%	72.9%	79.1%
	4-hour ED performance (all types)	<i>82% by Mar '27</i>	70.6%	71.1%	67.0%	68.9%	68.4%	82.9%	80.2%	85.0%*
	12-hour ED performance	<i>96.1%</i>	92.2%	92.0%	90.1%	88.7%	86.5%	93.7%	94.7%	95.0%
	Ambulance handover	<i>Reduce toward 15 mins</i>	27	33.1 mins	68.7 mins	53.2 mins	76.4 mins	30 mins	29 mins	28 mins
Elective & Diagnostic	GP Referral Growth YTD*	<i>Per planning assumption</i>	0.0%	10.9%	13.0%	13.2%	17.1%	0.0%		
	18w RTT Performance	<i>74.7% for RUH</i>	70.4%	70.3%	71.1%	70.4%	70.6%	74.7%	83.4%	92.0%
	52 Week Waiters	<i>Reduction towards zero</i>	310	183	155	133	156	198	62	0
	52 Week Waiters %	<i>Improvement on 1%</i>	0.9%	0.5%	0.4%	0.4%	0.4%	0.8%	0.4%	0%
	Diagnostics 6 week wait	<i>13.1% for RUH</i>	13.7%	14.7%	13.1%	11.8%	13.4%	12.50%	9.0%	1.0%
Cancer	28 day FDS *	<i>80% annual ave</i>	81.2%	79.8%	79.4%	78.8%	76.3%	80.0%	80.5%	80.7%
	31 day*	<i>94%</i>	92.8%	92.5%	95.0%	94.4%	95.4%	94.2%	96.0%	96.1%
	62 day RTT*	<i>80%</i>	74.2%	68.5%	70.0%	71.0%	68.9%	80.5%	82.7%	85.1%
Workforce	30% Reduction in agency use	<i>30% improvement from M06</i>	<i>tba</i>	13.3 WTE	21.2 WTE	11.6 WTE	14 WTE	5 WTE	3 WTE	0
	10% reduction in bank spend	<i>10% reduction from M06</i>	<i>tba</i>	283.7 WTE	289.2 WTE	302.9 WTE	296.2 WTE	237 WTE	-10%	-10%
	Sickness rate (rolling 12 month average)*	<i>Improvement</i>	<i>tba</i>	5.5%	5.5%	5.6%	5.6%	4.8%	4.6%	4.4%
Finance	2% productivity improvement	<i>(min 2% improvement)</i>	2.0%	6.5%	3.5%	1.9%	4.9%	5.0%	2.7%	1.5%
	Savings Plan	<i>37.6m (£56.6m over 3 yrs)</i>	8,779	1,400	2,170	3,089	4,861	37.6m	10.3m	8.7m
	Balanced or surplus financial position	<i>Balance or surplus</i>	(4,904)	(2,886)	(5,935)	(7,583)	(10,585)	0.0m	0.0m	0.0m
Discharge	Non Criteria to Reside (NC2R)	<i>Number of NC2R</i>	78	88	100	103	116			
	Pathway 0 - Home	<i>% within 24 hours</i>	97%	95.0%	94.4%	94.8%	93.1%			
	Pathway 1 - Home with support	<i>% within 48 hours</i>	100%	43.5%	44.1%	36.7%	38.9%			
	Pathway 2 - Community setting	<i>% within 48 hours</i>	100%	31.6%	26.8%	22.8%	19.2%			
	Pathway 3 - Residential care	<i>% within 7 days</i>	100%	42.9%	40.6%	38.2%	39.0%			

* one month lag

2.3 Assurance Committee Summary

Committee	Assurance Level	Key Focus Areas	Assurance Summary / Escalation
Quality & Safety	Limited Assurance	Hospital at Home, IPC performance, End of Life Care, CQC readiness, clinical audit governance, Medlock workforce risk and procedural HTA follow-up.	Limited assurance was reached because material risks remain in UEC flow, corridor care, infection prevention, End of Life Care capacity, maternity safety and wider regulatory follow-through. July recorded 602 patients spending more than 45 minutes in an ED corridor, representing 6.5% of attendances. CQC assurance must now test sustained improvement against the 53 UEC actions rather than completion alone. The HTA inspection provides positive assurance: the mortuary remains suitable for licensing, most standards were met and no significant patient care or dignity concerns were identified. Ten procedural findings are being managed through an agreed improvement plan, with five actions complete, four due by October 2026 and the Estates flooring action extended to August 2027. The Committee also highlighted the need to embed IPC explicitly in winter planning, strengthen assurance on diagnostic-results endorsement and maintain oversight of maternity digital interoperability and urgent-triage escalation.
Finance & Performance	Limited Assurance	Financial recovery, cash, UEC recovery, NCTR, cancer performance, EPR readiness, winter planning, diagnostics and RTT.	Limited assurance was reached because the financial, operational and delivery trajectories remain materially exposed. The year-to-date deficit is £10.6m, £5.6m adverse to plan; the medium forecast is £19.9m and requires approximately £1.5m monthly improvement, while cash support remains necessary. FIPB evidence shows £42.9m of savings identified against the £42.1m target, but only £28.5m, or 68%, is Green, leaving a £7.27m development gap to the end-September ambition. FIPB has commissioned refreshed divisional recovery plans by 11 September, team-level trajectory and deliverable visualisation for 15 September, a Medicine deep dive and options to reduce temporary staffing, agency and

			waiting-list initiative exposure. FPC also escalated July UEC demand growth, NCTR of 116, the circa 72-bed winter deficit, digital capacity and clinical-safety constraints, dermatology recovery, and the need for a prepared commissioner negotiating position on demand, discharge, HCRG and block-contract exposure. Positive assurance remains in RTT, diagnostics and 4.9% year-on-year productivity improvement.
People & Culture	Limited Assurance	Sickness absence, workforce plan, temporary staffing, appraisal compliance, workforce risks, Healthier Workforce Programme and bank partner implementation.	Limited assurance was reached because sickness absence remains above trajectory, with over 17,500 WTE days lost, and workforce pressures continue to affect service delivery, financial performance and resilience. Oncology and haematology workforce risk remains under active mitigation following investment, while maternity and Hospital at Home workforce risks require reassessment to ensure scoring reflects the level of concern identified through triangulation. Positive assurance was received that the Healthier Workforce Programme is progressing and that bank partner implementation is being actively monitored, although operational, staff and reputational risks require continued oversight.

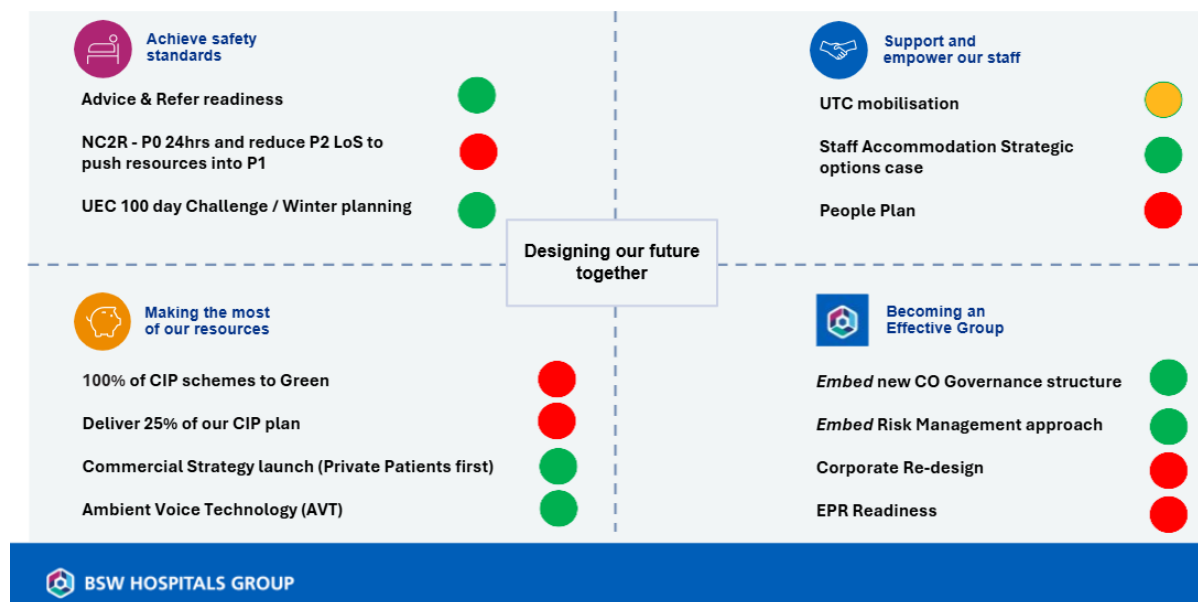
Across the first assurance cycle, COMC concluded that the committee reports are beginning to provide a stronger route for escalation. Continued focus is needed on improving triangulation across quality, performance, workforce and finance, supported by rescoring the register using the Group 5+5+5 methodology, progressing risk housekeeping and improving risk education for staff and senior leaders.

Please see **Appendices 1, 2 and 3** for further detail.

Section 3: Deep Dive / Other Business

Figure 8: RUH Priorities for Quarter 2

Q2 Priorities



The following deep-dive sections provide further detail on the highest-priority issues identified through the first assurance cycle, with a focus on areas requiring executive oversight, cross-committee escalation or further risk review.

EPR Readiness

Shared EPR implementation continues to progress, with tangible mitigations now in place or emerging in several enabling areas. However, the current cycle does not support de-escalation of EPR as an organisational delivery risk. The position is now best described as **progressing but constrained by key implementation dependencies**: capital funding, CCIO leadership and training facilities have strengthened readiness, but outpatient template configuration, CNIO and CSO capacity, migration-critical data quality and cutover activity planning remain material risks requiring executive grip.

Key progress in the previous period includes:

- Confirmation of capital funding for anaesthetic monitors which were a key enabler for introduction of the Shared EPR theatre and anaesthetics module.
- Appointment of RUH Chief Clinical Information Officer (CCIO).
- 60% of training facility requirements have been identified (from 0% in the previous period).
- Post-cutover activity planning will be reviewed through the RUH Business Planning Working Group. This will develop the approach to mitigating the estimated 25% reduction in activity during the five-to-eight-week period after cutover.

A key cutover risk is the volume of **clinics that do not follow a fixed schedule**. Fixed schedules are required so patient appointments can be migrated accurately. The programme requirement is for 75% of schedules to be fixed for Trial Load in October 2026 and 100% for cutover in October 2027. Approximately 32% of booked appointments at RUH are not linked to a fixed schedule, principally in Urology, Dermatology, Gastroenterology, General Surgery, Trauma and Orthopaedics. Work is under way with specialties to move to fixed schedules;

however, achieving 100% will not be possible without significant operational and performance impact. This creates a risk to workflow readiness, service capacity and safe implementation, particularly ahead of the October 2026 testing gateway. Key examples include:

- **Loss of capacity:** A fixed clinic schedule in dermatology will result in a loss of 480 cancer appointments per annum. Due to the volumes in skin cancer referrals, this would result in the Trust failing the 28-day Faster Diagnosis Standard.
- **Theatre/clinic room utilisation:** flexible schedules enable optimal use of theatres and clinic rooms, meaning a proportion of schedules are necessarily flexible.

A system approach will therefore be required to manage testing and migration for clinics that cannot be fixed because of operational constraints, for example by minimising the period for which the clinic schedule needs to be fixed.

COMC also noted that specialty-level briefing and escalation will be needed to ensure clinical teams understand the risks associated with non-standard clinic templates and the implications for testing, migration, and go-live readiness. Clear escalation into Finance and Performance Committee and Group Digital governance will be required so that progress, constraints and residual risks are visible and actively managed.

Figure 9: EPR readiness refresh — movement from previous overall readiness baseline

Readiness domain	Current assessment	Committee judgement
Governance and executive ownership	Improving	EPR is now visible through Finance and Performance Committee, COMC and Group Digital routes, but reporting still needs to move from awareness to accountable delivery.
Clinical leadership and safety capacity	Partially mitigated	RUH CCIO has been appointed, providing a confirmed mitigation for senior clinical leadership. CNIO and CSO capacity remain unresolved and are still critical to workflow sign-off, clinical safety assurance and legacy-system decommissioning.
Outpatient templates and migration readiness	High risk	Approximately 32% of booked appointments at RUH are not linked to fixed schedules. This is a separate outpatient migration indicator and should not be conflated with the previous overall EPR readiness judgement, which also stood at 32%. The 75% fixed-schedule requirement for Trial Load in October 2026 and 100% requirement for cutover in October 2027 will require specialty-level work, clear exception handling and a system approach for clinics that cannot safely be fixed without operational harm.
Training, backfill and operational capacity	Partially defined	Training facilities have moved from 0% to 60% identified. Activity planning post-cutover will be reviewed through the RUH Business Planning Working Group to mitigate the estimated 25% reduction in activity over the 5–8 week post-cutover period, but backfill, release capacity and operational impact remain unresolved.

Data quality and readiness evidence	Insufficient assurance	Migration-critical data quality issues, including unoutcomed appointments and patient index merges, remain insufficiently evidenced and require a quantified recovery trajectory before the next assurance cycle.
Theatre and anaesthetics readiness	Mitigated enabler	Capital funding for anaesthetic monitors has been confirmed, removing a key enabling constraint for introduction of the Shared EPR theatre and anaesthetics module.

The remaining programme risks now requiring focused executive follow-up are CNIO/CSO capacity, migration-critical data quality, specialty ownership of fixed-schedule exceptions, and operational backfill for training and cutover.

Overall, the refreshed assessment should be read against the previous overall EPR readiness judgement of 32%. There has been genuine movement in several enabling areas, including confirmed anaesthetic monitor capital funding, appointment of the RUH CCIO, identification of 60% of training facility requirements and routing of post-cutover activity planning through the RUH Business Planning Working Group. However, this does not yet support de-escalation because the least mature areas are those most likely to determine safe progression through Trial Load and cutover: outpatient template standardisation, operationally safe exception handling, data quality, CNIO and CSO capacity, training backfill and specialty-level ownership. Separately, 32% of booked appointments are not currently linked to fixed clinic schedules; this is a coincidental but important migration-risk indicator rather than a restatement of the overall readiness score. The Committee should therefore expect the next EPR update to provide a revised overall readiness score, a quantified trajectory to Trial Load, named owners for each dependency and explicit escalation of any issue that cannot be resolved within RUH.

