Royal United Hospitals Bath
NHS Foundation Trust

# Royal United Hospitals Bath NHS Foundation Trust Annual Report and Accounts

1 April 2023 to 31 March 2024

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Presented to Parliament pursuant to Schedule 7, paragraph 25(4)(a) of the National Health Service Act 2006

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# Statement from the Chair and Chief Executive

We are immensely proud of the progress we've made toward realising our vision with the You Matter Strategy. Like much of the NHS, the past 12 months have presented many challenges, but our commitment to partnering with those we care for, those we work with, and our community remains steadfast.

The quality of care we deliver is a priority for the entire Trust and its people. For our patients, we ensure that advice and treatment are effective, safe, kind, and compassionate, always striving for improvement by listening to feedback. For our colleagues, we focus on creating conditions that enable the delivery of high standards of service every day. And for our community, we aim to instil confidence that their local hospital is there for them when needed and is making a positive impact.

We take great pride in being a place where our people want to work. The recent NHS Staff Survey rated the Royal United Hospitals Bath NHS Foundation Trust (RUH) as one of the best hospitals to work for in England, and among the top three in the Southwest. We are dedicated to fostering a culture of kindness, civility, and inclusivity.

Our staff have reported feeling that they make a real difference at work, reflecting positively on our Improving Together program, which empowers staff to lead improvements in their areas. We were thrilled to celebrate our Maternity services team's recent 'outstanding' rating from the Care Quality Commission (CQC), placing it in the top three percent in England, showcasing the positive impact of change led by our dedicated staff.

While we have celebrated many successes over the last year, we have also faced significant challenges. Like other NHS organisations, we are experiencing increased financial pressures due to rising costs, new standards post-pandemic, increased demand, and managing through substantial periods of industrial action. Despite these pressures, our priority remains providing high-quality services to those we care for.

In 2023/24, our Emergency Department saw the highest volume of patients since 2019, with an 8% increase in attendances and a 9% increase in ambulance arrivals. Ensuring timely care is crucial, and we have made progress, ending the year with a performance of just over 69%. We are setting ambitious targets to continue this improvement into the next year.

For patients well enough to be at home, our same day emergency care service now serves 33.2% (19,000 people) of urgent medical visits. Feedback on our Hospital at Home service has been very positive.

Despite a challenging year, we have seen real successes, particularly in the NHS's elective recovery program. We have significantly reduced waiting times for planned procedures, performing 115% of the target elective activity, making us one of the best performing hospitals in the Southwest.

We continue to reduce waiting times for treatment, successfully treating all patients who have been waiting over 104 weeks and significantly reducing those waiting over 65 weeks. Our

acquisition of Sulis in 2021 has supported these efforts, and we are excited about our new elective orthopaedic centre at Sulis Hospital Bath, set to open in early 2025.

Innovation and technology remain at our core. Thanks to RUHX's fundraising efforts, we purchased a surgical robot in 2023, enhancing the precision and safety of our surgeries. We are also grateful to the Friends of the RUH for their support, contributing over 20,000 hours of volunteering.

Collaboration is key at the RUH, demonstrated by our partnership in the Acute Hospital Alliance with Great Western Hospital NHS Foundation Trust and Salisbury NHS Foundation Trust. Our joint development of an Electronic Patient Record will enhance care delivery across the three Trusts.

As we begin year two of our Trust strategy, we are excited to open our new Dyson Cancer Centre. This centre will provide a cancer services hub for over 500,000 people in the Southwest, transforming the care for those living with cancer.

Thank you for your unwavering support over the coming year. People are at the very core of our strategy, and we remain committed to ensuring that our patients, staff, and community feel valued and appreciated in everything we do.

through a shared approach. In March 2024 we announced that we would be developing an Electronic Patient Record together, a digital platform that will support the delivery of care across the three Trusts efficiently, effectively and safely.

We are excited to begin year two of our Trust strategy by opening the doors of our new Dyson Cancer Centre. The purpose-built centre brings together many of the RUH's cancer services under one roof to provide a cancer services hub for over 500,000 people in the Southwest and promises to transform the care of those who are living with cancer. We're grateful to everyone who has helped us create this amazing building.

Thank you for your unwavering support over the coming year. People are at the very core of our strategy, and we remain committed to ensuring that our patients, staff, and community feel valued and appreciated in everything we do.

**Alison Ryan**

**Chair**

**Cara Charles-Barks**

**Chief Executive**

# Performance Report

## Overview of performance during 2023/24

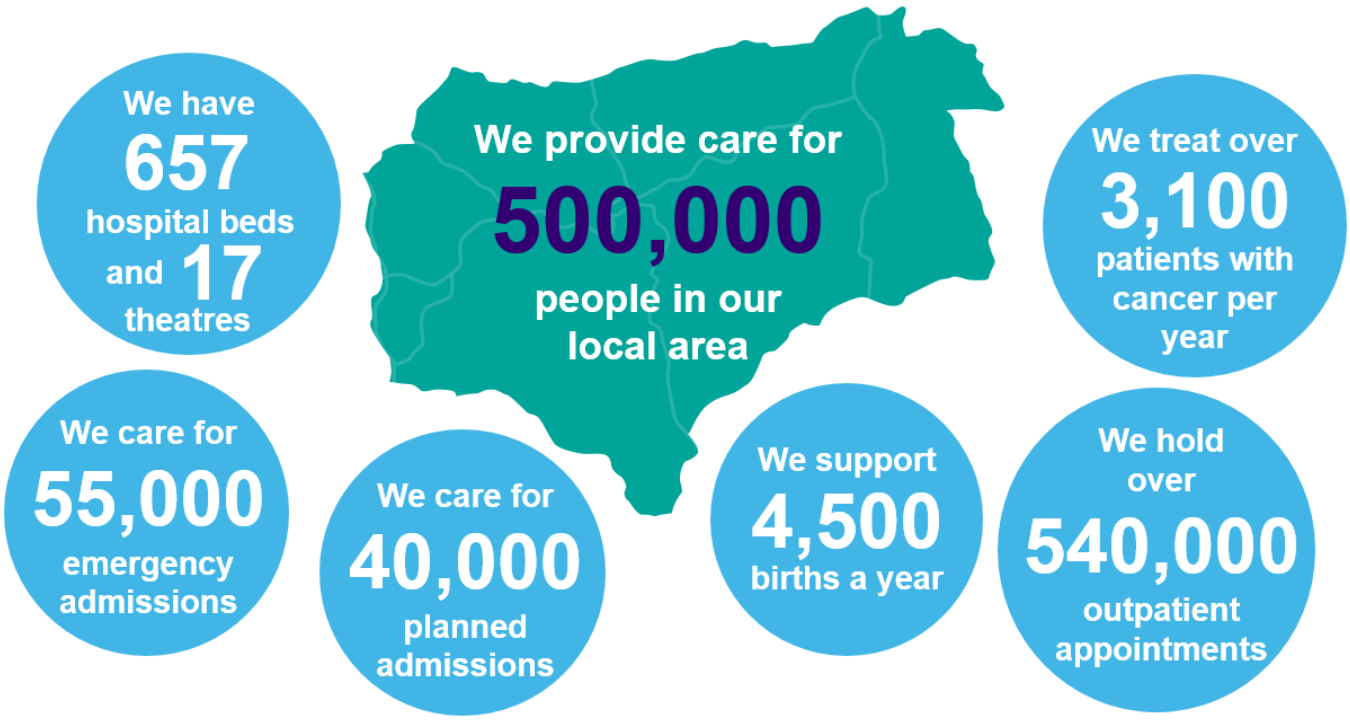
The purpose of this overview is to provide a summary of the Group's history, the context within which its services are provided, and levels of financial and operational performance during the year.

### Introduction to Royal United Hospitals Bath NHS Foundation Trust

The Royal United Hospitals Bath NHS Foundation Trust is authorised under the National Health Service Act 2006 to provide goods and services for the purposes of the Health Service in England. It was established as an NHS Trust in 1992 and achieved Foundation status in November 2014. The Trust provides a wide range of services including medicine and surgery, services for women and children, accident and emergency services, and diagnostic and clinical support services.

On 1 February 2015 the Trust acquired the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RNHRD) which further expanded the RUH's portfolio of specialist treatment and rehabilitation, including for rheumatology, chronic pain, and chronic fatigue syndrome/ME.

On 1 June 2021, following a competitive bidding process, the Trust acquired from the Circle Health Group, 100% of the share capital of Circle Hospital Bath. On completion of the transaction, the facility's name was changed to Sulis Hospital Bath. The hospital is situated in the Peasedown St John area on the outskirts of Bath, and it contains 28 ensuite bedrooms, 22 day-case beds and 4 operating theatres. The hospital carries out a range of acute, minor, and more complex surgery, as well as other types of treatments. As well as its care for private self-funded and insured patients, since its inception the hospital has also treated NHS patients as part of the "Choose and Book" system. Sulis Hospital Bath is managed as a limited liability company by its own Board of Directors, but it is a wholly owned subsidiary of the RUH.



## Purpose and activities

The Trust, including Sulis Hospital, serves a population of approximately 500,000 residents across Bath and North East Somerset, West Wiltshire, Somerset, and South Gloucestershire. In addition to our core local population, we also treat people visiting our area, including tourists, students, and overseas visitors. On most health indicators, ranging from life expectancy to infant mortality, people living in our catchment are healthier than average for England. However, we know that this is not the case for all our communities. We also know that our population is getting older, with increasingly complex health conditions.

Our dedicated workforce of clinical and non-clinical staff deliver a range of high-quality services from our main acute hospital site in Combe Park to the north-west of the centre of Bath. Maternity services are provided from several community birth centres, and the Trust runs outpatient centres across the region.

As a Foundation Trust, we are governed by a unitary Board of Executive and Non-Executive directors working alongside a Council of Governors representing the populations we serve and our key stakeholders.

Our core business is the provision of NHS services under contracts mainly to the Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB), and to other local commissioners as well as NHS England specialised service commissioners. The BSW ICB became a legal entity on 1 July 2022 following the enactment of the Health and Care Act 2022, and it is responsible for bringing together and coordinating the work of local NHS organisations, local authorities, and other partners to improve population health and establish shared strategic priorities. The Trust is a key player within this partnership and is working closely with partners to share and embed best practice and improve the quality of care.