Finance Overview

The financial position has deteriorated to a £10.6m year-to-date deficit, £5.6m adverse to plan. Key drivers include non-delivery of savings, continued Sulis operational pressures, critical-incident and industrial-action costs, structural commissioner-funding gaps and high temporary staffing expenditure. The medium forecast reduces the projected deficit from £30.5m to £19.9m but requires approximately £1.5m of monthly improvement, delivery of all Green and Amber savings assumptions and mitigation of current operational pressures. There is no evidenced route to break-even, and even the best-case scenario retains approximately £10m of unidentified risk. The Committee supported progression of the working-capital application, while noting that increased savings delivery alone does not remove the year-end cash risk. FIPB provides the delivery evidence behind this judgement. At Week 20, £42.9m of savings had been identified against the £42.1m target, but Green-rated schemes remained at £28.5m, or 68%, leaving a £7.27m development gap to the ambition of £35.77m Green by the end of September. FIPB has therefore moved from opportunity identification to delivery control: refreshed divisional recovery plans are due through 11 September; the 15 September review will require visualisation of plan against trajectory and team-level deliverables; Medicine will receive a deep dive; and recommendations will be developed on bank, agency, waiting-list initiative and administrative controls. The programme must prioritise recurrent, cash-releasing delivery and protect named delivery capacity, including replacement of dedicated savings-programme coordination.

Cash is the most critical financial issue now facing the organisation. Current forecasts indicate that the Trust will run out of cash during September or October without further mitigation. Group-level mitigations are being explored, but the organisation is likely to need to apply to

NHS England for emergency cash support. This will require Board approval and will need to be supported by a credible recovery path, demonstrating how the Trust will reduce the deficit, strengthen savings delivery and stabilise its cash position.

Winter Plan

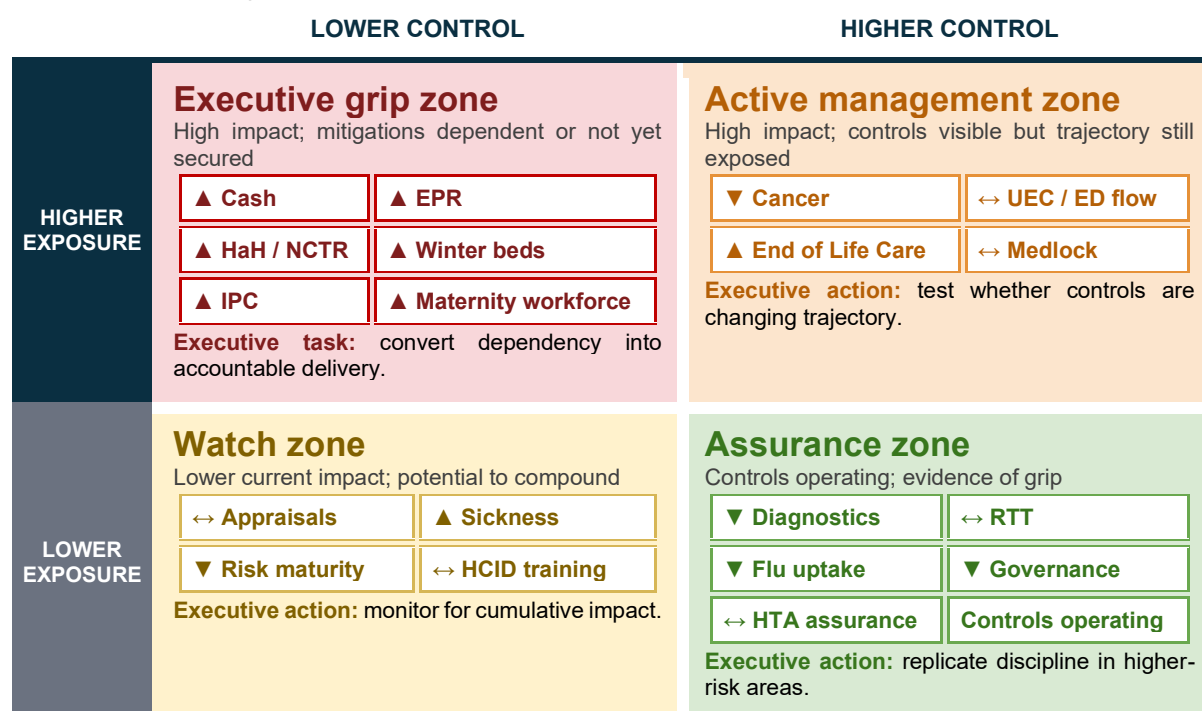
COMC reviewed the developing RUH winter plan, which is being prepared against a materially challenging operational baseline. Modelling indicates a potential peak-period adult bed deficit of approximately 72 beds if current demand, flow and NCTR assumptions remain unchanged. The plan is being developed using learning from winter 2025/26, staff feedback and system planning assumptions, with a focus on capacity, flow, NCTR reduction, demand management, front door streaming, vaccination, staff resilience and estates constraints.

The Committee recognised that the plan is more mature than at the equivalent point last year but remains dependent on key assumptions and external enablers. These include use of Medical Short Stay (MSS) capacity, agreement on surgical assessment and enhanced care models, progress on NCTR and high-intensity user demand reduction, activity-related funding discussions with commissioners, and clarity on whether any national or system funding will be available for Ward 4. The absence of confirmed Ward 4 funding remains a significant risk to winter resilience, particularly if activity and bed demand continue to exceed plan. COMC supported an out-of-committee route to meet the 30 August submission deadline, with further work required to quantify funding, workforce and governance implications before final sign-off.

Section 4: Risk Escalation

Figure 10: Risk portfolio view — concentration of exposure and control

A consolidated view of the major risks surfaced through COMC, showing where Board attention should focus to reduce residual exposure.



Methodology: the priority is to move risks out of the **Executive grip zone** by converting exposed dependencies into named owners, funded decisions, system escalations and time-bound milestones. Directional markers indicate month-on-month judgement: ▲ **worsening**, ↔ **stable**, ▼ **improving**.

4.1 Escalation Gateway

Category	Risk ID & Title	5+5+5 Score	Reason for Escalation
☒ Strategic (G-Line)	Financial recovery, system demand and EPR delivery	Formal 5+5+5 scoring to be confirmed	The £10.6m year-to-date deficit and likely cash-support requirement, system demand and winter-capacity exposure, and residual EPR clinical-safety and operational dependencies require Group visibility and decisions beyond RUH's delegated control.
☐ Operational (T-Line)	Discontinuation of RUH Hospital at Home Service (3314)	20 (5+5+5 scoring to be completed)	Risk 3314 has been escalated as a new major risk because the future sustainability of the Hospital at Home service is uncertain following the withdrawal of external funding and unresolved decisions about ongoing RUH funding. This creates a significant risk to patient flow, emergency care performance, winter resilience, capacity management, workforce stability, quality of care and system resilience. The risk remains high because funding arrangements are not yet agreed and planned mitigating controls have not been fully implemented.
	Workforce Challenges on Medlock (3324)	16 (5+5+5 scoring to be completed)	Risk 3324 has been escalated as a new major risk due to ongoing nursing workforce shortages within Medlock. Vacancies and long-term sickness are creating challenges in maintaining safe staffing levels, which could adversely affect patient care, patient experience and service sustainability. Although several controls and recruitment initiatives are in place, the service continues to rely on agency staff and temporary mitigations.

4.2 Risk Narrative

The principal risk theme emerging from COMC is that a number of operational pressures are now converging into strategic delivery risks for the Care Organisation and Group. Hospital at Home and virtual ward provision remain the most immediate escalation, with risk to patient flow, winter resilience and clinical safety if the future commissioning model does not provide sufficient capacity or fails to recognise the different acuity and clinical model requirements of step-up and step-down care. Although local mitigations are being pursued, including further correspondence with HCRG and the ICB, the current position remains insufficiently mitigated and requires Group visibility.

Infection prevention and control also requires escalation through a risk lens. Risk 2557 relates to the Trust's ability to maintain IPC-compliant isolation facilities, with the shortage of side rooms and en-suite accommodation creating a risk that infectious patients cannot be appropriately isolated. This increases the potential for hospital-acquired infections and impacts IPC performance. However, COMC recognised that the Trust's *C. difficile* and *E. coli* outlier position cannot be attributed solely to estate constraints. External IPC support is therefore being sought to provide an additional perspective on the drivers of performance, strengthen improvement actions and support a clearer improvement trajectory. As part of this work, Risk 2557 may need to be reviewed and broadened to ensure it reflects the full range of contributing factors, including estate constraints, clinical practice, operational flow, stewardship and wider IPC controls.

EPR readiness should be treated as an organisational risk rather than solely a programme-delivery issue. Concerns include data-cleansing capacity, unresolved Clinical Safety Officer capacity, gaps in senior clinical leadership for some workstreams, limited digital representation in assurance forums and the risk that non-standard clinic templates will prevent progression through the October testing gateway. This remains underrepresented in the formal risk register relative to the level of concern expressed through assurance committees.

COMC also identified risks that need to be more clearly scored and surfaced in the next cycle, including NCTR, maternity workforce and safety, winter bed capacity, cancer performance, workforce productivity and sickness absence. The Committee noted that no specific risks scoring 12 or above had been formally escalated through the first Risk Management Group report because the new process is still being embedded but expects the next cycle to provide clearer formal escalation using the Group 5+5+5 methodology.

Section 5: Care Organisation Context

The first full cycle of the Care Organisation governance structure has improved visibility of cross-cutting risks and strengthened triangulation between quality, workforce, performance and finance. The consistent themes emerging across the assurance committees are demand growth, workforce sustainability, financial recovery and readiness for major transformation programmes. These pressures remain significant and will require continued prioritisation, executive oversight and Group support over the coming months.

Delegated approvals and investment decisions

COMC considered the Respiratory Consultant business case under the Care Organisation's delegated authority arrangements and approved it in principle, supporting the case for investment in 2.0 WTE substantive Respiratory Consultants to address a structural capacity shortfall affecting RTT delivery, lung cancer pathways, workforce resilience and patient outcomes. The Committee was supportive of the case, noting that the rationale was clearly articulated and that substantive recruitment would replace temporary capacity, strip out reliance on short-term locum, WLI and insourcing costs, and provide a more sustainable workforce model. COMC requested further sharpening of the case, including clearer quantification of the financial implications and assurance around the proposed financial treatment. Final approval will be taken through Chair's action, in line with the relevant Standing Financial Instructions (SFIs) and delegated authority arrangements.

COMC considered the Perinatal Workforce Risk Mitigation and Birthrate Plus Phase 1 and 2 business case and supported the case in principle as a safety, workforce and regulatory compliance response to a materially changed risk environment. The Committee noted the changed national context following recent maternity reviews and the NHS England 10-point action plan, alongside the local Birthrate Plus reassessment. Although births have reduced by 5.5%, acuity and complexity have increased significantly, with 76% of births now in the two

highest complexity categories and an overall maternity workforce gap of 21.74 WTE identified. Phase 1 proposes cost-neutral redeployment and skill mix changes within the existing establishment, while Phase 2 seeks to address the minimum safe staffing gap through immediate recruitment of 15.12 WTE.

The Committee recognised the case as time-sensitive because of its links to safe staffing, Maternity Incentive Scheme requirements, clinical-negligence exposure and external confidence in maternity services, notwithstanding the service's previous CQC outstanding rating. With recruitment rounds due within 19 days, COMC agreed with the BSW ICB Place Director for Bath and North East Somerset that Band 5 and Band 6 recruitment should proceed at a £100k exposure to preserve the immediate opportunity. The remaining £840k exposure will be held and progressed through Group governance and the ICB Triple Lock before final approval. COMC also noted the need to close the loop on previous public and political commitments relating to alongside midwifery-unit provision through the developing estates strategy.

The Committee recognised the case as time-sensitive because of the link to safe staffing, Maternity Incentive Scheme requirements, clinical negligence exposure and the need to maintain external confidence in maternity services, notwithstanding the service's previous CQC outstanding rating. Given the time-sensitive nature of the case, and with recruitment rounds due to take place within the next 19 days, COMC agreed with the Place Director BANES BSW ICB that the Band 5 and Band 6 recruitment should be signed off at a £100k exposure to avoid losing the immediate recruitment opportunity. The remaining elements of the case, equating to £840k exposure, would be held and progressed through Group governance and ICB Triple Lock before final approval. COMC also noted the need to close the loop on previous public and political commitments relating to alongside midwifery unit provision as part of the developing estates strategy.

COMC approved the Rowlands Outpatient Pharmacy Contract Extension, supporting a £242,000 full-year effect uplift to the Pharmacy budget from Trust reserves to fund the time-limited extension of the Rowlands outpatient pharmacy contract. The extension is required to maintain safe and timely outpatient dispensing while the Trust mobilises the Wholly Owned Subsidiary outpatient pharmacy model, which has been approved by BSW Hospitals Group Board for planned go-live in 2026/27. The Committee noted that, although the extension creates an in-year cost pressure, the agreed annual rate of approximately £842,000 remains favourable against current market conditions and the rolling three-month notice period limits longer-term financial exposure. Approval mitigates the risk of outpatient pharmacy service instability, loss of contractual indemnity, disruption to the Wholly Owned Subsidiary mobilisation timeline and an unfunded Pharmacy pressure.

COMC supported the High Consequence Infectious Disease (HCID) preparedness paper and agreed that training should be put in place for key frontline areas. This will focus on FFP3 fit testing, HCID Personal Protective Equipment (PPE) donning and doffing competency, and development of a core training team to strengthen operational readiness and mitigate Risk 3264. The Committee noted a particular challenge in ensuring clinical medical staff across the organisation are able to attend the required training, given the need to release staff safely from operational duties while maintaining service cover. A further challenge was noted for nursing staff within Medical Assessment Unit (MAU) and MSS specifically, where the same requirement to release staff for training creates additional operational pressure.

Group programme responsibility: Commercial Programme

A refreshed outline Commercial Strategic Plan has now been received for this Group Board. It moves the programme from opportunity scoping towards a Group delivery framework, covering the financial imperative, commercial principles, leadership, PMO, benefits

management, engagement and a refined approach to reinvestment. The supporting appendices provide a streamlined programme scope and a brief update on current projects. As the strategy is on the Group Board agenda, this report simply notes the progress and does not duplicate the detailed proposals.

The programme continues to group opportunities across private care; pharmacy and research; estates and commercial estate; and other commercial activity. The immediate next step is Group Board consideration of the proposed ambition, governance and reinvestment approach, with a separate Board development session also being explored.

Summary and next steps

The latest assurance cycle confirms a position of limited assurance that is being actively managed. Financial, operational and quality risks are increasingly interdependent, but a clearer control framework and defined mitigations provide a credible route to stronger assurance. The organisation is responding to the £10.6m year-to-date deficit through the working-capital application, strengthened FIPB oversight, refreshed divisional recovery plans, a Medicine deep dive and tighter control of temporary staffing and waiting-list expenditure. System demand and winter pressures are being addressed through joint RUH and SWASFT data analysis, review of alternative pathways, strengthened Care Coordination, the UEC 100-day programme, UTC reconfiguration, Hospital at Home planning and targeted action on NCTR. Quality mitigations include external IPC review, a pre-winter CQC action stocktake, maternity workforce action and strengthened diagnostic-results assurance; procedural HTA findings continue to be managed through the agreed improvement plan. EPR readiness is progressing through confirmed capital funding, CCIO leadership, training-facility identification, specialty template work and structured post-cutover planning.

These actions do not yet remove the residual risks, particularly where delivery depends on commissioner decisions, community-provider capacity, Group prioritisation or protected clinical and digital resource. However, the next phase is a practical one: convert each mitigation into a named owner, funded or agreed action, quantified trajectory and time-bound assurance point. The Group Board is therefore asked to support the system and resource decisions that RUH cannot make alone, while holding the Care Organisation to account for demonstrable movement in savings, demand, conveyance, NCTR, corridor care, workforce resilience and EPR readiness. With this disciplined approach, the next assurance cycle should be able to show not only that controls are in place, but that they are beginning to change outcomes.

Appendices

Appendix 1: RUH Finance and Performance Committee Upward Report

Appendix 2: RUH Quality and Safety Committee Upward Report

Appendix 3: RUH People and Culture Committee Upward Report

Appendix 1: Report from the Finance & Performance Committee to the Care Organisation Management Committee

Care Organisation	Royal United Hospitals Bath NHS Foundation Trust
Committee	Finance & Performance Committee
Meeting date	28 th July 2026
Author	Roxy Milbourne, Interim Head of Corporate Governance John Palmer, Executive Chair
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance
Linked to Strategic Priority (s)	Financial Sustainability; Operational Performance; Digital Transformation
Linked BAF principal risk(s)	Financial Sustainability; Demand and Capacity; EPR Delivery; Infrastructure and Capital Investment
Reporting period	July 2026

1. Executive summary

The Committee reviewed the July Integrated Performance Report, financial position, risk profile, EPR readiness and digital services assurance. Diagnostic performance remained ahead of trajectory, with 88.2% of patients receiving diagnostics within six weeks against a target of 86.2%, and RTT performance remained above trajectory at 70.4%, with 52-week waiters reducing from 155 to 133. However, significant concerns remain in urgent and emergency care, with ED attendances 3.6% above plan, non-elective admissions 12.4% above plan and twelve-hour performance reducing to 88.7% against a trajectory of 92.1%. Cancer performance also deteriorated, with 28-day Faster Diagnosis Standard performance reducing to 75.1% and 62-day performance to 68.6%. The Committee noted a year-to-date deficit of £7.6m, £2.8m adverse to plan, and highlighted the need for continued focus on financial recovery, organisational readiness for EPR implementation, and a clearer response to demand and capacity pressures through strengthened recovery planning and development of new strategic risks.

2. Alert, Advise, Assure

2.1 Alert

- **Integrated Performance Report (UEC Performance)** - Four-hour ED performance improved from 56.6% in May to 57.8% in June, but remains significantly below the 72% trajectory. Twelve-hour performance reduced to 88.7% against a trajectory of 92.1%, with 22% of admitted patients waiting more

than 12 hours in June. Demand continues to exceed planning assumptions, with ED attendances 3.6% above prior year levels and non-elective admissions 12.4% above plan. The Committee concluded that the organisation requires a clearer improvement plan on a page for the year, distinguishing actions within the Trust's direct control from wider system dependencies, ahead of anticipated regulatory scrutiny. A focused recovery plan has been requested.

- **Cancer Performance** - Faster Diagnosis Standard performance reduced to 75.1% against the 80% standard, whilst 62-day performance reduced to 68.6% against the 80% standard. The Committee noted particular concerns regarding Dermatology, Breast and Gynaecology pathways, including a 50% increase in skin referrals and over 300 additional referrals compared with June 2025, placing increasing pressure on diagnostic and treatment capacity. The Committee requested immediate corrective action and further engagement with the Cancer Alliance to secure the support, funding and resourcing required to scale recovery plans and clarify recovery expectations.
- **EPR Organisational Readiness** - The Committee identified significant concerns regarding clinical engagement, clinical safety leadership, CNIO arrangements, data quality and training capacity. A comprehensive readiness action plan is required before the next meeting.

2.2 Advise

- **Finance and Performance Risk Profile** - The Committee agreed that the current risk profile does not fully reflect a number of emerging strategic threats. Additional risks are being developed relating to commissioner funding adequacy, capacity to deliver the Cost Improvement Programme, organisational dependency on HCRG and longer-term demand versus capacity pressures.
- **Estates and Infrastructure Risks** - The Committee discussed whether significant estates risks, particularly fire safety, electrical capacity, backlog maintenance and business continuity, are sufficiently visible through existing reporting arrangements and requested further review.
- **Financial Recovery Position** - The Committee noted a year-to-date deficit of £7.6m, £2.8m adverse to plan, driven by demand, escalation costs and contract settlement pressures. Whilst 101% of the savings target has been identified, only 60% (£25.1m) is currently assessed as green and £3.1m of savings had been delivered by the end of quarter one. Continued focus is required on CIP delivery, escalation cost quantification and commissioner funding discussions.
- **Elective Recovery** - The Committee noted that RTT performance remained above trajectory at 70.4% against a trajectory of 69.6%, whilst 52-week waiters reduced from 155 to 133 and the organisation continued to maintain zero patients waiting over 65 weeks. Notwithstanding this progress, the Committee advised

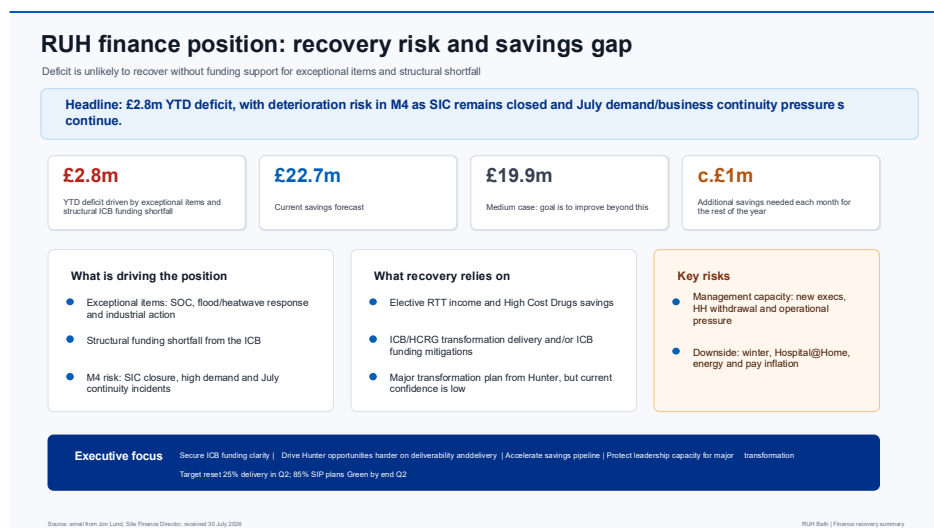
that implementation of the referral centre and dermatology recovery should remain under close review, given ongoing referral growth and emerging service consolidation discussions across the Group.

- **Group Digital Services Governance** - No representative attended the Committee to support discussion of the digital services report. Concerns remain regarding local engagement arrangements and assurance routes following recent governance changes, and COMC is asked to support resolution of Care Organisation engagement and escalation routes.

2.3 Assure

- **Diagnostics Performance** - Diagnostic performance improved to 88.2% of patients receiving diagnostics within six weeks against a trajectory of 86.2%, with breaches reducing by 82 compared with the previous month. The Committee recognised the substantial improvement achieved over the preceding year and received assurance that diagnostics recovery remains ahead of trajectory.
- **Risk Management Maturity** - The Committee noted active work underway to strengthen risk governance, ownership, reporting methodology and alignment with the Group risk framework. Further updates will be received at future meetings.
- **Financial Recovery Oversight** - The Committee agreed quarter two recovery milestones requiring 25% savings delivery and 85% of schemes to be rated green, providing a clearer framework for monitoring delivery performance over the remainder of the year. The Committee received assurance that 101% of the overall savings target had been identified, albeit with further work required to improve delivery confidence.

Figure 1 – Visualisation of current financial position



- **Sub-group Reporting** - The Committee noted that Finance Improvement Programme Board and Clinical Productivity and Management Group business had been covered, with written upward reports to be provided in future to strengthen assurance and escalation to the Committee.

3. Risk review

The Committee noted that implementation of the Group 5+5+5 risk methodology remains in progress. Risks reviewed at this meeting continue to be managed and reported primarily using the existing likelihood x consequence scoring framework, with transition to the Group methodology forming part of the wider risk management development programme. The Committee received assurance that work is underway to strengthen risk ownership, reporting and governance arrangements.

3.1 Risks formally escalated to the Managing Director

The risks below remain reported using the current likelihood x consequence methodology. Residual 5+5+5 scores have been included where available to support transition to the Group framework.

Risk ID & Title	Current Score	Controls Assessment	Reason for Escalation
Delivery of Annual Financial Plan	13	Partially Effective	Remains a significant strategic risk due to savings delivery requirements, funding uncertainty and demand pressures.
Working Capital Cash Shortfall	13	Partially Effective	Continued risk arising from financial deficit, commissioner funding uncertainty and savings delivery performance.
Insufficient Capital Funding	12	Partially Effective	Capital constraints continue to impact delivery of strategic priorities, infrastructure investment and risk mitigation activity.
Business Interruption from Backlog Maintenance and Critical Infrastructure	12	Partially Effective	Increasing backlog maintenance liability and infrastructure deterioration creates ongoing operational resilience risks.

3.2 Narrative on escalated risks

Delivery of Annual Financial Plan (Score 13)

The risk remains above threshold due to ongoing challenges delivering savings targets alongside increasing demand and commissioner funding uncertainty. Whilst enhanced financial controls, turnaround support and system collaboration arrangements are in place, the Committee concluded that these controls remain only partially effective given the scale of the underlying financial challenge. Reduction in risk score is likely to require improved savings delivery performance and greater alignment between activity growth and funding.

Working Capital Cash Shortfall (Score 13)

Financial pressures continue to create a risk to cash availability, particularly where savings delivery and funding assumptions are not realised. Controls including cash management arrangements, revenue support planning and enhanced financial oversight remain in place but do not fully mitigate underlying structural pressures. Risk reduction is dependent upon financial recovery and sustained improvement in system funding arrangements.

Insufficient Capital Funding (Score 12)

The Committee noted continuing tension between capital availability and investment requirements across digital, infrastructure and service priorities. Capital prioritisation arrangements provide assurance regarding decision making, but the scale of competing demand means controls remain only partially effective. Reduction in risk will require additional capital allocation or reprofiling of investment priorities.

Business Interruption from Backlog Maintenance and Critical Infrastructure (Score 12)

The risk remains elevated due to the scale of the Trust's backlog maintenance requirement and increasing frequency of infrastructure failures. Current mitigation focuses on prioritisation of available capital and reactive management of emerging issues. The Committee noted that sustained reduction will require significant investment beyond current funding levels and continued oversight of critical infrastructure risks.

3.3 Risks reviewed for context (scoring 10–11)

Risk ID & Title	Category	5+5+5 score	Controls assessment	Committee view
Anaesthetic Monitors Requirement for EPR	Strategic	10	Partially Effective	Capital approval remains required to secure anticipated EPR benefits. Committee agreed continued monitoring appropriate.
Non-Replacement of Medical Equipment	Operational	11	Partially Effective	Significant capital pressures remain. Committee agreed current score

Risk ID & Title	Category	5+5+5 score	Controls assessment	Committee view
				appropriately reflects increasing exposure.

4. Good practice and innovation

- Diagnostic services continue to demonstrate sustained improvement and strong performance against national standards, providing evidence that focused recovery approaches can deliver measurable benefits.
- The Committee welcomed detailed work underway through the 100-day challenge programme to identify operational improvements within the Trust's direct control, particularly in urgent and emergency care.

5. Committee approvals and recommendations

5.1 Approved by the Committee

- Approved the recommendation to award the End User Devices contract to CDW following completion of a competitive procurement process through the NHS SBS framework.
- Endorsed quarter two financial recovery milestones of 25% savings delivery and 85% green-rated savings schemes.

5.2 Recommended to the Care Organisation Management Committee

- Support development and oversight of additional strategic risks relating to commissioner funding, demand and capacity, HCRG dependency and CIP delivery capability.
- Note the requirement for a strengthened organisational UEC recovery plan on a page for the year and a consolidated EPR readiness action plan ahead of future assurance reviews.
- Support resolution of local engagement and assurance routes for Group Digital Services following changes to governance arrangements.
- Maintain visibility of elective recovery, referral centre implementation and dermatology service consolidation through future performance reporting.
- Note that written upward reports from the Finance Improvement Programme Board and Clinical Productivity and Management Group will be provided in future to support clearer escalation and assurance.

6. Looking ahead

The Committee will receive:

- Updated Finance and Performance Risk Register including newly proposed strategic risks.
- Urgent and Emergency Care recovery plan.
- EPR organisational readiness action plan.
- Elective recovery update, including referral centre implementation and dermatology service consolidation.



- Estates and Facilities reporting arrangements and assurance framework.
- Progress against quarter two financial recovery milestones and CIP delivery targets.
- Written upward reports from the Finance Improvement Programme Board and Clinical Productivity and Management Group.