The Trust is divided into a number of clinical and non-clinical divisions: medicine, surgery, family and specialist services, estates, and facilities and corporate. We provide a service for patients needing emergency and unplanned specialist care, 24 hours a day, every day of the year. From that core is built a comprehensive planned surgical, medical and diagnostics service for adults and children typical of a district general hospital of our size. Specialised care is also delivered in several areas including:

- Cancer care
- Cardiac and stroke
- Care for older people, particularly those with dementia
- Higher levels of critical care
- Pulmonary hypertension
- Maternity services
- Rheumatology, pain, and fatigue (from the RNHRD and Brownsword Therapies Centre)
- Specialist orthopaedics (surgery on joints and bones)

A small number of patients each year use our facilities for private treatment when capacity allows.

The RUH, in partnership with local universities and colleges, also plays a major role in education and research. We are recognised as one of the most research-active medium sized acute Trusts in the country.

In 2023 we published our new Trust Strategy, *You Matter*. Developed together with our members, our staff and with local partners, our strategy puts people at the heart of everything that we do:


We are committed to being an organisation where every voice matters; we help you have your say, we listen, and we act. This is an ambitious vision for our people, and we know that it will take time to get there together. We work in a changing environment, so we will need to be flexible, and to continue to listen to our people to make sure that we are going in the right direction.

We will deliver this Strategy through:

**Our values**

Our well-established organisational values are the bedrock of our Trust culture. Along with our commitment to kindness and civility and equality, diversity, and inclusion, they underpin our approach to bringing our strategy to life for all of our people.

Everyone Matters
Working Together
Making a Difference

**Improving Together, our operating system**

Improving Together sets out how we work together to achieve our strategy.

At its heart, Improving Together is about Quality Improvement, giving the people closest to the issues the time, permission, skills, and resources they need to problem solve. It involves a

systematic and coordinated approach to solving problems using specific methods and tools with the aim of bringing about a measurable improvement.

Each year, working collaboratively with staff and stakeholders and using Improving Together methodology, we will set our **breakthrough objectives** and **mission critical projects**, which set out what we will do in this year to move towards our vision. In 2023/24, our breakthrough objectives were:

| | Breakthrough Goal | Performance in 2023/24 |
|---|---|---|
| The people we work with | Reduce the percentage of staff reporting they have experienced **discrimination** at work from colleagues | When weighted, 8.11% of respondents stated they experienced discrimination from a manager or colleague. Although this is an increase on the previous year, the Trust is still ranked 39th amongst its benchmark group, placing in the third quartile. |
| The people in our community | Elective productivity<br><br>See and treat 9% more patients (against 2019/20 activity) for planned care to help reduce waiting times | The Trust delivered 13% more elective activity in 2023/24 and this translated to 115% elective income compared to 2019/20. Compared to 2022/23, this was 2% higher activity and 7% higher income. The Trust met its target to deliver 9% more elective activity and income than 2019/20. At the end of 2023/24, the Trust met its target of having 0 patients waiting for 78 weeks. There were 39 patients, against a target of 98, waiting over 65 weeks in 3 specialities. |
| The people we care for | **A&E waiting times**<br>To ensure 76% of patients attending the emergency department are seen within 4 hours | 62.2% of patients were seen within the Emergency Department within 4 hours vs 52.0% at the end of 2022/23. This represents a 10.2% improvement for patients attending the Combe Park site but does not meet the national standard of 76% |

Throughout the year, we monitor our progress towards our goals using the measures of success set out above and use our comprehensive Board Assurance Framework to monitor new and existing risks to delivering our strategy. Monthly updates on our progress are published and scrutinised by our public Trust Board.

Over a longer term, our five **strategic initiatives** set out the programmes of work to support delivery of the Strategy over the next 3-5 years:

- Clinical transformation
- Culture and leadership
- Financial resilience
- Future estates
- Digitally enabled


**Integrated Care System and Partnership working**

The Trust is part of the Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care System (ICS). The BSW ICB is responsible for bringing together and coordinating the work of local NHS organisations, local authorities, and other partners to improve population health and establish shared strategic priorities. The Trust is a key player within this partnership and is working closely with partners to share and embed best practice and improve the quality of care, both at system level and locally through the Bath and North East Somerset (BaNES) and Wiltshire Integrated Care Alliances. More about this can be found here:

https://bswtogether.org.uk/blog/bswtogether/hospitals-working-together-across-bsw-leading-innovation/

The Trust is actively engaged in leading work with our acute Trust partners at Salisbury Foundation Trust and the Great Western NHS Foundation Trust in Swindon through a provider collaborative (BSW Acute Hospital Alliance). In order to continually improve the services that we run for our patients and carers, the ability to work with partner health and care agencies remains crucial. As part of the Acute Hospital Alliance (AHA), we are working collectively to deliver a single Electronic Paper Record system which will enable our clinical teams to work more effectively with each other and have a programme of work to look at closer clinical and corporate service working across the three Trusts. The Trust has many partners, many beyond the BSW ICS boundary, all of which remain pertinent to delivering outstanding care.

The Trust works closely with partners at a local level to deliver more integrated care, including our Local Authorities, mental health, primary care and local third sector organisations for the benefit of our local population. We are a partner in Wiltshire Health & Care LLP, the adult community services provider in Wiltshire. We are increasingly developing strategic partnerships, for example with the University of Bath and Dorothy House Hospice Care, building on our respective strengths and mutual interests so we can best serve the people in our community.

**Acute Hospital Alliance**

We are part of the BSW Acute Hospital Alliance (AHA), working collaboratively alongside colleagues in Swindon and Salisbury to deliver the priorities set out in the Integrated Care Strategy.

NHS England now requires all NHS trusts to be working in at least one provider collaborative, with a focus on fully realising the benefits of working at scale, reducing unwarranted variation, and transforming services for the future.

Our collaborative (set up in 2018) pre-dates this requirement meaning we've had time to make some good progress with our collaborative working, relationship-building, and governance arrangements.

Our three Trusts have long recognised there is much more we can do by working together to help and empower people, than by acting as individual organisations.

In 2023/24 we were selected as the only South West collaborative to join the first wave of innovators in NHS England's new Provider Collaborative Innovators Scheme.

This scheme recognises the role that providers play working with partners in systems to deliver better care.

Being part of the scheme is recognition of what we've done so far along with our potential to do much more in the future – it will help accelerate our development.

Other achievements in 2023/24 include the following:

- Developing our joint clinical strategy, which considers how we can maximise the collective opportunities to strengthen clinical services, reduce variation, and scale up best practice.

- A focus on priority specialties – orthopaedics, dermatology, gastroenterology, and urology. As an example of some of the work we have done, we have created an improvement plan to tackle the rise in waiting lists for dermatology and are looking at ways to provide a more resilient and sustainable service for our population, including the expansion of tele-dermatology. The plan involves short-term measures to increase capacity, and longer terms plans to manage the demand upon this service.
- Introducing robotic surgery to BSW – our first robotic procedure took place at Great Western Hospital in May 2023 and since then surgical robots have been rolled out in Bath and Salisbury, helping surgeons to deliver operations with higher levels of precision and helping to improve recovery times and outcomes for patients. Robots are being used for general surgery, urology, and gynaecology and over time will be used for more specialities and more patients.
- Continuing to roll out Improving Together, our collective approach to empowering our teams to embed continuous improvement. This acts as the golden thread running through all that we do to make our three Trusts safer places to receive care and better places to work.
- Securing permission to build two additional modular theatres for elective operations at Sulis Hospital Bath, which will be used as an NHS elective surgery hub for patients across the South West. The new facility will deliver 3,750 non-emergency, orthopaedic operations for NHS patients each year.
- Placing digital at the heart of what we do will enable us to maximise the benefits of new technology, meeting higher expectations on digital ways of working.
- Our focus on digital saw our plans to deliver a shared Electronic Patient Record in BSW approved by NHS England in March 2024. This will be a real shift in the way we work which will allow us to deliver real benefits including increased efficiency, better staff experience and improved patient care.
- We have carried out analysis of our staffing models in nursing, midwifery, Associated Healthcare Professionals, Healthcare Scientists, and our medical workforce, to help us better understand what the right model for staffing is in the future.
- A significant part of our work is also focused on collaboration between our corporate teams, and we launched a programme looking at how we can empower these teams to identify opportunities to work at scale where benefits can be realised. Teams currently involved in this work are People, Digital, Finance, Estates, Communications, Legal, Governance, and Research and Innovation.
- We have formalised our relationships with a Committee in Common (made up of CEOs and Chairs of our Trusts), an Electronic Patient Record Joint Committee of Boards, and our Executive teams also meet regularly through the year. But while these formal arrangements give us a structure to work within, the key to our success lies in how we collaborate and work together, and we have explored how we can realise our collective potential with joint coaching and development time for our executive directors and investing in our clinical leadership capacity.

More recently we have begun to work even more closely with the Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care Board ensuring close strategic alignment in how work together to deliver the BSW Integrated Care Strategy.

# Performance Analysis

## Operational performance overview

The Trust produces an integrated balanced scorecard which outlines how it is performing against three domains: 'People We Care For', 'People We Work With', and 'People in our Community'. Details of financial and operational performance at Sulis Hospital is also incorporated within this scorecard and contributes to the overall assessment as to whether the Trust is achieving its agreed objectives. The scorecard measures performance against the NHS (National Health Service) Oversight Framework 2023/24 which is aligned to the priorities set out in the NHS Long Term Plan and the legislative changes brought about by the Health and Care Act 2022.

The Trust's integrated balanced scorecard incorporates the five national themes set out in the Oversight Framework: quality of care, access, and outcomes, preventing ill-health and reducing inequalities, people, finance and use of resources, leadership, and capability.

The Trust has a well embedded data quality assurance framework to ensure a high level of data integrity is maintained which is led by the Trust's Quality and Safety Group. Our reporting against national standards is robust and regularly audited.