Appendix 2: Report to the Care Organisation Management Committee

Care Organisation	Royal United Hospitals Bath NHS Foundation Trust
Committee	Quality and Safety Committee
Meeting date	29 th July 2026
Author	Roxy Milbourne, Interim Head of Corporate Governance Jason Lugg, Executive Chair
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance / For Decision / For Information
Linked to Strategic Priority (s)	
Linked BAF principal risk(s)	
Reporting period	July 2026

1. Executive summary

The Committee reviewed key quality, safety and governance risks including the Hospital at Home service, infection prevention and control performance, CQC preparedness, clinical audit arrangements and implementation of the revised risk management framework. Whilst assurance was received in several areas, the Committee identified the sustainability of Hospital at Home services, emerging infection prevention concerns, End of Life Care resilience and audit participation and governance as matters requiring ongoing executive oversight. The Committee also approved the Human Tissue Authority Board Assurance Statement and received assurance regarding ongoing improvements to risk management arrangements.

2. Alert, Advise, Assure

2.1 Alert

- **Hospital at Home Service Risk** - The Committee reviewed a newly escalated risk relating to the potential reduction of the Hospital at Home service. Members considered this one of the most significant current operational and quality risks given the potential impact on admission avoidance, patient flow and winter resilience. Discussions with HCRG, commissioners and system partners are ongoing and COMC oversight is requested.
- **IPC Performance** - The Committee reviewed current *Clostridioides difficile* and *E. coli* performance and noted concern regarding deteriorating trends despite strong

antimicrobial stewardship. Additional external assurance and further analysis are being undertaken to understand causation and identify improvement actions.

- Clinical Audit Non-Participation - The Committee identified concerns regarding non-participation in a number of national audits due to workforce and capacity constraints. Members agreed that future decisions not to participate in mandatory audits should require organisational oversight and formal governance approval.

2.2 Advise

- End of Life Care - The Committee discussed End of Life Care assurance arrangements, workforce sustainability and future CQC preparedness. Members noted ongoing concerns regarding specialist workforce resilience and requested further development of reporting and governance arrangements to ensure robust executive oversight.
- Risk Management Framework - The Committee received an update on implementation of the revised risk management framework and transition to the 5+5+5 methodology. Significant progress has been made through establishment of the Risk Management Group, although work remains ongoing to improve risk quality, consistency and reporting.
- CQC Preparedness - Members reviewed progress against existing CQC action plans and noted increasing likelihood of future inspection activity across Children and Young People, Critical Care, Outpatients and End of Life Care. The Committee requested continued reporting regarding inspection readiness and delivery of outstanding actions.
- Upward Reports - Upward reports from the Insight and Improvement Committee, Vulnerable People Committee and Medicines Management Committee highlighted ongoing work relating to PSIRF implementation, Oliver McGowan training, LeDeR review capacity, safeguarding resilience and medicines safety. These areas continue to require monitoring and system engagement.

2.3 Assure

- Human Tissue Authority (HTA) / Mortuary Governance - The Committee approved the HTA Board Assurance Statement following review of compliance arrangements and recent inspection findings. Positive feedback was received from a recent unannounced HTA inspection, with no significant patient care and dignity concerns identified, providing assurance regarding current mortuary and HTA governance arrangements.
- Risk Management Improvements – The Committee received assurance regarding the establishment of the Risk Management Group and progress implementing the revised risk methodology, which is expected to strengthen organisational understanding and management of risk.
- Annual IPC Report - The Committee approved the Director of Infection Prevention and Control Annual Report and noted achievement of statutory reporting requirements,

delivery of strong antimicrobial stewardship and continued investment in infection prevention infrastructure.

3. Risk review

The Committee noted that implementation of the Group 5+5+5 risk methodology remains in progress and risks considered at this meeting continue to be reported using the existing likelihood x consequence scoring framework.

3.1 Risks formally escalated to the Managing Director

Risk ID & Title	Current Score	Controls Assessment	Reason for Escalation
3314 Discontinuation of RUH Hospital at Home Service	20	Planned controls not yet fully implemented	New major risk relating to withdrawal of funding and potential impact on patient flow, quality, safety, workforce and system resilience.
3324 Workforce Challenges on Medlock	16	Significant gaps remain	New major workforce risk relating to vacancies and long-term sickness affecting safe and sustainable service delivery.

3.2 Narrative on escalated risks

Hospital at Home Service Sustainability (Score 20)

The risk has been escalated following the proposed reduction in Hospital at Home capacity associated with changes to contracting arrangements. The Committee noted the potential impact on patient flow, admission avoidance, service resilience, workforce stability and patient safety. Current mitigations include ongoing engagement with commissioners and system partners; however, longer-term service sustainability remains unresolved and the risk remains rated 20.

Medlock Workforce Challenges (Score 16)

The Committee reviewed a newly escalated workforce risk relating to nursing vacancies and long-term sickness within the Medlock unit. Mitigations include active recruitment, use of agency staff, redeployment of skilled staff and support for return to work. Whilst these measures provide some mitigation, workforce pressures continue to impact service resilience and the risk remains rated 16.

3.3 Risks reviewed for context (scoring 10–11)

Risk ID	Title	Score	Committee View
3241	Specialist palliative care workforce resilience	12	Committee approved reduction in score following recruitment and

			service mitigations. Continued monitoring required.
2973	Insufficient medical palliative care provision	16	Committee discussed End of Life Care and palliative care resilience. Remains a significant area for oversight despite mitigations with Dorothy House.

4. Good practice and innovation

- Human Tissue Authority Preparation and Inspection Response - Positive feedback was received following an unannounced HTA inspection, reflecting strong multidisciplinary engagement, governance arrangements and operational preparedness.
- Risk Management Transformation - Establishment of the Risk Management Group and implementation of the 5+5+5 methodology is strengthening organisational risk maturity and promoting greater consistency of risk assessment across the Care Organisation.
- Barcode Medication Administration - The Medicines Management Committee reported a significant improvement in barcode medication administration compliance, demonstrating measurable gains in medicines safety and digital adoption.

5. Committee approvals and recommendations

5.1 Approved by the Committee

- Human Tissue Authority Board Assurance Statement approved for submission (29 July 2026).
- Director of Infection Prevention and Control Annual Report 2025/26 approved for onward progression and publication.
- Downgrade of Specialist Palliative Care Workforce Risk following successful recruitment and implementation of mitigation measures.

5.2 Recommended to the Management Committee

- Maintain oversight of Hospital at Home service sustainability and associated patient safety implications.
- Note ongoing concerns regarding IPC performance and support organisational actions to address *Clostridioides difficile* and *E. coli* trends.
- Support development of strengthened clinical audit governance arrangements and oversight processes.
- Continue oversight of End of Life Care capacity, workforce resilience and preparedness for future regulatory review.

6. Looking ahead

At its next meeting, the Committee will receive further updates on implementation of the new risk management framework, pressure ulcer improvement work, infection prevention and control performance, CQC readiness, End of Life Care governance arrangements and progress against quality improvement actions arising from audit and upward reporting processes. The Committee will also review delivery of agreed actions relating to Hospital at Home, audit governance and HTA oversight arrangements.

Appendices (optional)

None

Appendix 3: Report to the Care Organisation Management Committee

RUH People & Culture Committee assurance report v2

Care Organisation	Royal United Hospitals Bath NHS Foundation Trust
Committee	People & Culture Committee
Meeting date	28 July 2026
Author	Jude Gray, Group Chief People Officer / Director of Human Resources
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance, with specific Alert / Advise / Assure recommendations
Linked to Strategic Priority(s)	Developing an engaged workforce; Making our teams diverse and inclusive; Making our services safer; Improving financial sustainability
Linked BAF principal risk(s)	Workforce sustainability; workforce productivity and temporary staffing; staff experience and wellbeing; workforce controls and risk governance
Reporting period	June to July 2026, drawing on the RUH People & Culture Committee bundle and late papers for 28 July 2026

1. Executive summary

The People & Culture Committee met to consider a broad assurance agenda covering leadership development, employee relations, workforce plan (M02 WTE/£ against plan), annual flu delivery, Fairer Deal for Nurses, the Healthier Workforce Programme, workforce risks and implementation of new assurance committee arrangements. The papers indicate positive assurance on leadership development, flu delivery, ER governance and establishment of the new governance framework; however, the assurance position is mixed because sickness absence, appraisal compliance, temporary staffing dependency and high-scoring workforce risks require active Management Committee oversight.

The Committee's principal concern is the continued impact of workforce resilience pressures on organisational performance and the need to deliver sustainable improvements through the Healthier Workforce Programme and associated workforce planning initiatives.

2. Alert, Advise, Assure

2.1 Alert - matters requiring Management Committee attention or action

Sickness absence remains the principal workforce pressure. The June IPR reports rolling 12-month sickness absence at 5.6%, above the required trajectory for the March 2027 target of 4.8%, with more than 17,600 WTE days lost year-to-date. Anxiety, stress and depression remain the primary drivers.

Healthier Workforce Programme has matured but delivery risk remains. The programme has been structured around Healthy Work, Healthy Leadership, Healthy Culture, Healthy Systems & Support, and Healthy Environment. Partial assurance remains because improvement may be affected by winter pressures, manager capacity, data limitations and the risk that the programme is viewed as sickness management rather than long-term culture and wellbeing change. The Management Committee should seek assurance that the Healthier Workforce Programme is sufficiently prioritised, resourced and focused on measurable reduction in root causes, not just activity delivery. A Healthier Workforce programme plan and delivery plan were requested for P&C in Sept 2026.

Workforce plan delivery and temporary staffing dependency remain off-track. The IPR reports total workforce levels approximately 61 WTE above plan, with bank staffing exceeding 300 WTE for the first time since August 2025. Cleaning and Emergency Medicine Nursing are reported as the largest bank users, and consultants account for most agency expenditure. Management Committee oversight is needed on the trajectory back to plan, the financial impact of bank and agency use, and the link to workforce CIP delivery.

Major workforce risks require formal escalation. The risk report identifies one workforce risk scoring 20 and four scoring 16. The highest risk is Oncology / Haematology workforce and service delivery due to consultant workforce shortages and reliance on agency cover. Risks at 16 relate to ED workforce gaps, Speech & Language Therapy inpatient provision, palliative care succession planning and Medlock oncology workforce challenges.

2.2 Advise - ongoing monitoring, partial assurance or emerging concern

Leadership development is strong but variable across the Group. The Annual Leadership Report described the substantial activity across GWH, RUH and SFT, including RUH programmes for Aspiring Leaders and Developing & Excelling Leaders. The papers advised that continued variation in leadership development provision could limit our ability to deliver a consistent leadership culture. Work is planned over Q2 and Q3 to shape a Group and Care Organisation offer aligned to the NHS Leadership and Management Framework. A proposal and implementation plan will be taken through Committee in January 2027.

Employee Relations reporting has improved but data maturity varies. The first Group ER Annual Report provided a useful comparative baseline across GWH, RUH and SFT and applied EDI and Restorative Just and Learning lenses. It identified variation in EDI case-impact recording and different case management systems. Further work is required to improve consistency of reporting, strengthen understanding of workforce inequalities and ensure that EDI considerations are reflected within routine workforce assurance arrangements.

Appraisal compliance remains significantly below standard. The IPR reports appraisal compliance at 77.98% against a 90% target, with no Division currently achieving the standard. Recovery plans are in place, but the Committee should continue to seek assurance on divisional ownership, overdue appraisals and the quality of appraisal conversations as well as completion rates.

Fairer Deal for Nurses carries national timetable, capacity and funding risks. The national delivery plan is required by 31 July 2026, with all Band 5 nursing roles to be reviewed by October 2028. Risks include job evaluation capacity, project management resources and unclear national funding or back-pay arrangements. A Task and Finish Group has been established with named co-chairs, site nursing and HR leads and staff-side representation. A programme update is proposed from September 2026 through People & Culture Committee and Senior Nursing Workforce meetings.

2.3 Assure - positive assurance achieved

Annual flu campaign delivery provides strong assurance. RUH achieved 63.6% frontline staff vaccination uptake, placing 2nd in the South West and 6th nationally. Delivery was supported by a no-incentive model, blended access, flexible hours, data-led targeting, visible leadership and strong communications.

New governance arrangements are operational. The Committee received the approved Terms of Reference and draft annual workplan for 2026/27. The new Care Organisation assurance committee framework is intended to strengthen assurance, improve oversight of risks and provide clearer escalation to the Care Organisation Management Committee.

3. Risk review

3.1 Risks formally escalated to the Management Committee

The Committee noted that implementation of the Group 5+5+5 risk methodology remains in progress. Risks considered at this meeting continue to be reported using the existing likelihood × consequence scoring framework. The Committee reviewed workforce risks scoring 15 and above and received assurance that all risks scoring above 15 had been reviewed or updated within the previous two months.

Risk ID / Title	Score	Assurance judgement	Reason for escalation
2124 - Oncology / Haematology Workforce and Service Delivery	20	Limited assurance	Consultant substantive gap, continued reliance on locum cover, service sustainability and patient access risks.
2075 - ED Workforce Gaps Affecting Quality and Performance	16	Partial assurance	Medical and nursing workforce gaps continue to affect quality, safety, flow and staff wellbeing.
3067 - Speech & Language Therapy Inpatient Provision	16	Partial assurance	Demand and capacity mismatch and inequitable provision across specialties, with quality and safety implications.
3241 - Palliative Care Nursing Succession Planning	16	Partial assurance	Loss of time and expertise due to inadequate succession planning and expected workforce reduction.
3324 - Workforce Challenges on Medlock	16	Partial assurance	Specialist oncology nursing shortages, vacancy and sickness pressures and limitations in sustainable mitigation.
3137 - Under-established Medical Workforce for Dermatology	15	Partial assurance / notify	Risk below formal 16+ table but remains high and should be visible due to impact on capacity, waiting times and existing staff burnout.

3.2 Narrative on escalated risks

2124 Oncology/Haematology Workforce and Service Delivery (Score 20)

This remains the Committee's highest-rated workforce risk. Significant consultant vacancies continue, with the service dependent upon locum provision and existing substantive staff working beyond contracted job plans to maintain service delivery. Whilst a workforce investment case has progressed and agency cover remains in place, controls are only partially effective and the service continues to experience capacity constraints, workforce resilience concerns and risks to patient access. Reduction of the risk will require successful recruitment to substantive consultant posts and delivery of the wider workforce investment plan.

2075 ED Workforce Gaps Affecting Quality and Performance (Score 16)

The Committee reviewed ongoing workforce shortages within the Emergency Department, including nursing vacancies, registrar recruitment challenges and high sickness absence levels. Whilst extensive recruitment, rostering and temporary staffing controls are in place, workforce pressures continue to create risks to patient flow, operational performance and staff wellbeing. Reduction of the risk will depend on successful recruitment and improved workforce resilience.

3067 Speech & Language Therapy Inpatient Provision (Score 16)

The Committee noted continued concerns regarding unequal and insufficient speech and language therapy provision across inpatient services. Existing controls focus on prioritisation and triage of activity; however, the underlying demand and capacity gap remains unresolved. Reduction of the risk would require investment in staffing capacity and development of a more sustainable seven-day service model.

3241 Loss of Time and Expertise within the Palliative Care Nursing Team (Score 16)

The Committee heard that a significant proportion of the specialist palliative care nursing workforce is approaching retirement age, with a reduction in workforce capacity anticipated. Temporary reductions in weekend service provision have been implemented to reduce demand pressures, but longer-term succession planning remains required. Reduction of the risk depends upon successful workforce planning and recruitment into specialist roles.

3324 Workforce Challenges on Medlock (Score 16)

Workforce shortages within Medlock continue to place pressure on safe and sustainable cancer service delivery. Existing mitigation relies on redeployment from other services, agency staffing and ongoing recruitment activity. Whilst these controls provide short-term resilience, risk remains elevated due to the specialised nature of the workforce and continuing recruitment challenges.

3.3 Risks reviewed for context (scoring 10–11)

Risk ID & Title	Category	5+5+5 score	Controls assessment	Committee view
3137 Under-established Medical Workforce for Dermatology	Operational	15	Partially Effective	Scoring remains appropriate. Workforce shortages continue to affect outpatient, cancer and advice-and-guidance capacity despite mitigation through locum and recruitment arrangements.
2764 Nursing, Allied Health and Midwifery Workforce Cost Reduction	Strategic	12	Partially Effective	Committee noted ongoing monitoring is required to ensure safer staffing establishments and agreed skill mix continue to be maintained whilst delivering financial efficiencies
2533 Hospital at Home Staffing Levels	Operational	12	Partially Effective	Workforce vacancies continue to limit service resilience and scalability; recruitment activity remains ongoing.

4. Good practice and innovation

- **Healthier Workforce measurement framework:** Development of the Healthy Workforce Programme as an integrated, organisation-wide approach to improving workforce wellbeing, resilience and engagement. The programme distinguishes leading, intermediate and outcome measures, shifting assurance from activity reporting toward evidence of root-cause change.
- **RUH flu campaign model:** Targeted and flexible delivery enabled RUH to achieve 63.6% frontline uptake, 2nd in the South West and 6th nationally.
- **Group leadership development alignment:** The proposed design once, deliver locally approach offers a practical route to consistency while retaining local context.

5. Committee approvals and recommendations

5.1 Approved by the Committee

- The Committee is asked to approve the Annual Leadership Report and note the direction of travel toward an aligned Group leadership offer.
- The Committee is asked to receive the approved Terms of Reference and review the draft annual workplan for 2026/27.

- The Committee is asked to note the implementation of the new assurance committee framework and provide feedback on gaps or amendments to the workplan.

5.2 Recommended to the Management Committee

- Note the mixed assurance position and require a clear recovery trajectory for sickness absence, temporary staffing, workforce plan delivery and appraisal compliance.
- Receive formal escalation of workforce risks scoring 16 and above, with particular focus on Oncology / Haematology risk 2124 scoring 20.
- Support Fairer Deal for Nurses delivery by ensuring job evaluation capacity, project management support and finance dependencies are visible and escalated early.
- Endorse continued development of the Healthier Workforce Programme as a culture, wellbeing and productivity programme, not solely an absence-reduction initiative.

6. Looking ahead

The next RUH People & Culture Committee is scheduled for 23 September 2026 with agenda items identified on the Forward Plan. Key follow-up items should include the September position on sickness absence and temporary staffing, divisional appraisal recovery, RAG-rated Fairer Deal for Nurses delivery, Healthier Workforce Programme measures, progress on ER action plan and review of high-scoring workforce risks, including Oncology / Haematology and ED workforce controls.

Public Council of Governors

Agenda item	6
Report title	Summary Update on Digital Transformation & EPR
Date of meeting	10 th September 2026
Sponsor	Jonathan Hinchliffe, Group Chief Digital & Information Officer and EPR Senior Responsible Officer
Prepared by	Digital Business Management
Approval Process: (where has this paper been reviewed and approved)	This report provides a summary overview based on formal updates provided to the following governance forums: • BSW Hospitals Group EPR Programme Board • BSW Hospitals Group EPR Assurance Committee • BSW Hospitals Group Digital Service Management Board • BSW Hospitals Group Executive Committee • BSW Hospitals Group Board

☐ **FOR ASSURANCE**
☐ **FOR DECISION**
☒ **FOR INFORMATION**

STRATEGIC ALIGNMENT *(Tick all priorities that this paper materially supports)*

☒ Developing an engaged workforce	☒ Making our teams diverse and inclusive
☒ Making our services safer	☒ Improving timely access to our services
☒ Improving the experience of those who use our services	☒ Improving our financial sustainability
☒ Improving health equity	

LINKS TO RISK REGISTER

Risk ID	Principal risk title
SFT 8929, GWH 1654, RUH 3387	Insufficient digital, data, and technology resource to meet increasing Group demand
SFT 8930, GWH 1655, RUH 3388	LAN refresh and network infrastructure resilience
SFT 8931, GWH 1656, RUH 3389	Insufficient clinical informatics capacity and capability across the Group

KEY MESSAGES

- The BSW Hospitals Group continues to make strong progress towards the implementation of a single Electronic Patient Record (EPR). This will provide clinicians with better access to patient information, support safer and more joined-up care, and help deliver a more consistent experience for patients across the region.
- The EPR programme has progressed with a re-baselined delivery plan for go live, with significant focus on testing, organisation readiness and operational planning. More than 650 Digital Champions have been engaged, and hundreds of staff have already participated in demonstrations and engagement events to support successful adoption.
- The BSW Hospitals Group is expanding the use of digital innovation, including Microsoft Copilot and Ambient Voice Technology. These tools have the potential to reduce administrative burden, support clinical productivity and allow staff to spend more time focused on patient care.
- All three organisations have achieved a positive Data Security and Protection Toolkit (DSPT) assurance position, demonstrating continued commitment to protecting patient information. At the same time, investment in cyber security, infrastructure and data services is strengthening the foundations needed to support future digital transformation.

RECOMMENDATION

The Public meeting of the RUH Council of Governors is asked to note the update provided on Digital Transformation and the EPR Programme.

APPENDICES

Appendix A	The Roadmap to EPR
Appendix B	EPR Uncovered – sample poster

Digital Transformation & EPR Update

Reporting Period	September 2026
Prepared by	Digital Business Management
Report Owner	Jonathan Hinchliffe, Group Chief Digital & Information Officer

1. EXECUTIVE SUMMARY

1.1. ALERT

- Specialist digital capacity and digital confidence remains a significant cross-cutting risk across the BSW Hospital Group.
- Continued executive support is required to prioritise capacity, funding and escalation decisions through the new Group governance model.
- With the rollout of Copilot Premium, staff are reminded that approved AI tools within the NHS tenancy can be used safely, including patient-identifiable information when appropriate controls are followed.

1.2. ADVISE

- The digital portfolio remains complex, interdependent and increasingly Group-wide in nature.
- Delivery of the single EPR, single data warehouse, ambient voice technology, infrastructure resilience, cyber improvement and clinical documentation programmes will require sustained alignment across care organisations, suppliers, clinical teams and corporate functions.

1.3. ASSURE

- The Group received a positive DSPT assurance position, with all three organisations achieving significant assurance with minor improvement opportunities.
- Good progress continues across the Group Digital Portfolio, supported by the establishment of the new Group Digital Service Governance model including the Digital Service Management Board as the central operational governance forum attended by representatives from all three care organisations.
- Delivery is progressing across infrastructure, cyber, clinical systems, data and transformation programmes.

2. KEY UPDATES

2.1. Electronic Patient Record (EPR) Programme

- The single EPR Programme is a key strategic priority for the BSW Hospitals Group. It is clinically led, built for care and powered by digital.
- A single integrated Electronic Patient Record (EPR) will transform how we deliver care across Royal United Hospitals Bath (RUH), Great Western Hospital Swindon (GWH),

and Salisbury NHS Foundation Trust (SFT), to deliver safer and more connected services for patients.

- The single EPR will provide a shared digital patient record across the three hospitals, supporting safer and more joined-up care, better access to relevant information, and more consistent clinical and administrative processes.
- Following extensive executive review and assurance activity, the recommended Go Live Option was formally approved by BSW Hospitals Group in May 2026, which identifies a 1+2 approach, with first Go Live in July 2027 for GWH, second Go Live in late-October 2027 for both SFT and RUH concurrently.
- The approval of the Go Live delivery approach enabled formal replanning which was independently assured by Berkley Assurance and provided a re-baselined plan, and the development of the EPR Roadmap to support wider communication and engagement (please see Appendix A– The EPR Roadmap).
- The programme continues to delivery at pace; current work is focused on testing the system thoroughly, checking data quality, preparing staff and services, and ensuring clinical safety before implementation. The benefits will be realised progressively during implementation and subsequent optimisation.
- Organisation readiness arrangements are being established across the three organisations, supported by more frequent oversight and improved dashboards. In parallel onsite visits were conducted by our assurance partner (critical friend) St Vincents. Local teams are progressing plans for operational activity during go-live, a digital skills assessment has been launched to help tailor training to staff needs alongside securing training facilities, in addition to reviewing data quality, clinical safety and device readiness.
- Around 650 Digital Champions had been signed up by the end of July 2026. To date the programme has demonstrated the EPR system to 401 staff across 59 locations, with further regular on-site drop-in clinics 'EPR Uncovered' planned to answer questions and support continued engagement (please see Appendix B – EPR Uncovered Roadshow poster). This is in addition to a fortnightly schedule of topics presented via the Bitesize Academy, in-person nursing events, and the establishment of Operational Specialist Interest Groups.

2.2. Artificial Intelligence (AI) and Ambient Voice Technology (AVT)

- A controlled deployment is underway following the allocation of 6,000 Copilot Premium licences to the BSW Hospitals Group. Staff are encouraged to complete available training shared with the licence allocation, to explore embedded AI capabilities, and participate in future hackathons. The Copilot licence operates within approved NHS security boundaries and should be for work-related activities to prevent potential IG or cyber security risk.
- Rollout planning is progressing across the Group to support the deployment of Ambient Voice Technology (AVT) with Microsoft Dragon Copilot. There are circa 150 licences per care organisation currently funded through national investment. Integration support and training will be provided through Microsoft and Accenture. An initial demonstration of the Dragon Copilot AVT was provided to approx. 180 clinical and operational colleagues.

2.3. Corporate Service Transformation – Group Digital Service

- In response to the establishment of BSW Hospitals Group, a controlled transition to a revised Group Digital Service governance model was taken during May to June 2026 period. This maintained service continuity while establishing new governance forums and transferring existing business into these revised arrangements.
- The Digital Service Management Board is established as the central operational governance forum for digital services across the Group. It brings together oversight of service delivery, change, risk management and transformation, and will support the transition from organisation-specific reporting to service-based reporting aligned to the emerging single Group Digital Service operating model.
- The Group Digital Service redesign is progressing to plan as part of the Corporate Services Transformation programme. To date, the service has delivered savings of 6.6% against the 11% target through vacancies and non-pay measures. Phase One formal consultation concluded on 30 June 2026, establishing a revised senior leadership structure and beginning the integration of teams into a single digital service. Preparations are now under way for the final Phase Two formal consultation, which is expected to begin no earlier than autumn 2026. The focus is now on team integration to strengthen the single-service identity.

2.4. Data, Analytics & Information Services

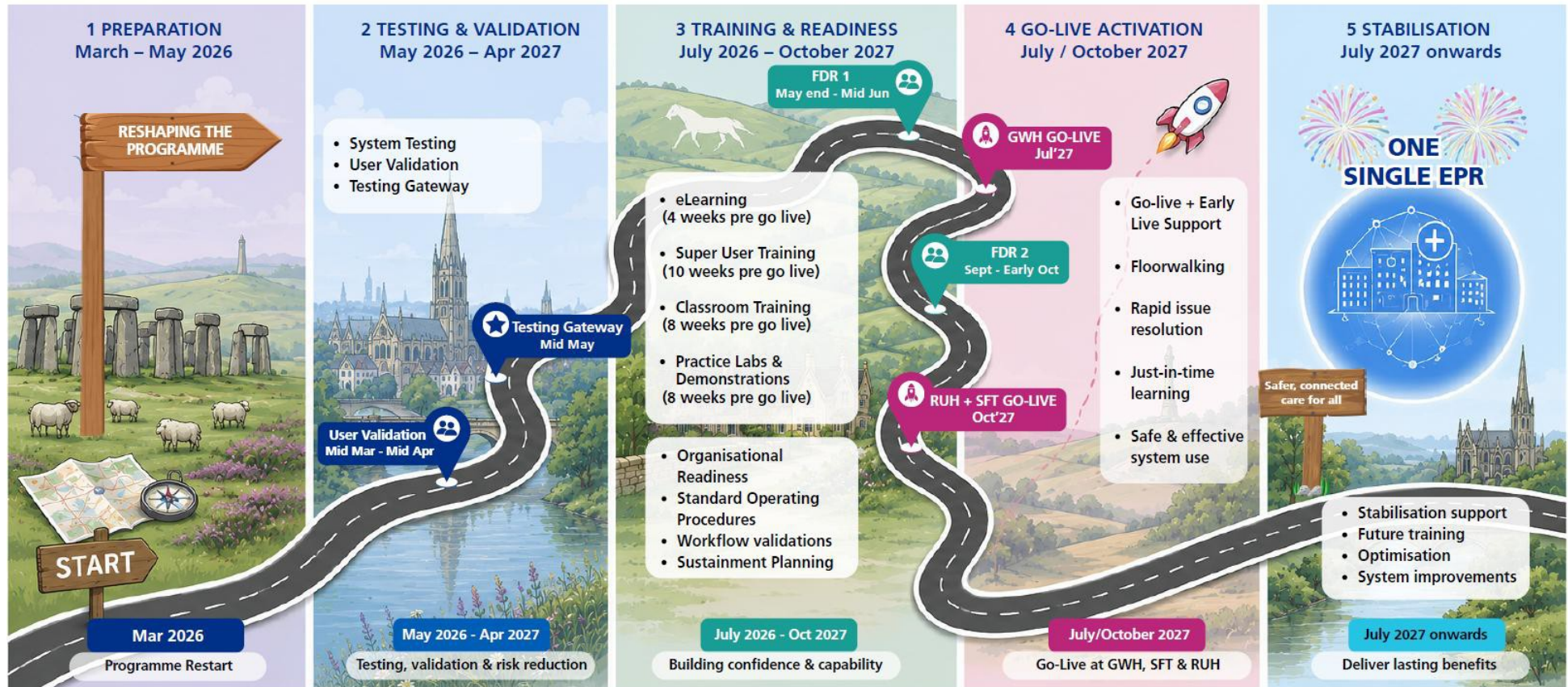
- The single data warehouse programme is a major enabling transformation for consistent Group reporting, operational analytics and performance oversight.
- Progress is being made on unified reporting and group performance reporting; however, business intelligence capacity remains constrained by competing demands, manual consolidation of data across systems and increasing reporting requirements.
- The Group has approved two key business cases:
 - o The Business Intelligence Capacity Business Case will seek to improve resilience and responsiveness, create protected transformation capacity, strengthen coding analytics, and support demand management.
 - o The Clinical Coding Transformation Programme will bring consistency across the three care organisations, introducing standard definitions, a common reporting cadence and consistent measures covering demand, workforce, productivity, backlog, completeness, depth, quality and benefits.