### Introduction

2023/24 has been a challenging year for the organisation but we have seen some real successes. This year the NHS has been focusing on its elective recovery programme of which the Trust has been one of the best performing hospitals within the Southwest. This has led to significant progress in reducing waiting times for planned procedures and is the springboard to further improvements during coming years.

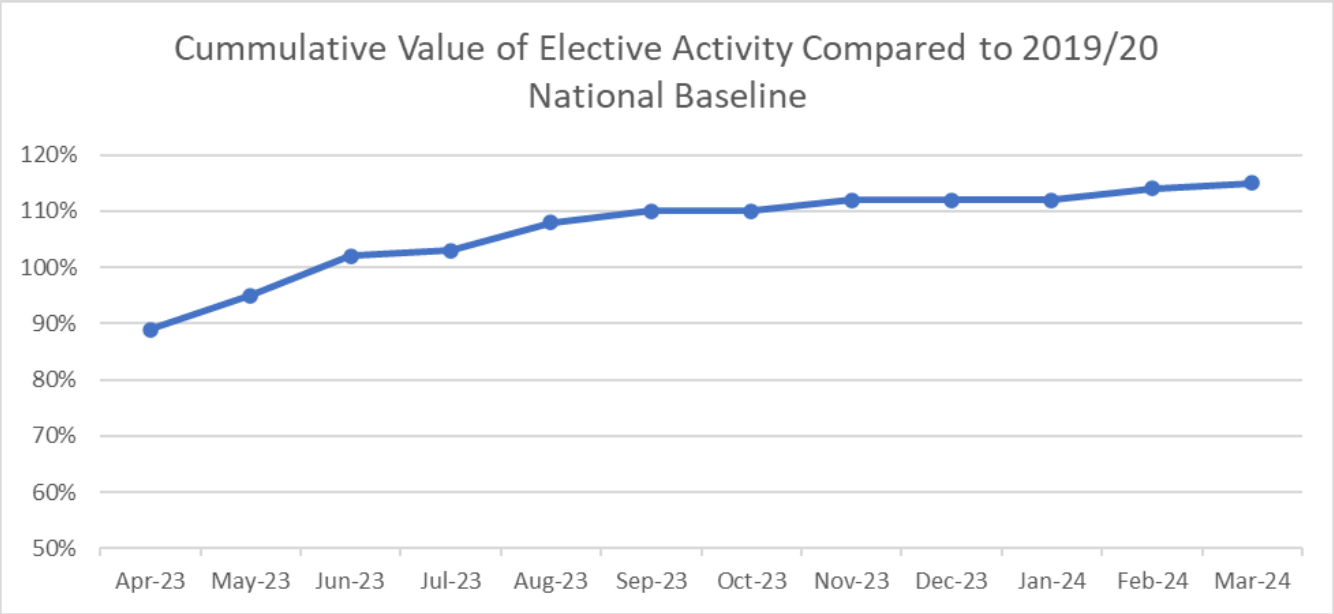
The NHS has also been trying to ensure that it is able to continue to deliver high quality non elective care and this remains a significant priority at the RUH. This year has also been heavily influenced by the continuation of significant COVID outbreaks within the hospital which has limited bed availability. The Trust has over the last year continued to significantly develop and progress areas of innovation and development which will help to reduce bed occupancy.

The main risks facing the Trust throughout the year, related to workforce; the availability of beds; and finance (more information on risks can be seen in the Annual Governance Statement). The Trust also noted risks, as identified through its internal audit programme, relating to Infection Prevention and Control, eRostering, DSP Toolkit, Risk Management and Patient Experience. The risks and internal audit responses are monitored by the Board and its Committees to ensure that appropriate and timely action is taken to mitigate the risks occurring and to address any control issues identified.

## Elective Care

Elective recovery continues to be a priority for the wider NHS during 2023/24 and the RUH has had significant success in supporting this delivery. The headline measure had been for the national average performance to deliver 107% of 2019/20 value weighted activity, this was lowered to 103% following industrial action. The RUH was set a target of 109% of 2019/20, reduced to 106% to account for the impact of industrial action on elective work.

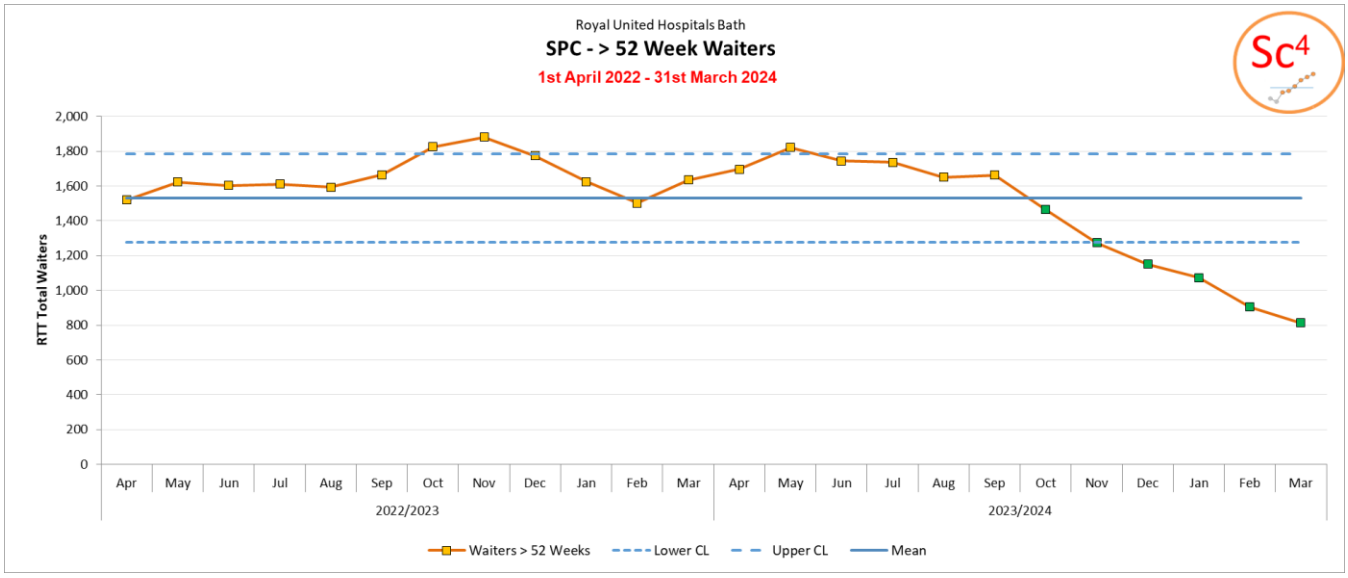
The below graph demonstrates that the Trust has been able to deliver 115% against this nationally set target during 2023/24. The RUH is one of the few organisations within the BSW system who have been able to deliver this performance.

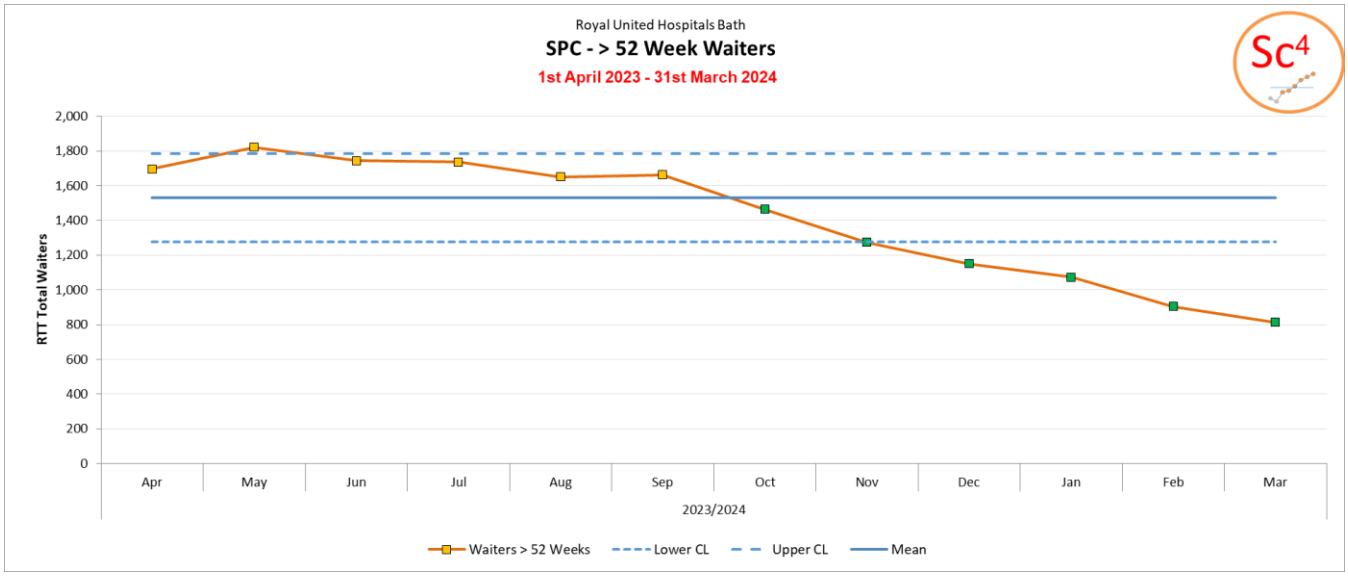



## Elective waiting times and activity

The RUH continues to focus on reducing the length of time patients are waiting for treatment. During 2023/24 the Trust has been successful in treating all its patients who have been waiting for over 104 weeks for their care. The Trust has also made huge progress in treating all patients who have been waiting over 78 weeks for their care. The number of 65-week waits has reduced from a peak of 269 patients down to 39 at the end of March 2024.

The Trust is now focused on reducing the number of patients who are waiting over 52 weeks. As the graphs overleaf demonstrate, the Trust is also starting to deliver significant improvements in the number of patients waiting for treatment. Graphs can be seen overleaf.