2.5. Assurance of BAU services

- The independent CAF-aligned Data Security & Protection Toolkit (DSPT) reviews for GWH, RUH and SFT provide an improved and positive Group assurance position, with all three organisations achieving significant assurance with only minor improvement opportunities. The improvement focus is proportionate and targeted, including RUH recovery planning and dependency mapping, GWH and SFT refinement of National Data Opt-Out recording, and Group-wide standardisation of information governance processes, evidence and assurance arrangements.
- Cyber security controls continue to provide assurance, with activity aligned to national, ICS and Group requirements. The Group is using common cyber posture reporting, Microsoft Defender and BitSight insight to support a stronger collective approach.

- Infrastructure work continues across network resilience, storage modernisation, connectivity, Windows 11 compliance, identity services and shared platform alignment.
- Changes to email display names and the linking of organisational containers to support future digital convergence activities has been successfully completed. These steps are enablers for future initiatives such as the single data warehouse, single domain, single active directory and a single EPR environment.

APPENDIX A – The Road to EPR



APPENDIX B – EPR Uncovered Roadshow Poster 1 – Mobility & Devices



The EPR team is **hitting the road** across our Care Organisations!

First Topic	What to Expect
Mobility & Devices See how our new single EPR supports safer, more connected care at the bedside. This demo showcases how staff can record observations in real time, receive clinical alerts, access patient information on mobile devices. Discover how integrated mobile workflows help reduce duplication, speed up escalation of deteriorating patients, and put the right information in the hands of the right people, wherever care is being delivered.	- Live demo of real workflows - See how it works in your role - Ask questions & share feedback - Help shape our future

WE ARE VISITING AREAS FROM JULY 20TH FOR 2 WEEKS ON THIS TOPIC.

We'll be spending time on wards and in departments across the three Care Organisations.

Please don't worry if your area is busy – patient care comes first, and we'll work around operational pressures to minimise disruption.

RUH Council of Governors

Agenda item	7
Report title	RUH Medium Term Plan 2026/27–2028/29: Q2 2026/27 update
Date of meeting	10 September 2026
Sponsor	John Palmer, Managing Director
Prepared by	Fiona Bird, Deputy Director of Strategy
Approval Process: (where has this paper been reviewed and approved)	The Medium Term Plan was approved by the Extraordinary Board of Directors on 10 February 2026 and revised following regional feedback before resubmission on 18 March 2026. Delivery is monitored through the Integrated Performance Framework reported monthly to the Board of Directors.

☒ **FOR ASSURANCE**
☐ **FOR DECISION**
☒ **FOR INFORMATION**

STRATEGIC ALIGNMENT *(Tick all priorities that this paper materially supports)*

- | | |
|--|---|
| ☒ Developing an engaged workforce | ☐ Making our teams diverse and inclusive |
| ☒ Making our services safer | ☒ Improving timely access to our services |
| ☒ Improving the experience of those who use our services | ☒ Improving our financial sustainability |
| ☒ Improving health equity | |

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
To be confirmed	Delivery of the Medium Term Plan: operational performance, workforce, transformation and financial sustainability

KEY MESSAGES

The RUH is now delivering its three-year Medium Term Plan, with priorities cascaded through divisions, specialties and teams using the Improving Together framework. The attached update summarises the Quarter 2 corporate priorities, July 2026 performance against the breakthrough objectives and the wider business plan scorecard.

The plan remains focused on improving access and outcomes, increasing activity, supporting the workforce and restoring financial sustainability.

Delivery continues to depend on effective demand management, capital and revenue funding, sufficient capacity to increase activity, safe workforce changes, significant productivity and savings, and sustained transformation capability. Progress is monitored through the Integrated Performance Framework.

Work has also begun to refresh the plan for 2027/28 with BSW Hospitals Group and system partners, incorporating learning from 2026/27, updated assumptions, specialty-to-Group plans, Integrated Neighbourhood Teams and Shared EPR implementation. A further update is planned for the Council of Governors in December.

RECOMMENDATION

The Council of Governors is asked to:

- Receive and note the Quarter 2 update on delivery of the RUH Medium Term Plan 2026/27–2028/29, including current priorities, performance, principal delivery dependencies and the approach to refreshing the plan for 2027/28.

RUH Medium Term Plan 2026/27 – 2028/29

Q2 2026/27 update

The RUH, where you matter



Delivering on our vision – business planning



To ensure we are providing high quality care for the people and communities we serve, we set a plan for our future.

Like all NHS organisations, we have developed a three year plan setting out how we will use our resources and meet national priorities. This includes improving access to services, supporting our workforce and maintaining financial sustainability.

We know the challenges are significant, with growing demand and pressure on services. Our plan contains a number of delivery risks resulting from the financial and operational context we are working in. We are working to mitigate those risks in collaboration with our partners. We have also already made strong progress, including improvements in elective, diagnostic and cancer care. We are working hard to build on these improvements as we start to deliver this plan.

We are ambitious for the future. This plan sets out how we will continue to improve services and outcomes for our patients through our *Improving Together* approach.

Medium term plan - 2026/27

The RUH, where you matter

Medium Term Plan – summary



Our three year plan sets out how we will improve services for patients, support our staff and ensure we are financially sustainable.

It focussed on delivering **better access to care and improved outcomes** for our population, including reducing waiting time for treatment, improving urgent and emergency care, ensuring timely diagnosis and treatment for conditions such as cancer.

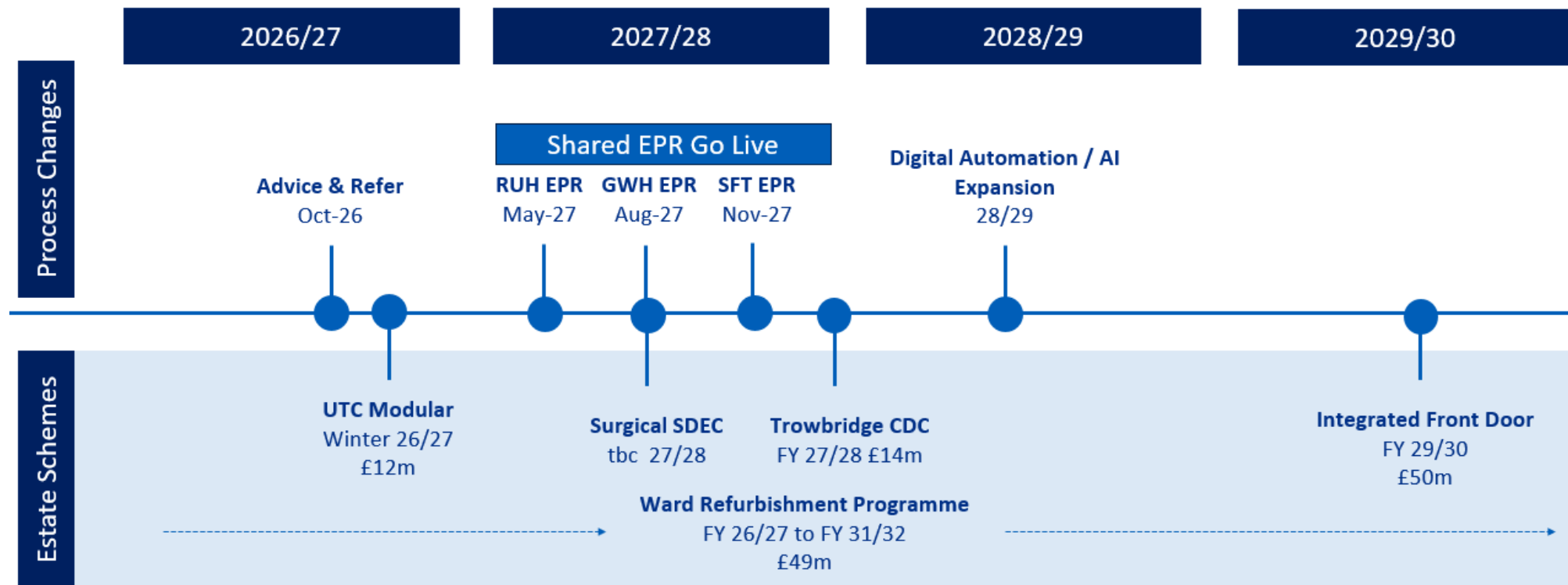
Alongside this, the plan describes how we will **increase the amount of care** we provide, making better use of our theatres, clinics and diagnostics, while also supporting more people to received care closer to home where appropriate.

A key part of the plan is delivering significant **improvements in productivity and efficiency**, so that we can reinvest resources into frontline services and live within our means. This includes reducing reliance on temporary staffing, simplifying how we work and using technology to support us, and growing our portfolio of commercial activities.

Overall, the plan describes how we will build on our early improvements in 2025/26 to recover performance, transform the way care is delivered, and create a sustainable future for our services over the next three years.

Medium Term Plan – summary

The plan also sets out how we **will invest in our services and infrastructure**, including digital systems, estate improvements and new ways of working, to ensure we can meet future demand and continue to improve care. The image below summarises planned capital investment over the next three years:



On the next slide, we summarise the outcomes our Medium Term Plan 2026/2027 – 2028/29.

RUH Business Plan 2026/27 to 2028/29

	Metric	RUH plan Mar '26	26/27 national standard	26/27 RUH Plan	27/28 national standard	27/28 RUH Plan	28/29 national standard	28/29 RUH Plan
UEC	4-hour ED performance (type 1 / all types)	72% / 78%	82% by Mar '27	75.3%	83%	80.2%	85%	85.0%
	12-hour ED performance	4.9%	3.9%	6.3%	Year on year reduction	5.3%	Year on year reduction	5.0%
	Ambulance handover	33 mins	Reduce toward 15 mins	30 mins	Further improvement	29 mins	15 mins	28 mins
Elective & Diagnostic	18w RTT Performance	68.7%	74.7% for RUH (65% or 7% Improvement, whichever is higher)	74.7%	Bridge between 74.7% and 92% Target	83.4%	92%	92.0%
	52 Week Waiters	<1%	Improvement on 1%	198 (0.8%)		62 (0.4%)		0
	DM01	16.1%	3% improvement at ICB level 13.1% for RUH	12.5%	To bridge between 13.1% and 1%	9.0%	99%	1.0%
Cancer	28d FDS	80%	80% annual ave	80.0%	80% annual ave	80.5%	80% annual ave	80.7%
	31d	94%	94%	94.2%	96%	96.0%	96% annual ave	96.1%
	62d RTT	75%	80%	80.5%	82.5%	82.7%	85%	85.1%
Workforce	30% Reduction in agency use	5.0 WTE	30% improvement relative to M6	-5wte	Improvement	-2wte	Zero agency spend	0
	10% reduction in bank spend	261 WTE	10% reduction relative to M6	-10%	Improvement	-10%	30% reduction relative to 25/26	-10%
	Sickness rate (rolling 12 month average)	5.3%	Improvement	4.8%	Improvement	4.6%	4.1%	4.4%
Finance	2% productivity improvement	6.7%	% for RUH (2% improvement)	5.0%		2.7%	“Sustained improvement”	1.5%
	Savings Plan	15.0m (29.7m)	37.6m (£56.6m over 3 yrs)	37.6m	10.0m	10.3m	8.6m	8.7m
	Balanced or surplus financial position	£20.5m	Balance or surplus	0.0m	Balance or surplus	0.0m	Balance or surplus	0.0m

Setting our 2026/27 priorities

Using our Improving Together improvement methodology, we have set our Breakthrough Objective, Corporate Project and Strategic Initiatives for 2026/27. Together, these harness our collective efforts to deliver the outcomes set out in the Medium Term Plan.

Breakthrough Objectives

A set of key objectives derived from the most pressing organisational issues. They are defined with yearly targets and deployed to relevant frontline teams to focus on.

They require a significant breakthrough in addressing a problem and constitute a major stretch for the organisation.

12-18 months timeframe

Corporate Projects

Direct and significant contribution to the Breakthrough objectives or a national mandate

Large scale change that requires resources from across the organisation

Benefits in year

Strategic Initiatives

Longer-term initiatives which support the Trust strategy. They have an executive sponsor and involve multiple teams.