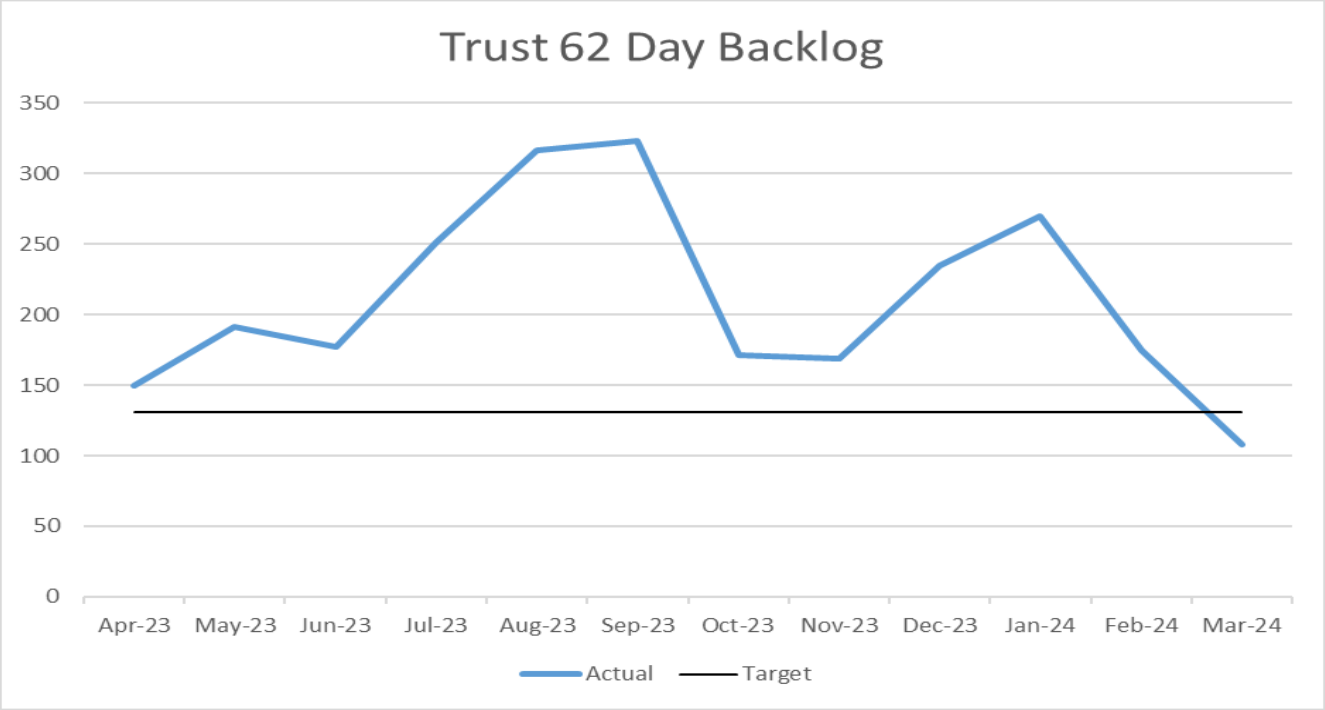

## Infection, Prevention and Control

There were 77 Trust apportioned cases of *C. difficile* during 2023/24. This was 36 cases over the threshold set by NHSE. This equates to a 6.9% increase in cases compared to last year. The increase in the number of cases is a concern and has been reflected in the numbers nationally. This infection has a significant impact on bed occupancy and side room usage over an extended length of time.

## Cancer

During 2023/24 at the RUH 69.6% of patients with a new cancer diagnosis began their cancer treatment within 62 days of referral. Performance has been challenged due to increasing demand, most notably within the diagnostic phase of pathways. Despite these challenges the RUH has continued to deliver some of the strongest performance within the region.

The Trust has worked hard to reduce the backlog of patients who have waited over 62 days for their diagnosis and/or treatment and has made considerable improvements against this metric, over-achieving against the target and delivering the best performance in Cancer Alliance.




2023/24 saw the RUH launch its surgical robotics programme, delivering state of the art surgical care to our cancer patients. In April 2024 the Trust opened the new Dyson Cancer Centre, helping us transform the care we provide to our patients.

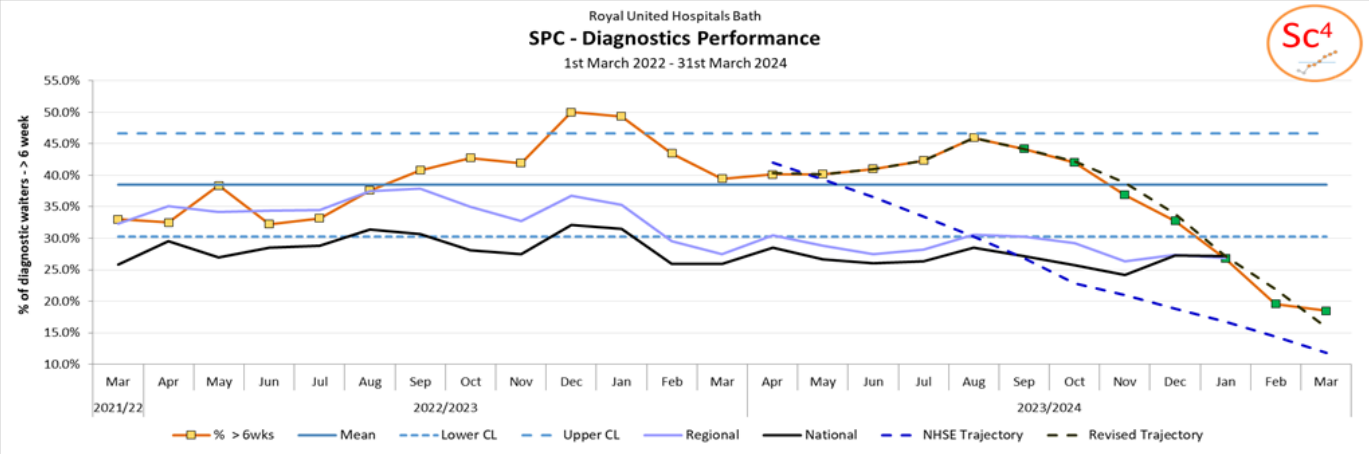
## Diagnostics

Demand for diagnostic services has significantly increased over the last year driven by the ongoing increase in demand for cancer diagnostics, specialist tests, long waiting patients on an RTT (Referral to Treatment) pathway and the prioritisation of cancer standards. The hospital has been focusing on ensuring sufficient capacity is in place by increasing the number of hours that our services are running and through use of all available additional capacity.

The percentage of patients accessing a diagnostic test within 6 weeks is increasing, the actual number of patients breaching is reducing and the total activity for diagnostics performed per month is also increasing (now exceeding 10k tests per month). The graph below demonstrates the Trust's performance for the year, achieving 18.47% in March 2024 (against a target of 15%), which shows improvements in performance in the second half of the year, as the new ways of working, improve productivity and additional capacity have delivered.

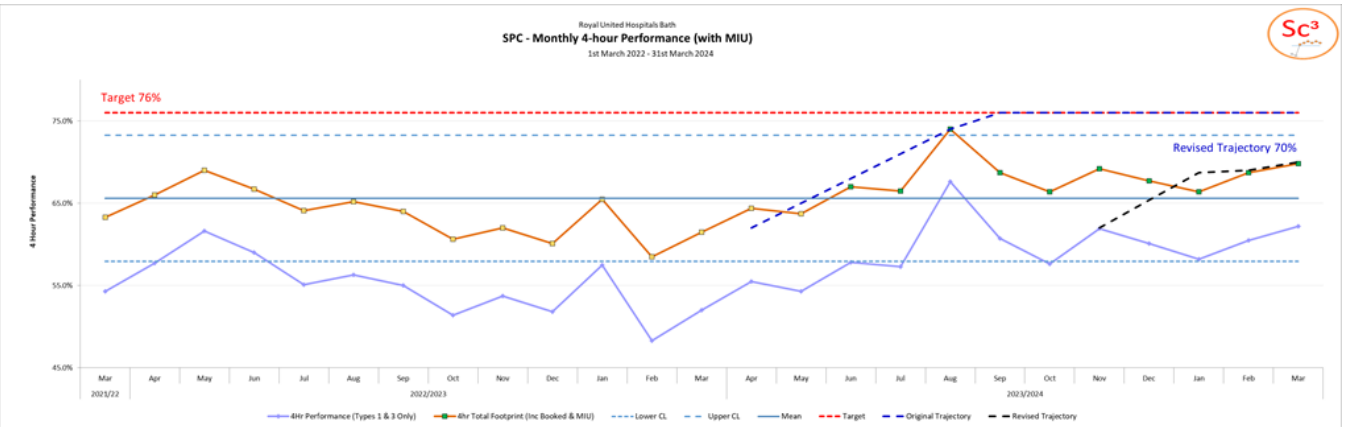
The plan for 2024/25 is supported on:

- Increased diagnostic capacity (above 2023/24 levels) provided by the Clinical Diagnostic Centre (CDC) for USS, CT, MRI, Echocardiography and Endoscopy.
- Approval of diagnostic elective recovery schemes to continue into 2024/25 – Radiology mobile Units on site, Endoscopy weekend insourcing and Cardiology physiological examinations.
- Transfer of sleep studies service to the CDC (from late May 2024) – the top contributor to breaches, however the move also supports a technology change which will further improve access for patients.
- NHS England supporting access to additional CDC capacity.

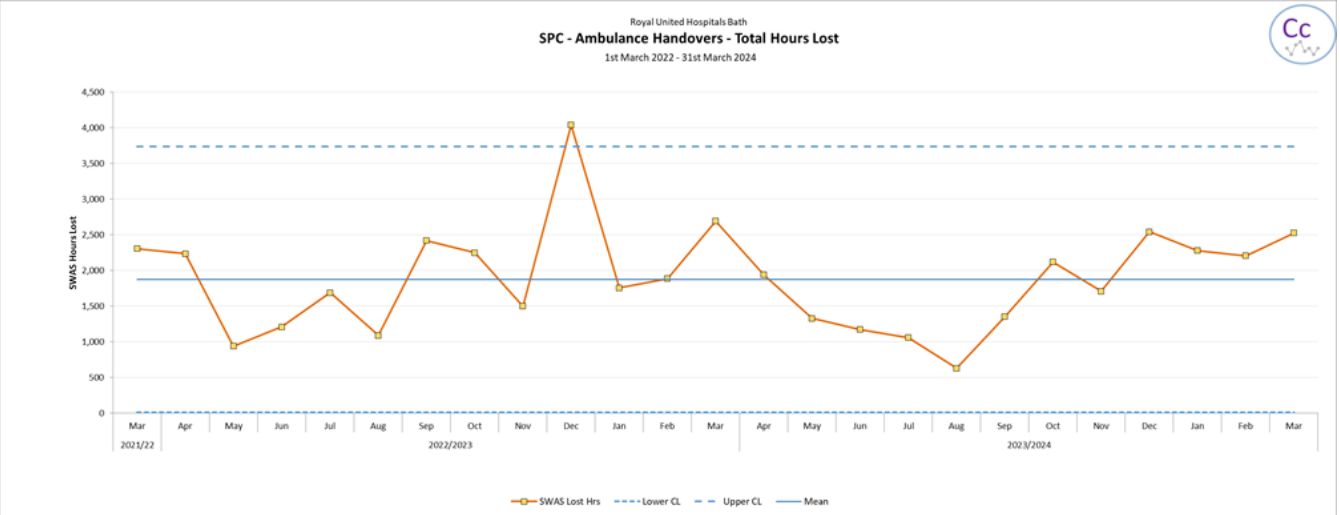



## Urgent Care

During 2023/24 the Trust continued to be monitored against the national access target of treating 76% of patients attending its Emergency Department within 4 hours of arrival and achieved a combined performance of 67.7% for the year. Unmapped performance (thereby representing activity on the Combe Park site only) has increased from 52.0% in March 2023 to 62.2% in March 2024, a 10% absolute increase but the relative increase is 20% during this period. The RUH has, alongside the rest of the NHS, seen significant challenges in the delivery of the 4-hour performance target. Attendances have increased by 6.1% in year, particularly to the urgent treatment centre, alongside an increase of 9.9% in ambulance conveyances. The average number of children presenting per day has also increased to 63 from 51 the previous year, including those who require access to mental health services. Flow out of the Emergency Department has also affected performance which is correlated to operating at high bed occupancy rates (96%) and the number of patients without a criterion to reside exceeding the system target of 55, noting a reduction from 116 patients in April 2023 to 86 patients in March 2024.

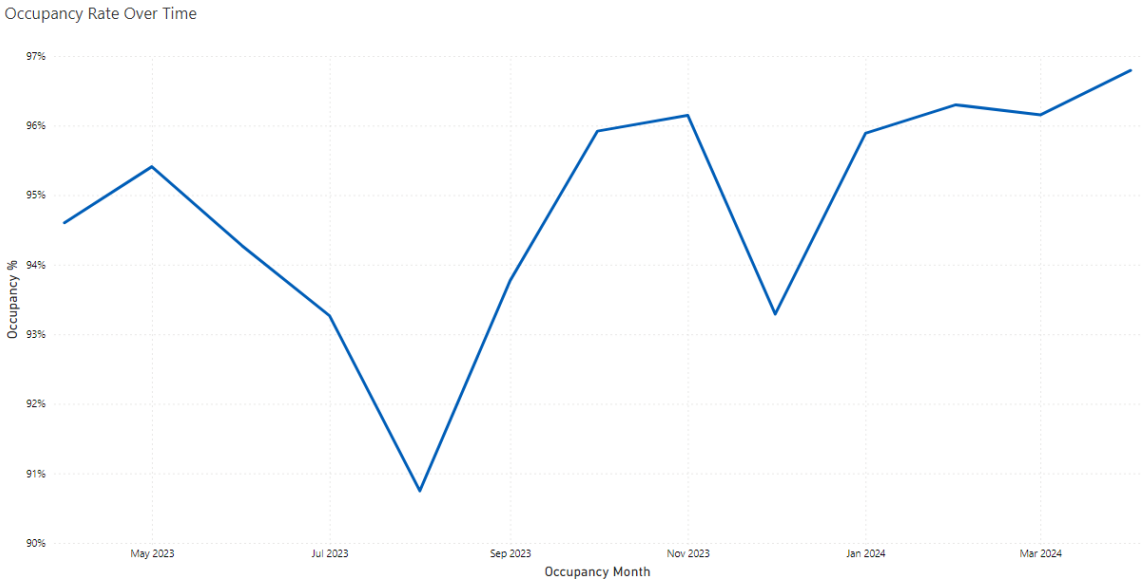



One of the other key urgent care measures is supporting timely ambulance handovers within 30 minutes. The below graph demonstrates the number of hours where there has been a delay in handing patients over from the ambulance service to the hospital. Performance in year has improved by 1.2% to 53.7% of patients handed over within 30 minutes of arrival. Whilst mitigation has been put in place to improve handover times, including the cohorting of ambulances during periods of peak demand to provide improved clinical oversight, this standard remains a significant priority to resolve in 2024/25.

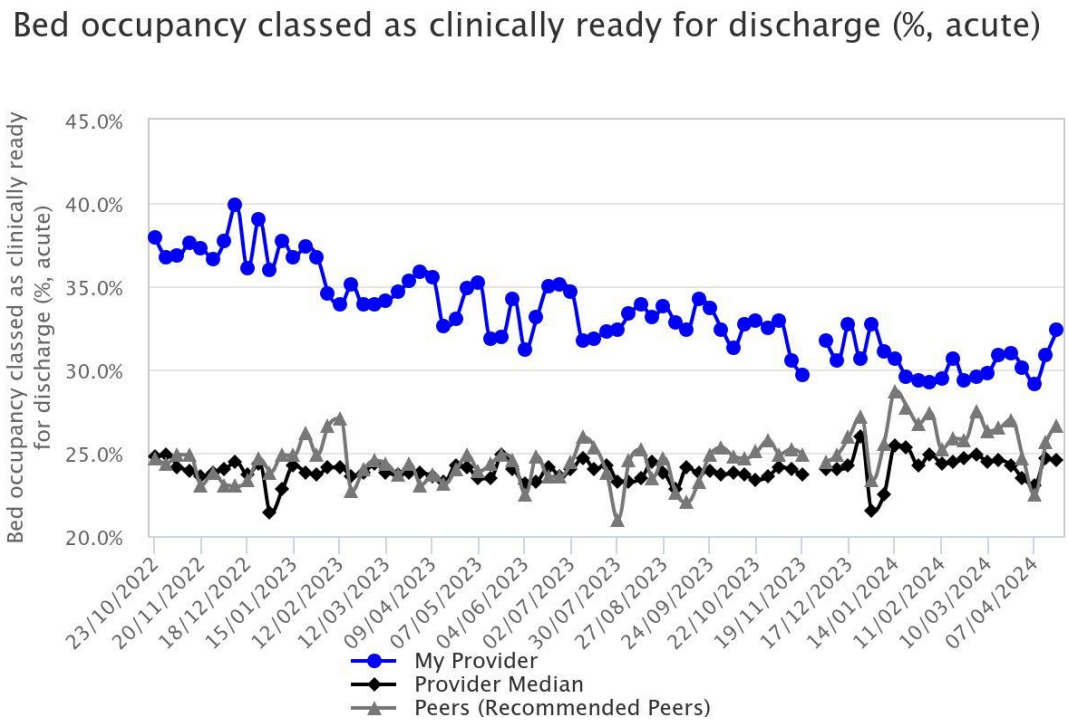



## Bed occupancy

One of the major factors influencing performance against both the 4-hour ED target and the requirement to reduce ambulance handover delays is the ability to admit patients into the hospital in a timely manner. A key driver of this is ensuring there is sufficient bed availability. In February 2023 NHS England introduced a target for each hospital to get their bed occupancy to below 92%. The graph below demonstrates that the RUH bed occupancy is consistently well above this level, averaging 94.6% in 2023/24 for acute beds. It is known that bed occupancy above this point increases the operational challenges and increases internal delays, slows down new admissions, and increases infections risks.

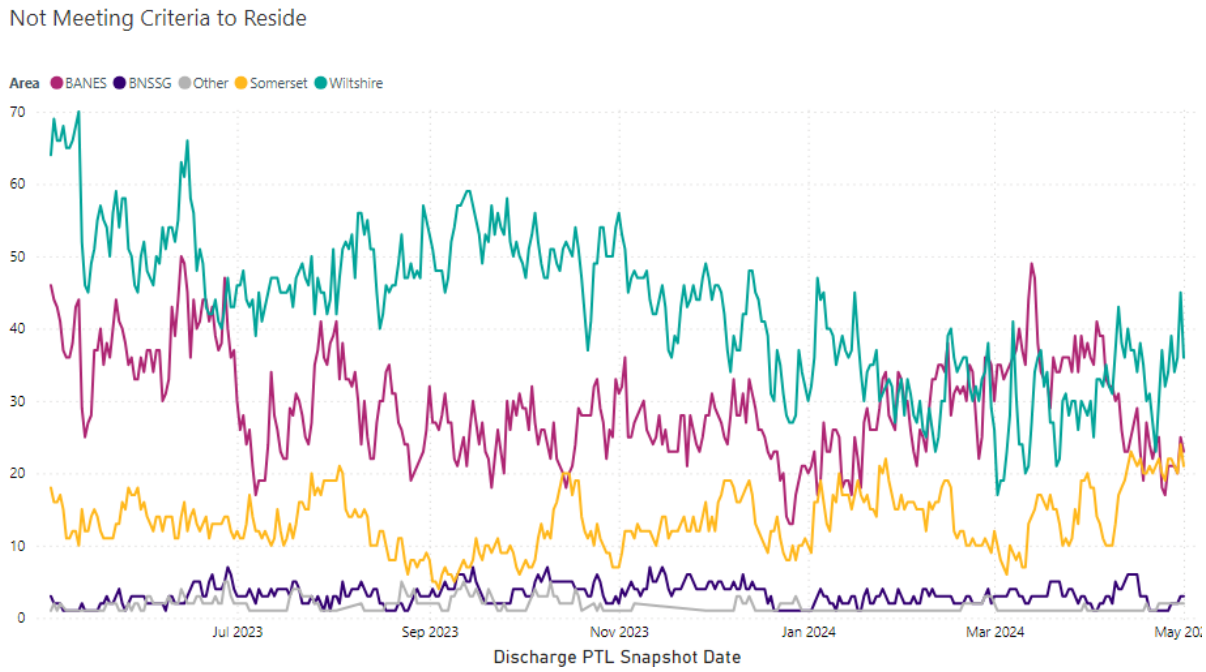



The high bed occupancy is driven by several factors, including the number of patients who are medically fit for discharge but are unable to leave due to insufficient care at home or in the community. The Trust has continued to be a national outlier for the number of patients who are medically fit for discharge (non-criteria to reside or NC2R) and waiting community support.