3 – 5 years timeframe

2026/27 priorities

The RUH,
where you matter

Our Strategic Initiatives

Our 2026/27 Breakthrough Objectives

Our Corporate Projects

The **people** we care for

Partnerships

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



Achieve safety standards



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

The **people** we work with

Service Redesign

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



Support and empower our staff



Improve sickness rate absence to 4.8%

The **people** in our community

Commercial Opportunities

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



Making the most of our resources



Deliver £37.6m of Savings
Exceed 2% Productivity

UTC Modular Build
Advice & Refer
Demand Management & Discharge

Healthier Workforce Programme
Clinical Admin Transformation
Medical E-Rostering
Staff Accommodation

Digitalisation of Outpatients
Shared EPR
Trowbridge Neighbourhood & Community Diagnostic Centre
Project Clean Heat

What our plan is reliant on



Fewer people needing hospital care where appropriate

The plan assumes that, working with our partners in BSW, we can safely reduce demand on urgent and emergency services by supporting more people in the community and avoiding unnecessary attendances.

Investment in key facilities and buildings goes ahead

Delivery depends on funding for improvements such as a new Urgent Treatment Centre and longer-term redevelopment of the hospital front door

We continue to receive national and system funding support

The plan assumes specific funding is secured (e.g. for cancer care and elective recovery) and that additional activity above plan will be paid for.

We can treat more patients and reduce waiting times with available capacity

It relies on increasing activity and making full use of available theatres, clinics and diagnostic services, with potential to do more if extra funding is available

Workforce changes improve efficiency without impacting care

The plan assumes we can reduce reliance on temporary staff, manage vacancies, and reshape the workforce while maintaining safe, high-quality services.

Significant cost savings and productivity improvements are delivered

A key assumption is that ambitious efficiency savings and productivity gains can be achieved across the organisation.

National funding assumptions hold true

This includes pay awards and inflation being funded as expected and key programmes (like go live of Shared Electronic Patient Record) being delivered without major disruption.

Ongoing improvement support and transformation capacity is maintained

The plan assumes continued support for improvement and enough organisational capacity to deliver major changes alongside day-to-day services.

RUH 5 Year Strategic Staircase

While we are focussed on delivery in 2026/27, we are also taking a longer term view of our future, outlined in the strategic staircase.

The staircase will continue to evolve as we make progress, but helps focus our efforts on the big strategic changes we want to make for our patients, our staff and our communities.

2025/26
Group - Corp Services - First Phase Services - EPR preparation - Clinical Transformation Preparation - Group Governance preparation
Care Organisation - Risk Model: Design and Build - Statutory Target Recovery - Call to Action - Turnaround - CQC ED Response
Capital - UEC Environmental improvements - UTC Business Case - Integrated Front Door BC - MEA – asset realisation
£20.5m Deficit

2026/27
Group - Corporate Services – Second Phase Services - EPR – 1 year out - Clinical Transf'ion: Phase 1 - Group Governance established - Commercial Strategy established
Care Organisation - UEC Build – Phase 1 - RTT Compliance 52 weeks - CQC Requires Improvement Back to Good plan - Digital – Ambient Voice Technology roll out
Capital - UEC Modular (£12m) - Estates Safety Fund £5.3m - Build SULIS Business Case for Private Patient Expansion – Manor House - Sale and leaseback residences and car park
c. £11m

2027/28
Group - EPR implementation x 3 - Clinical Transformation: Phase 2 - GWH PFI completion - R&D Expansion - Collaboration with Universities - Group Elective Strategy
Care Organisation - EPR imp October - UEC Build – Phase 2 - CQC Good - Digital Implementation Plan - Administration Transformation - Robotic Surgery Expansion
Capital - Integrated Front door (£50m) - Estates Safety Fund ward refurbishment (£8.9m pa) - Increase Sulis NHS Private Patient footprint - Backlog maintenance plan
c. £9m

2028/29
General Election
Group - Clinical Transformation: Phase 3 - Optimise EPR
Care Organisation - UEC Build – Phase 2 - Digital Plan Implemented - CQC Outstanding - Launch of Integrated Training School - Corporate Administration Transformation
Capital - Integrated Front door (£50m) - Estates Safety Fund Ward refurbishment (£8.9m pa) - Expand to SULIS Swindon - Backlog maintenance programme
Break even

2029/30
Group - Clinical Transformation: Phase 4 - Optimise EPR
Care Organisation - UEC – Integrated Front Door completion - Digital Plan Implemented
Capital - Integrated Front door (£50m) - Estates Safety Fund Ward refurbishment (£8.9m pa) - Expand to SULIS Swindon - Backlog maintenance programme - Rejoin Future Hospitals Programme?
Break even

Delivering the plan – Q2 2026/27

The RUH, where you matter

Q2 2026/27



We are now working on delivering our plan.

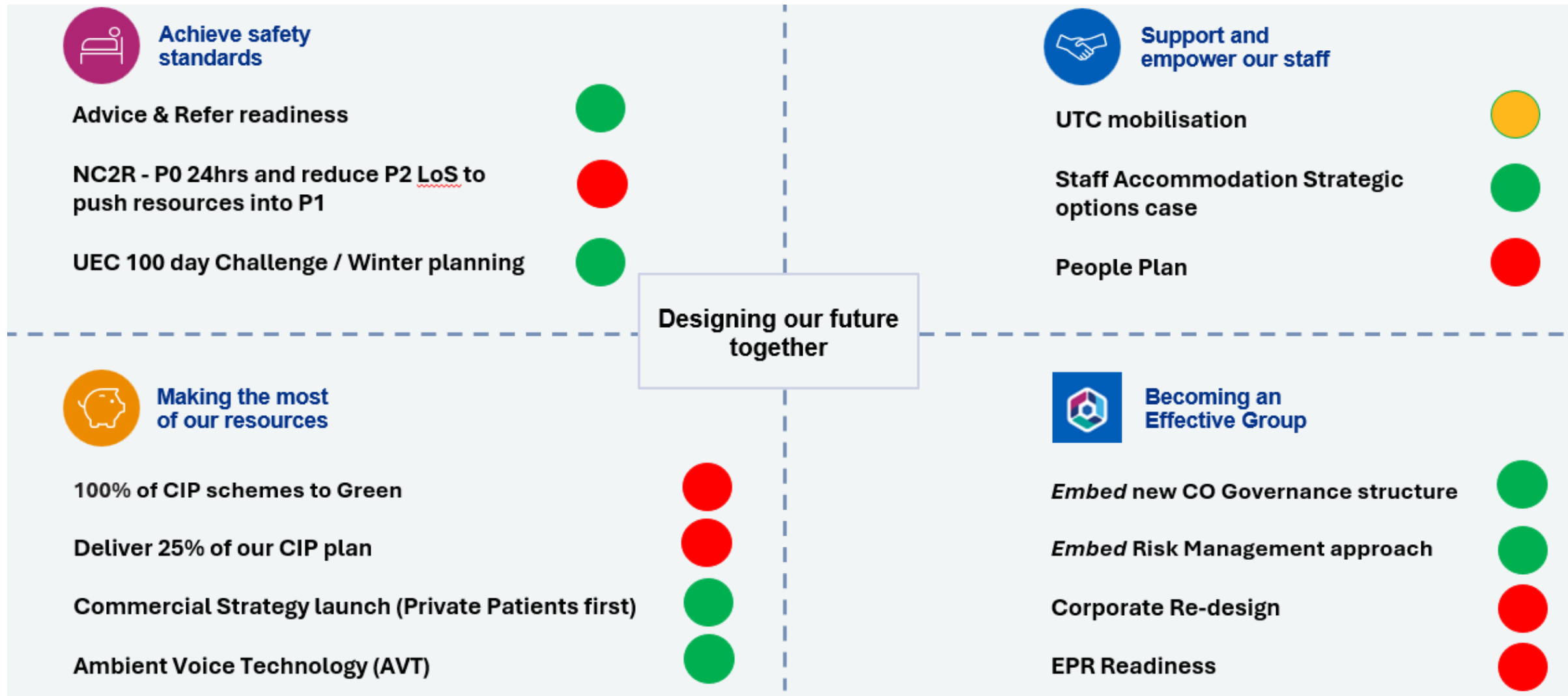
Our Improving Together framework gives us the tools, behaviours and routines to deliver and monitor our priorities. Priorities have been cascaded through our Divisions, specialties and teams, so everyone can understand how they contribute.

The next three slides summarise our:

- Priority corporate projects for the second quarter of 2026/27
- Performance against the breakthrough objectives in July 2026
- The full business plan scorecard for July 2026.

The Integrated Performance Framework to Board of Directors provides Board of Directors with a monthly overview of our progress against the standards and objectives outlined in the plan

What do we need to achieve in Quarter 2?



Performance of Breakthrough Objectives

LATEST AVAILABLE PERFORMANCE | JULY 2026



STATUS MIX

- 5 Intervention required
- 1 Watch
- 1 Ahead

Diagnostics is the single area ahead of trajectory.

PRIORITY AREA	LATEST POSITION	STATUS
No Criteria to Reside LOS	RUH Performance 93.1% vs 95%; <u>Community</u> 82 patient vs 35	● Off track
Corridor care	192 min avg; up from 162 min	● Off track
52-week waits (RTT)	156 patients; up 17% from 133	● Off track
Diagnostic waits	86.58% vs 86.30% trajectory	● On track
Cancer 28-day diagnosis	76.3% vs 78.8% trajectory*	● Off track
Sickness absence	5.24%; year-end target 4.8%	● On track (in month), Off track (12-month average)
Savings delivery	62% green vs 80% Q1 target	● Off track

* Cancer July performance is unvalidated. Corridor and RTT use month-on-month movement where no explicit target is shown. Source: current performance deck.

2026/27 Business Plan Scorecard

July 2026

Performance against trajectory (in year)

3 Year Plan Profile

Domain	Metric	Apr-26	May-26	Jun-26	Jul-26	Year End 26/27 RUH Plan	Year End 27/28 RUH Plan	Year End 28/29 RUH Plan
UEC	ED Attendance Growth YTD	3.6%	3.0%	4.2%	3.9%	-0.5%		
	NEL Admission Growth YTD	12.4%	5.5%	5.6%	5.6%	-4.6%		
	Eliminating Corridor Care	556 (15%)	683 (15%)	587 (6.5%)	602 (6.5%)	0	0	0
	4-hour ED performance (type 1)	61.2%	56.6%	57.8%	56.2%	77.2%	72.9%	79.1%
	4-hour ED performance (all types)	71.1%	67.0%	68.9%	68.4%	82.9%	80.2%	85.0%*
	12-hour ED performance	92.0%	90.1%	88.7%	86.5%	93.7%	94.7%	95.0%
	Ambulance handover	33.1 mins	68.7 mins	53.2 mins	76.4 mins	30 mins	29 mins	28 mins
Elective & Diagnostic	GP Referral Growth YTD*	10.9%	13.0%	13.2%	17.1%	0.0%		
	RTT Open Pathways	39,237	40,061	39,606	41,031	32,987	29,547	26,785
	18w RTT Performance	70.3%	71.1%	70.4%	70.6%	74.7%	83.4%	92.0%
	52 Week Waiters	183	155	133	156	198	62	0
	52 Week Waiters %	0.5%	0.4%	0.4%	0.4%	0.8%	0.4%	0%
	Diagnostics 6 week wait	14.7%	13.1%	11.8%	13.4%	12.50%	9.0%	1.0%
Cancer	28 day FDS *	79.8%	79.4%	78.8%	76.3%	80.0%	80.5%	80.7%
	31 day*	92.5%	95.0%	94.4%	95.4%	94.2%	96.0%	96.1%
	62 day RTT*	68.5%	70.0%	71.0%	68.9%	80.5%	82.7%	85.1%
Workforce	30% Reduction in agency use	13.3 WTE	21.2 WTE	11.6 WTE	14 WTE	5 WTE	3 WTE	0
	10% reduction in bank spend	283.7 WTE	289.2 WTE	302.9 WTE	296.2 WTE	237 WTE	-10%	-10%
	Sickness rate (rolling 12 month average)*	5.5%	5.5%	5.6%	5.6%	4.8%	4.6%	4.4%
Finance	2% productivity improvement	6.5%	3.5%	1.9%	4.9%	5.0%	2.7%	1.5%
	Savings Plan	1,400	2,170	3,089	4,861	37.6m	10.3m	8.7m
	Balanced or surplus financial position	(2,886)	(5,935)	(7,583)	(10,585)	0.0m	0.0m	0.0m
Discharge	Non Criteria to Reside (NC2R)	88	100	103	116			
	NCTR % Occupancy	18.9%	21.4%	21.8%	24.5%			
	Pathway 0 - Home	95.0%	94.4%	94.8%	93.1%			
	Pathway 1 - Home with support	43.5%	44.1%	36.7%	38.9%			
	Pathway 2 - Community setting	31.6%	26.8%	22.8%	19.2%			
	Pathway 3 - Residential care	42.9%	40.6%	38.2%	39.0%			

* one month lag

Planning for 2027/28

The RUH, where you matter

Planning for 2027/28



As we move in to autumn 2026, we are starting to consider how we will refresh our Medium Term Plan for 2027/28.

We are working with our Group colleagues at GWH and SFT on the refresh, and with our partners across the health and care system.

We will:

- Look back at 2026/27, how we performed against our plan, where we still need to make progress, and what we can learn, using our Improving Together methodology
- Refresh our 2026/27 assumptions
- Develop detailed plans at specialty, division, Care Organisation and Group level
- Include some of the big changes we are expecting in 2027/28, including:
 - The development of Integrated Neighbourhood Teams in our communities
 - Go-live of Shared EPR across our three hospitals
 - Continued national focus on bringing down waiting times
- Respond to national planning requirements. We expect to get more information later this year.
- Return to Council of Governors in December to update on our work.

Public Council of Governors

Agenda item	8
Report title	External Audit presentation to the Council of Governors
Date of meeting	10 September 2026
Sponsor	Simon Wade, Chief Finance Officer
Prepared by	Deloitte
Approval Process: (where has this paper been reviewed and approved)	Internal Deloitte reviews. This paper summarises previous audit papers which have been through a rigorous internal review process and have been reviewed by the RUH Trust Audit and Risk Committee and management as appropriate.

☒ **FOR ASSURANCE**
☐ **FOR DECISION**
☒ **FOR INFORMATION**

STRATEGIC ALIGNMENT *(Tick all priorities that this paper materially supports)*

- | | |
|---|--|
| ☐ Developing an engaged workforce | ☐ Making our teams diverse and inclusive |
| ☐ Making our services safer | ☐ Improving timely access to our services |
| ☐ Improving the experience of those who use our services | ☒ Improving our financial sustainability |
| ☐ Improving health equity | |

LINKS TO RISK REGISTER

Risk ID	Principal risk title
N/A	N/A

KEY MESSAGES

Summary of findings from the FY25/26 audit. Topics covered: financial statements, annual report, value for money.

RECOMMENDATION

The Council of Governors is asked to note the report.

APPENDICES

None.



Royal United Hospitals Bath NHS Foundation Trust

**2025/26 External Audit Presentation to the
Council of Governors – 10 September 2026**

Scope of work and approach

We have three key areas of responsibility under the Audit Code

Financial statements

We will conduct our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller & Auditor General and applicable law. The Group prepares its accounts under the Group Accounting Manual (“GAM”) which is issued by the Department of Health and Social Care.

We are also required to issue separate group reporting to the NAO on the Group’s separate return required for the purposes of its audit of the Whole of Government Accounts and departmental accounts.

Annual Report

We are required to consider the completeness of the disclosures in the Annual Governance Statement in meeting the relevant requirements and identify any inconsistencies between the disclosures and the information that we are aware of from our work on the financial statements and other work.

As part of our work we review the remuneration report and annual report and compare with other available information to ensure there are no material inconsistencies. We also review any reports from the Care Quality Commission, NHS England and other relevant regulatory bodies and any related action plans developed by the Group.

Value for Money

We are required to consider the arrangements that the Trust has made securing financial resilience and economy, efficiency and effectiveness in its use of resources, if we identify any significant weaknesses to make recommendations, and to provide a narrative commentary on arrangements.

To perform this work, we are required to:

- Obtain an understanding of the Trust’s arrangements sufficient to support our risk assessment and commentary;
- Assess whether there are risks of a significant weakness in the Trust’s arrangements, and perform additional procedures if a risk is identified. If a significant weakness is identified, we report this and an accompanying recommendation;
- Report in our audit opinion if we have reported any significant weaknesses; and
- Issue a narrative commentary in our Auditor’s Annual Report on the arrangements in place.

Key Findings

Financial performance

Deficit

The Group made a deficit for the year of £74.0m (£2.4m deficit in 2024/25).
The Group's adjusted financial performance deficit was £20.5m (£4.2m deficit in 2024/25).

Cash Position

The Group's cash balance as at 31 March 2026 was £28.3m (£40.0m in 2025).

Financial performance

We have identified a significant weakness in the Trust's arrangements for financial sustainability, specifically concerning its ability to achieve planned savings and a breakeven position. In FY 25/26, the Trust has reported an adjusted deficit of £20.5 million and has delivered £19 million efficiency savings, representing 57% of its planned savings of £34 million. This indicates a shortfall in the Trust's delivery against its own targets.

For the 26/27 financial year, the Trust's plan submitted in February 2026 aims for a breakeven position, relying on £36.1 million in efficiency savings. However, a substantial portion of these planned efficiencies, £21.69 million (60.1%), are classified as high risk, with only £7.86 million (21.8%) fully developed, and £4.40 million (12.2%) currently unidentified, alongside a further £14.99 million (41.5%) classified as 'opportunity'.

This indicates a high risk of non-delivery for the FY 26/27 financial plan and the Trust's ability to achieve breakeven. For further information please see our report issued on 17 June 2026.

NHS Oversight Framework

To provide an overview of the level and nature of support required across systems and target support capacity as effectively as possible, NHS England and NHS Improvement have allocated trusts and ICB's to one of four segments. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4).

The Trust was rated as 3 at Q4 (4 at Q3) and 3 in the prior year.

Key Findings

Audit Findings

Financial Statements	We received the financial statements in line with the NHS timetable. No significant changes were made to the initial financial statements provided to audit.
Annual Report (including AGS and Remuneration Report)	We will work with the team to agree a timetable for the Annual Report and AGS to align with the NHS deadlines for FY27. We will work with the BSW group to design an efficient approach to the Remuneration Report testing for each Trust.
Controls	Several recommendations were raised relating to control improvements as reported in our Final Report to the Audit & Risk Committee dated 17 June 2026. Good responses to these were provided by management.
Value for Money (VFM)	We identified two significant weaknesses which were reported in our Final Report to the Audit & Assurance Committee dated 17 June 2026. These related to: Financial sustainability – We have identified a significant weakness in arrangements in respect of financial sustainability (how the Trust plans and manages its resources to ensure it can continue to deliver its services), specifically how the Trust would achieve its planned savings and breakeven position despite the acknowledged impact of the underfunding by the Integrated Care Board (ICB). Governance – We have identified a significant weakness in arrangements in respect of governance (how the Trust ensures that it makes informed decisions and properly manages its risks), specifically in the Trust’s ability to establish and maintain effective systems for the oversight, monitoring, and control of quality, safety, and operational performance in its urgent and emergency care services.
Audit Report	Our audit report was unmodified with the exception of reflecting the VFM significant weaknesses noted above.

Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

What we report

Our report is designed to provide the Council of Governors of Royal United Hospitals Bath NHS Foundation Trust with the key findings identified during the external audit of the Annual Report and Accounts for 2025/26 in line with the requirements of our terms of engagement.

Our report summarises the findings from our Final Report to the Audit & Risk Committee dated 17 June 2026.

The scope of our work

Our observations are developed in the context of our audit of the financial statements.

Use of this report

This report has been prepared for the Council of Governors of Royal United Hospitals Bath NHS Foundation Trust, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent.

What we don't report

As you will be aware, our audit was not designed to identify all matters that may be relevant to Royal United Hospitals Bath NHS Foundation Trust.

Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.

Finally, our views on internal controls and business risk assessment should not be taken as comprehensive or as an opinion on effectiveness since they have been based solely on the audit procedures performed in the audit of the financial statements and the other procedures performed in fulfilling our audit plan.

Deloitte LLP

Bristol | 8 September 2026



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Council of Governors

Agenda item	11
Report title	Council of Governors Elections 2026 – Update for Governors
Date of meeting	10 September 2026
Sponsor	Roxy Milbourne, Interim Head of Corporate Governance
Prepared by	Abby Strange, Corporate Governance Manager
Approval Process: (where has this paper been reviewed and approved)	Reviewed and supported by the Membership and Outreach Working Group at its most recent meeting, and approved for submission by Roxy Milbourne, Interim Head of Corporate Governance

☐ **FOR ASSURANCE**
☒ **FOR DECISION**
☐ **FOR INFORMATION**

STRATEGIC ALIGNMENT *(Tick all priorities that this paper materially supports)*

- | | |
|--|--|
| ☒ Developing an engaged workforce | ☒ Making our teams diverse and inclusive |
| ☐ Making our services safer | ☐ Improving timely access to our services |
| ☒ Improving the experience of those who use our services | ☐ Improving our financial sustainability |
| ☐ Improving health equity | |

LINKS TO RISK REGISTER

Risk ID	Principal risk title
N/A	N/A

KEY MESSAGES

This report provides the Council of Governors with an update on the 2026 Governor Elections.

While the forthcoming health Bill may introduce future legislative changes, Foundation Trusts must continue to comply with the current legal framework, including holding Governor elections and maintaining a quorate Council of Governors.

At the time of preparing this report, elections were underway across all constituencies with seats due for election in 2026, with nominations due to close on 8 September 2026. City of Bath is not included in this election round because two Governors were appointed to its seats during the previous election round. As the outcome of the current nomination process will not be available when the meeting papers are issued, a verbal update will be provided at the meeting. Where vacancies remain following the 2026 election, the Trust will not automatically undertake further elections, provided the Council retains sufficient voting membership to meet the statutory minimum membership and remain quorate in practice. Any departure from the vacancy provisions in the Trust Constitution will be documented, agreed through the appropriate governance route and kept under review, recognising the limited risk of challenge during this interim period.

Where appropriate, outgoing Governors may be invited to continue supporting the Council as non-voting co-opted participants to provide continuity and retain valuable experience. They will not count towards the statutory minimum membership or quorum and will not vote or take part in statutory decisions reserved to Governors.

The Membership and Outreach Working Group reviewed and supported this proportionate proposed approach at its most recent meeting. This includes continuing elections in all constituencies with seats due for election in 2026, maintaining sufficient voting membership to meet the statutory minimum membership and remain quorate in practice, managing any remaining vacancies without automatically undertaking further elections, and using non-voting co-opted participants where appropriate.

RECOMMENDATION

The Council of Governors is asked to:

1. Note the update on the 2026 Governor Elections, including that a verbal update on the outcome of the nomination process will be provided at the meeting and that City of Bath is not included because two Governors were appointed during the previous election round.
2. Endorse the proposed approach for maintaining the statutory minimum membership and meeting quorum following the election process, including the proportionate management of any remaining vacancies and the use of non-voting co-opted participants where appropriate to support continuity.

APPENDICES

None

2026 Council of Governors Elections Update

Purpose

This report provides Governors with an update on the 2026 Governor Elections, explains the current national position regarding the future of NHS Foundation Trust Governor arrangements, and sets out the Trust's proposed approach to maintaining a quorate Council of Governors during the period of uncertainty.

Background

In July 2025, the Government's 10-Year Health Plan announced an intention to remove the statutory requirement for NHS Foundation Trusts to have Councils of Governors. The NHS Alliance and NHS England have subsequently advised that proposed legislation is being developed with the intention that these changes could take effect from 1 April 2027, subject to Parliamentary approval. However, no legislation has yet been passed and there remains uncertainty regarding both the final content and implementation timetable of the proposed changes.

Until any new legislation comes into force, Foundation Trusts must continue to comply with the current legal framework governing Governors and Councils of Governors, including the requirement to hold elections and maintain an effective and quorate Council.

2026 Governor Elections

Elections are proceeding as planned during summer and autumn 2026 for the Governor seats listed below. City of Bath is not included in this election round because two Governors were appointed to its seats during the previous election round.

Constituency	Seats
North East Somerset	1
Mendip	2, including 1 existing vacancy
North Wiltshire	1
South Wiltshire	1
Rest of England and Wales	1
Staff Governors	3
Total	9

The terms of office of the following Governors will conclude on 31 October 2026 and their seats will be subject to election:

- Vic Pritchard, North East Somerset
- Kate Cozens, Mendip
- Paul Newman, North Wiltshire
- Ian Lafferty, South Wiltshire
- Anne-Marie Walker, Rest of England and Wales
- Craig Jones, Staff Governor
- Fiona Marfleet, Staff Governor
- Gary Chamberlain, Staff Governor

Governors whose terms of office are ending are eligible to stand for re-election in accordance with the Trust Constitution, provided they have not reached the maximum permitted term of nine consecutive years of service.

Election Timetable

Civica Election Services has been appointed as the Independent Scrutineer for the elections, and the key dates to be aware of are as follows:

Milestone	Date
Notice of Election / nominations open	Monday, 10 August 2026
Nominations deadline	Tuesday, 8 September 2026
Summary of valid nominated candidates published	Wednesday, 9 September 2026
Final date for candidate withdrawal	Friday, 11 September 2026
Notice of Poll published	Tuesday, 29 September 2026
Voting packs dispatched	Wednesday, 30 September 2026
Close of election	Friday, 23 October 2026
Declaration of results	Monday, 26 October 2026

These dates ensure that all elections are completed before the current terms of office expire on 31 October 2026.

At the time of preparing this report, the nomination period remained open and the final position was therefore not available for inclusion in the meeting papers. A verbal update on the outcome of the nomination process will be provided at the meeting.

Maintaining a Quorate Council of Governors

Practical guidance from the NHS Alliance, reflecting confirmation from NHS England, recognises that many Foundation Trusts are considering how to manage Governor arrangements during the

period leading up to April 2027. The guidance confirms that routine elections should continue, while Trusts and their Councils may consider proportionate arrangements during this period of uncertainty, subject to current legislation and their constitutions.

The NHS Act sets out the statutory minimum membership of a Council of Governors:

- More than half the members must be elected from the public constituency.
- At least three members must be elected by the staff constituency.
- At least one member must be appointed by a qualifying local authority.
- At least one member must be appointed by a university where the Foundation Trust is affiliated to a university medical or dental school.

For the RUH, this equates to a minimum of:

- Five Public Governors
- Three Staff Governors
- One Local Authority Governor

This would result in a minimum Council of nine voting Governors. The Trust must also maintain the constitutional quorum for meetings, which is one-third of the total number of Governors, including at least three Public Governors and two Staff Governors.

Proposed Approach

Considering the national uncertainty surrounding the future of Councils of Governors, the following proposed approach was reviewed and supported by the Membership and Outreach Working Group at its most recent meeting and is presented to the Council of Governors for endorsement:

1. Proceed with the 2026 elections in all constituencies with seats due for election in 2026.
2. Encourage as many candidates as possible to stand for election and continue to promote the important role Governors play in representing patients, members, staff and local communities.
3. Where vacancies remain following the 2026 election, the Trust will not automatically undertake further elections, provided the Council retains sufficient voting membership to meet the statutory minimum membership and remain quorate in practice. This proportionate approach reflects NHS Alliance guidance and has been supported by the Membership and Outreach Working Group. Any departure from the vacancy provisions in the Trust Constitution will be documented, agreed through the appropriate governance route and kept under review, recognising the limited risk of challenge during this interim period.
4. Where appropriate, invite an outgoing Governor whose seat has not been filled to remain involved as a non-voting co-opted participant to retain experience, knowledge and continuity. Co-opted participants will not count towards the statutory minimum membership or quorum and will not vote or take part in statutory decisions reserved to Governors.
5. Continue to keep Governors informed of any developments relating to the forthcoming health Bill and any resulting changes to Foundation Trust governance arrangements.

This approach is intended to maintain the Trust's statutory requirements and a Council that remains quorate in practice, while any departure from the Trust Constitution is documented, agreed through the appropriate governance route and kept under review.

Recommendation

The Council of Governors is asked to:

1. Note the update on the 2026 Governor Elections, including that a verbal update on the outcome of the nomination process will be provided at the meeting and that City of Bath is not included because two Governors were appointed during the previous election round.
2. Endorse the proposed approach for maintaining the statutory minimum membership and meeting quorum following the election process, including the proportionate management of any remaining vacancies and the use of non-voting co-opted participants where appropriate to support continuity.

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