The chart above demonstrates the Trust has improved over the last 2 years but remains in the worst quartile nationally in terms of bed occupancy. The Trust had an average of 92 beds occupied by patients who no longer have criteria to reside.

The below graph demonstrates the breakdown of the locality non-criteria to reside waits.




Overall, non-criteria to reside volumes have decreased throughout the year; for example, Wiltshire have moved from a high of 70 patients in May 2023 to an average of 27 in March 2024. BaNES averaged 38 patients at the start of the year and despite improvements throughout the year, reverted to an average of 36 further. This has been attributed to the closure of a community hospital in October 2023.

The Trust has been working across all locality partners (Wiltshire, BaNES, and Somerset) to deliver improvements within the NC2R position. The Trust continues to support the following initiatives.

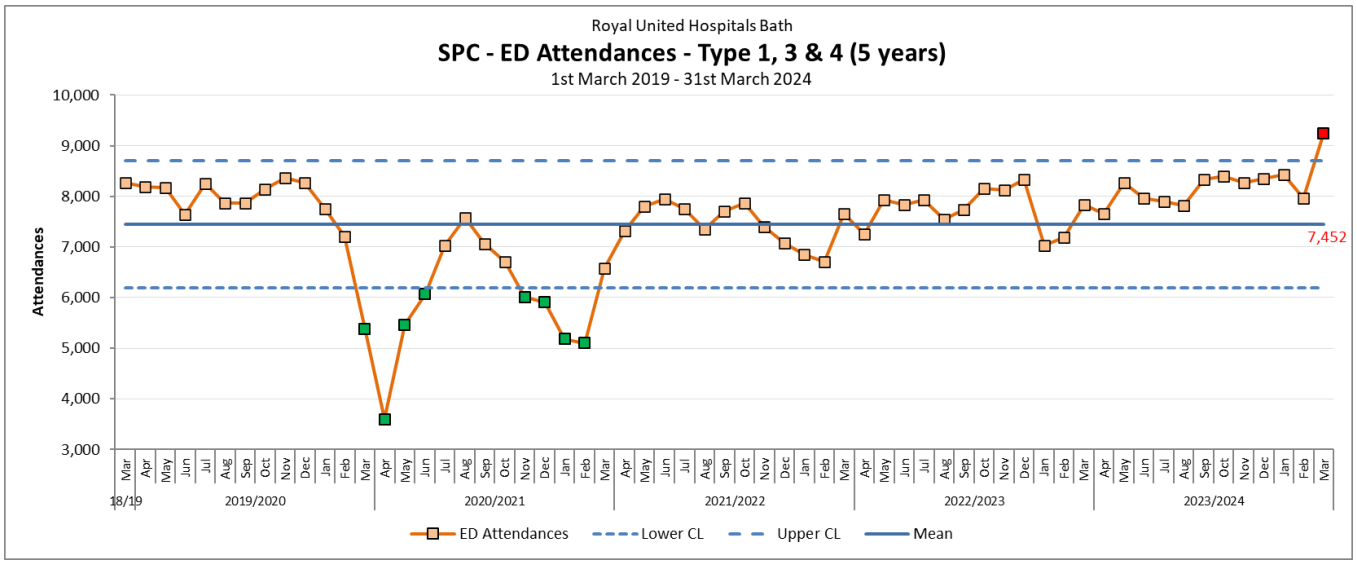
- In collaboration with reablement system partners, the RUH continues to optimise referrals to these services which include the RUH delivered Active Recovery Team (ART+). Over 2023/24 ART+ managed an active patients' caseload of 35 patients.
- Internal process improvement for:
    - Complex discharge planning - achieving zero patients with a plus 50-day length of stay with no criteria to reside.
    - Pathway zero reduction through multidisciplinary team working and improved daily data monitoring processes to ensure patients are on the right pathway for their clinical needs to reduce delays.
- Introduction of the transfer of care hub with the ambition to reduce bed request and streamline pathways and decision making – work continuing into 2024/25.
- Shared 'Home is Best' transformation plan – this is focused on ensuring patients receive the right care for their needs, removing barriers and delays and integrating work across teams. This has helped reduce the length of stay for patients going home from 17 to 7 days. The programme for 2024/25 is now targeting admission avoidance with collaborative strategies for long stay patients for example those with delirium.

- Community wellbeing hub opened in the RUH Atrium area staffed by the BaNES community hub team to support admission avoidance and prevention of emergency attendance for any patient in the BaNES and Wiltshire areas. Work links to the Riviam onward referral form to support early discharge planning with system partners.

## Emergency Department

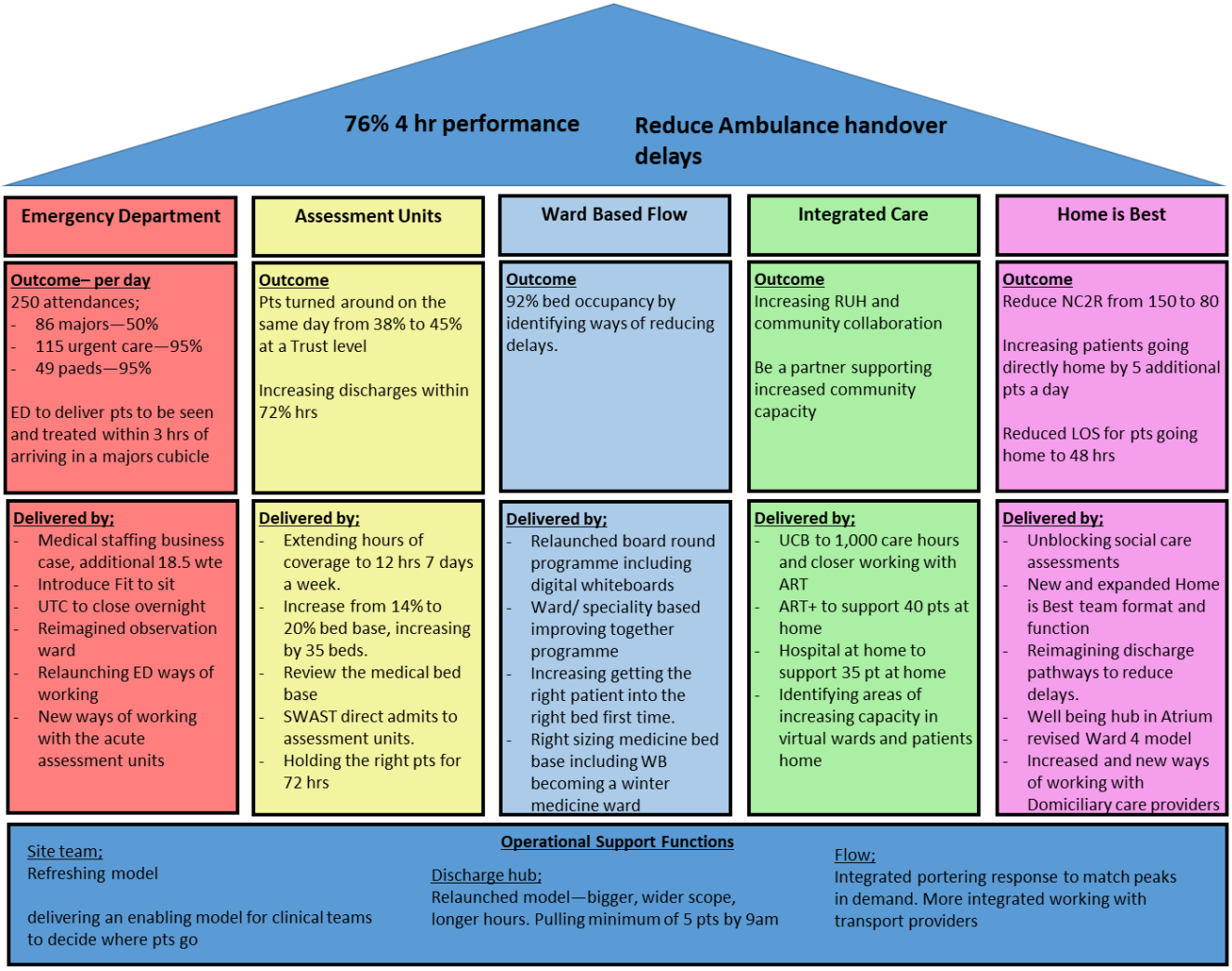
In 2023/24 the number of patients attending the Emergency Department (ED) was 98,602, the highest volume of patients seen over the last five financial years. The Trust, in March 2024 also had its most ever attendances into ED, 9,246, compared to 7,830 in March 2023.

The ED has also seen a change in the type of patients who are attending, with a growth in the more complex patients, those with a higher acuity, and an increase in the number of people attending through the Urgent Treatment Centre as walk ins or from NHS-111. As the hospital has increased the GP direct access into Medical Assessment Unit, the Older Person Assessment Unit, and the Surgical Assessment Units; 39.4% of urgent and emergency care patients now access a same day emergency care service (equivalent to 17.9k patients). Whilst there has been investment in ED staffing, the Trust is currently reviewing staffing within the ED to ensure that it matches the service needs especially for out of hours and at weekends and are in line with recognised best practice models.



## Trust Improving Patient Flow Together Strategy

The Trust has been running its Improving Patient Flow Together strategy since April 2021/22 and this has delivered real successes that have played a significant role in driving improvements within the RUH. During 2023/24 the Trust has refreshed the strategy. The diagram below demonstrates the different areas of focus within the strategy. It also identifies the key ambitions in each of these work streams and the developments the Trust is going to be undertaking to develop the improvements.




The programme is supported by our Trust quality improvement methodology Improving Together. This approach supports the identification of top contributors to poor performance so that actions get to the root cause of the problem. The programme is being supported by our dedicated Coach House, a team of skilled improvement practitioners that provides training and guidance in the various tools and techniques to frontline clinical teams to support them in making improvements. It is led by the Chief Operating Officer in partnership with the Chief Nurse and Medical Officer via a monthly Programme Board.

## Compliance with the Care Quality Commission

The Trust is compliant with the registration requirements of the Care Quality Commission (CQC) and is registered with no conditions applied.

During 2023-24 the Trust received inspections of the Medicine and Maternity core services and Radiotherapy. Full details on the CQC inspections can be found in the Annual Governance Statement.

## The Trust's Breakthrough Objectives for 2024/25

The Breakthrough Objectives for 2024/25 have been agreed as follows and will be reported on in next year's annual report:

### People we work with

- Reduction in the percentage of staff reporting they have experienced discrimination at work from colleagues (continuation from last year).

### People we care for

- Why not home, why not today? Reduce inpatient length of stay.

### People in our community

- Delivering a safe and sustainable service for our patients, making best use of available resources.

### Enabling Breakthrough Goal

- We Improve Together to make a difference.

These will form part of our performance focus for the coming year and will be reported on via our Integrated Performance report and scorecard on a bi-monthly basis.

## Sulis Hospital Bath Limited ("Sulis"), Performance Review 2023-24

Since acquisition in June 2021, a process of integrating appropriate services in the pursuit of improving patient care, efficiencies and collaboration for the region has been underway, with considerable success. Sulis retains a great deal of autonomy, whilst having oversight by RUH in all matter's governance, clinical and financial – a Subsidiary Oversight Committee comprised of Sulis and RUH Executives and NED representation is assured of performance.

Sulis' purpose, mission and values can be read in full here:
https://www.sulishospital.com/careers/our-purpose

During 2023-24, Sulis Hospital Bath had four key strategic objectives are documented in the table below and have been achieved as follows:

| Strategic Objective | Achieved? |
|---|---|
| Increase NHS capacity to support waiting times in the region. | Achieved through the optimisation of theatre, Outpatient and diagnostic utilisation and Inter-Provider Transfers (IPTs) with RUH, Bristol, Somerset, Devon and Cornwall Trusts. |
| Sustain private work to support the financial and market position in the region. | Achieved through the optimisation of theatre capacity, growth of the private GP service and additional new Consultants and services. |
| Increase diagnostic capacity as a Community Diagnostic Centre (CDC). | Achieved through the capacity of a dedicated MRI scanner, dedicated CT and X-Ray service and commencement of dedicated endoscopy services. |
| Achieve financial sustainability. | Achieved through the optimisation of capacity and good cost control, including NHS Procurement purchasing power, reduction of agency through recruitment and retention and focussed cost-saving projects. |

The focus for 2024/25 will be to:

- Increase margin and financial contribution to RUH – by making a £410k surplus in budget.
- Grow the Community Diagnostic Centre (CDC) services.
- Commence Sulis Elective Orthopaedic Centre (SEOC) services – the first patients are expected to be treated by end-December 2024. This is an NHS-funded development on the Sulis site serving patients from across BSW, including RUH, Salisbury and Swindon hospital. Surgeons will be delivering elective orthopaedic surgery in a ring-fenced site, throughout the year without the risk of losing beds due to pressures at host Trust sites. It is expected to increase overall orthopaedic surgical capacity at Sulis by over 3,500 cases per annum, releasing capacity at host Trusts for more complex activity.

- Combined project with RUH to manage Private Patient Unit activity is underway for Sulis-branded and managed activity to be cared for at the RUH site.

**Modular theatre**

The elective orthopaedic ward (Philip Yeoman) is a dedicated (ring fenced) ward at the RUH for elective orthopaedic surgery only. As a direct result there are reduced infection rates, shorter length of stay and fewer cancellations due to bed availability.

The modular theatre at Sulis was established at the beginning of April 2023 to provide a ringfenced arthroplasty service off site from the RUH acute hospital. This is to maintain year-round major joint operating that is regularly, both locally, and nationally, suspended at times of particular front door pressure meaning an increased need for non-elective beds. This is primarily focused during October to March, where this increase on non-elective beds impacts directly on and reduces our elective bed base.

To date 706 patients have received their surgery in the modular theatre, a significant proportion of these would not have had their surgery if it weren't for this facility. The theatre is run by a dedicated RUH team with visiting RUH surgeons working in collaboration with the Sulis teams who provide pre and post operative care.

We are very proud that the 2 hospitals have come together to work and ensure patients receive surgery which can be life changing. This model is being expanded with the building of an orthopaedic hub, SEOC (Sulis Elective Orthopaedic Centre) due to be opened at the end of 2024.

**Community Diagnostics Centre (CDC)**

The Community Diagnostic Centre (CDC) at Sulis began providing diagnostics services in the Spring of 2023. The CDC provides services, such as X-rays, MRI and CT scans, blood tests, ultrasounds, and endoscopies, in the community and away from the large hospital setting. These services provide greater convenience for local patients, and support staff to see more people in need of investigative care.

The CDC is a fantastic addition to our local NHS services as we become much more focused on prevention, and helping people to live longer, happier, and healthier lives, in which any potentially serious conditions can be spotted at the very earliest opportunity. Another advantage of carrying out more diagnostic care in the community is that staff at the Trust should have more time to focus on patients with more pressing and complex needs. The community centres provide an additional level of resilience to the local health and care system, with appointment cancellations during times of high demand or unexpected events becoming less likely.

**Ongoing Challenges**

Sulis continues to face ever-increasing cost challenges in light of the micro and macro-economic environment in which it operates. Recruitment, especially of clinical staff, is showing good progress but remains a key factor in the delivery of clinical services. Other cost pressures are managed effectively with numerous projects underway to take advantage of the Sulis-RUH relationship, whilst delivering clinically safe services with good clinical outcomes through a more effective model of care.

## Overview of financial performance

In 2023/24 the NHS has continued the drive to regain momentum delivering elective services and address waiting times, however industrial action during the year has impacted its ability to fully deliver this, alongside a continued high level of emergency and unplanned care. The impact of this was higher use of short-term staffing options to cover operational areas during industrial action. The financial impact showed in reduced income and the ability for the Trust to deliver QIPP, this also included the additional cost of temporary staff. The Trust was fully reimbursed for the net effect of the cost of the industrial action.

At the RUH itself, 2023/24 started with high numbers of patients who although medically fit to be discharged remained in hospital due to a lack of suitable support for them in the community. This led to the need for escalation areas to be created and the loss of the use of elective wards which were needed to accommodate medically sick patients. Since August 2023 the Trust has managed to maintain this below an average of 70 patients per day.

Payments to the Trust for patient activity continued to operate on the same block basis introduced in 2021/22 covering the majority of the clinical activity undertaken in the organisation. The incentive funding stream made available to target increasing elective activity and create additional capacity to help reduce waiting lists and minimise very long waits for treatment, also continued into 2023/24.

The Elective Recovery Fund (ERF) allows Trusts to earn additional income for achieving nationally set targets of elective activity which included day case, inpatient and outpatient care. The RUH received £15.8 million through this scheme, of which £3.1m was paid to compensate lost activity incurred through industrial action. This income was used to cover the costs of providing extended services to treat patients.

In 2023/24 variable income streams for outpatient diagnostics, chemotherapy and high-cost drugs and devices were introduced for activity and costs above 2022/23 outturn. This additional income helped off-set the higher costs incurred through providing these increases in activity.

£13.4 million of income has also been reported to off-set the NHS Pension liability the Trust is required to recognise in its accounts.

The ICB also made a variation payment of £20.5 million to reallocate the funds that they held in their capacity as Commissioner to each of the Providers as part of a risk share agreement.

Income flows from non-patient care services such as catering, car parking and non-clinical services have continued to increase over the course of the year. There have also been increased cost of sales, such as food prices, to deliver these non-patient services. Surpluses delivered from non-patient care activities are reinvested back within the Trust.

The financial performance of the Group (RUH and Sulis) varied over the period due to the pressures faced within the hospital, with escalation wards that were occupied by patients with no criteria to reside remaining open both before and after funding relating to winter pressures was received.

Following the required adjustments for national reporting, the Group reported an adjusted position £3.5 million deficit. Within this Sulis closed the financial year with a £0.3 million surplus with increases in NHS and private activity.

| | 2023/24 £000 | | 2022/23 £000 |
|---|---|---|---|
| **Group surplus for the period from continuing operations as per the Statement of Comprehensive Income** | **-4,918** | | **2,309** |
| Impairments | -4,684 | | -1,810 |
| Revaluations | 1,086 | | 9,815 |
| Other reserve movements | -1 | | -1 |
| Movement in fair value of charitable funds | 226 | | -345 |
| **Total comprehensive income for the period** | **-8,291** | | **9,968** |

| | | | |
|---|---|---|---|
| **Group surplus for the period from continuing operations as per the Statement of Comprehensive Income** | **-4,918** | | **2,309** |
| Remove impact of consolidating NHS Charitable fund | 2,348 | | 2,688 |
| Remove net impairments not scoring to Departmental expenditure limit | 2,161 | | -1,297 |
| Remove impact of capital grants and donations | -3,229 | | -3,736 |
| Remove net impact of DHSC centrally procured inventories | 148 | | 46 |
| **Adjusted financial performance for the period** | **-3,490** | | **10** |

The Group has faced significant cost pressures over the last few years. These have resulted from insufficient inflation funding, the rising cost of high-cost drugs and other consumables and the increased operational costs to deliver pre-pandemic levels of activity, many of which reflect the national situation within the NHS. The cost of bringing waiting lists back down to pre-pandemic levels, while also managing increasing levels of emergency and urgent care, also remains significant. At the same time, income derived from non-patient care related services, such as car parking and catering, did not recover sufficiently enough to cover the Trust's overheads.

The recovery of elective activity is an area of significant focus across the Trust and the wider BSW system, with detailed plans being outlined for areas needing the most support to reduce waiting lists. National incentive schemes will continue into 2024/25 to support Trusts to deliver as much of this activity as possible.

**Capital investment**

The Group invested £34.1 million in infrastructure, equipment, information technology and projects during 2023/24, (£47.7 million in 2022/23). Separately, the Group also recognised capital assets of £4.0 million related to leases which are now capitalised in line with accounting standards. Therefore, total capital invested for 2023/24 was £38.1 million.

The total programme was funded through a combination of internally generated cash and I&E surpluses, charitable donations, and significant additional public dividend capital (PDC) from the Department of Health and Social Care.

PDC funding was provided for the Cancer Centre project. In addition, external support was also made available for projects to support additional elective capacity, community diagnostics and

digital diagnostics. The Trust also received PDC funding for the System-wide electronic patient record system.

The capital programme has continued to seek to achieve a balance between maintaining and replenishing the asset infrastructure, reducing risk, and improving patient experience, within the context of significantly constrained capital funding and increased demand.

Significant in-year programmes included expenditure of:

- £6.2 million on various estates schemes including the single ITU project, day assessment unit works, works to support additional bed capacity and significant risks in critical infrastructure backlog expenditure.
- £6.6 million on the Cancer Centre, which includes the main Kier related works and enabling works.
- £7.6 million to support Community Diagnostics and the Sulis Orthopaedic Elective Centre (SEOC).
- £5.3 million on the digital programme, including additional investment in hardware to support changes in working practices, clinical systems, and infrastructure support as well as investment in cyber security. This included investment towards the BSW single electronic patient record system.
- £6.7 million on medical equipment, including Cath Lab replacement and theatre and diagnostic equipment. Within this, £3.8 million related to the purchase of a new robot and replacement Gamma Camera which were funded through charitable donations.
- £1.2 million for a ward project to support additional bed capacity and elective recovery.
- £0.5 million related to capital investment in Sulis Hospital which included X-ray equipment.
- £4.0 million which relates to right of use leases which are now required to be capitalised across the Group following changes in accounting standard.

These are capitalised costs only.

**Capital Impairments**

The Trust had capital impairments totalling £2.5 million of which £2.2 million related to an impairment on property valuation and £0.3 million capital asset impairments mainly for assets purchased during COVID. (£1.3 million in 2022/23).

**Going Concern disclosure**

After making enquiries, the Directors have a reasonable expectation that the services provided by the Group will continue to be provided by the public sector for the foreseeable future.

The definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual is "The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

For this reason, the Directors have adopted the going concern basis in preparing the accounts. The assessment considers at least the 12-month period from signing the financial statements at which point will be reviewed.

## Environmental matters

Living more sustainably can have a huge impact, both at work and at home. At the RUH, the Sustainability Team aims to embed sustainable development in everything we do. In order to achieve this, they plan to target actions to make a positive difference environmentally, socially, and financially to create an organisation that supports the well-being of our staff, our patients, and our wider community, through:

- Reducing our dependence on unrenewable resources such as fossil fuels and heavy metals.
- Reducing our dependence on substances that persist in nature.
- Reducing our destruction of nature.

In 2020, the Trust published its next five-year Sustainability Strategy. It focuses on ten themes to make the Trust more sustainable in everything that we do and ensure that we are an organisation that is fit for the future. It also includes a Carbon Reduction Strategy outlining how we plan to contribute to the local and national targets designed to reduce the impact on climate change.

The Greener NHS have since introduced an updated format to the Sustainability Strategy, known as the Green Plan. There are three new categories that have been mapped and incorporated into our existing areas of focus as follows: Medicines are covered within 'Designing sustainable care models'; Digital Transformation is included within 'Enabling sustainable travel & logistics'; and Food, Catering & Nutrition is covered within 'Using resources sustainably'.

### Recapping on the last year

| Area of focus | Objective | Achievements in the last 12 months | Planned projects | SDAT score |
|---|---|---|---|---|
| Managing our Carbon & Greenhouse Gases | To manage our carbon emissions to remain within safe limits in order to avoid irreversible climate change | • Successfully secured £21million in funding for a project to decarbonise heating onsite<br>• Completed the decommissioning of the Nitrous Oxide Manifold systems<br>• Trialled a Nitrous Oxide Mobile Destruction unit | Analysing Scope 3 emissions for hotspots | 37% |
| Adapting to Climate Change | Develop sites and services that are resilient to the adverse effects of climate change | • Ran a workshop with Board members to review climate change related risks<br>• Chiller replacements, window upgrades, application of solar film<br>• Successful site-wide generation blackout testing | Board Approved Adaptation Plan | 32% |

| Area of focus | Objective | • Achievements in the last 12 months | Planned projects | SDAT score |
|---|---|---|---|---|
| Designing sustainable care models | To improve care whilst maintaining environmental, social, and financial sustainability | • Reusable Theatre Hats have been introduced<br>• Project to rationalise glucose testing | Digital transformation to be assessed for risks to health inequalities<br><br>Inhaler disposal and recycling | 33% |
| Enabling sustainable travel & logistics | To be a Trust that approaches travel in a way that is innovative and prioritises sustainable modes of transport that are accessible to all | • 92% of the Non-Patient Travel Plan actions completed<br>• 36 members of staff have used the EV Salary Sacrifice Scheme to shift to an electric vehicle<br>• 72 members of staff have used the eBike loan scheme<br>• Cycle scheme certificates have doubled on the previous year<br>• Cycle scheme limit increased to allow staff to purchase electric bikes<br>• Another fleet vehicle has changed to electric<br>• Car parking charges have been reintroduced to encourage more sustainable modes of travel<br>• ECargo bike trial continues, with plans for a second bike<br>• Highest ever response rate for the travel to work survey<br>• First electric Big Lemon bus and Westlink, both servicing the hospital<br>• New shared Travel Officer jointly employed by RUH, B&NES and the Universities<br>• Large Travelwest Roadshow with 8 vendors running a series of activities | Fleet Review | 46% |
| Embedding sustainability | To become a thriving organisation that delivers benefits that extend beyond the traditional organisational boundaries whilst maintaining the highest quality of care. | • QI programmes embedding sustainability into training<br>• Sustainability criteria added to the Ward Accreditation<br>Working groups set up including Endoscopy and Theatres | Embed sustainability into staff induction | 39% |

| Area of focus | Objective | Achievements in the last 12 months | Planned projects | SDAT score |
|---|---|---|---|---|
| Managing our assets & utilities | To manage the trust's operational assets in a way that continually improves their efficiency and longevity | • Ran another winter TLC Campaign – encouraging turning off of equipment, turning lights out, and closing doors where safe and suitable to do so.<br>• Water audit completed<br>• New bins in catering areas and an external solar powered bin installed<br>• Energy projects underway including BMS upgrades; window replacements; and lighting upgrades, maximising CHP runtime, reduction of BMS set points, improving insulation of pipework. | Monitoring and Validation process for energy and water efficiency projects | 49% |
| Using resources sustainably | To ensure that we do not extract or pollute at a greater rate than nature regenerates | • Healthier and locally produced options introduced in catering outlets<br>• Lower impact packaging in catering introduced<br>• Compostable bins installed in the Lansdown Restaurant<br>• Two water coolers have been installed to encourage reusable water bottles | Measure the carbon footprint of meals | 49% |
| Creating a sustainable built environment | To ensure that sustainability underpins the design and construction of our capital projects | • Hard landscaping of the Wellbeing Garden nearly completed<br>• Cancer Centre completed and achieved BREEAM Excellence | Process to ensure design briefs require low carbon solutions | 54% |
| Empowering our people | To create a supportive environment where all our people feel motivated and empowered to consider sustainability in everything, they do | • RUH Staff members continue to use a behaviour change platform, logging over 4k sustainability actions in 2023/24<br>• Staff are encouraged to complete eLearning training on 'Delivering a Net Zero NHS' | Leadership training on sustainability | 62% |
| Enhancing Greenspace | To Protect and enhance the natural systems that we rely on, realising the benefits this brings to the health of our diverse population | • Biodiversity Plan created in conjunction with NHS Forest<br>• Bird boxes installed<br>• Wellbeing Garden designed and due to be planted using Forest Gardening principles, ensuring a self-sustaining biodiverse environment | Implement the Biodiversity Plan | 55% |

## Key areas of Focus

### Taking responsibility for our Carbon Footprint

We recognise that the Trust has a significant carbon footprint. Understanding where the RUH is today as a baseline, and what our plan as a Trust is going forward is crucial in us meeting the Climate Change Act requirement for net zero by 2050, and the Greener NHS target of 2045.

References to Scope 1, 2 and 3 emissions relate to the extent to which an organisation has control of or is responsible for. Scope 1 are direct emissions from owned or controlled sources.

Scope 2 cover indirect emissions from the generation of purchased electricity, steam, heating, and cooling consumed by the organisation. Scope 3 includes all other indirect emissions that occur in a company's value chain. The Trust came up with three steps to reducing our carbon footprint that comply with the Climate Change Act, support B&NES local plan to become carbon neutral by 2030 and more recently the Greener NHS (NHS England and Improvement) targets.

1. Drive down our Scope 1 and 2 emissions to net zero by 2030. These scopes are within our direct control. This will involve reducing our emissions as far as practicable, with the remaining being offset, inset, or captured according to relevant guidelines and certified methods.
2. All Scope 3 emissions will be measured and monitored as accurately as possible by 2025, and a target set for reduction of Scope 3 by 2030. Until we measure, we cannot manage, and cannot set a definitive medium target for Scope 3. A target will be quantified in the Sustainability Strategy covering 2026< at the latest.
3. By no later than 2045 the Trust will be net zero across all three scopes. Our progress will be monitored annually, with a revised strategy each 5 years.

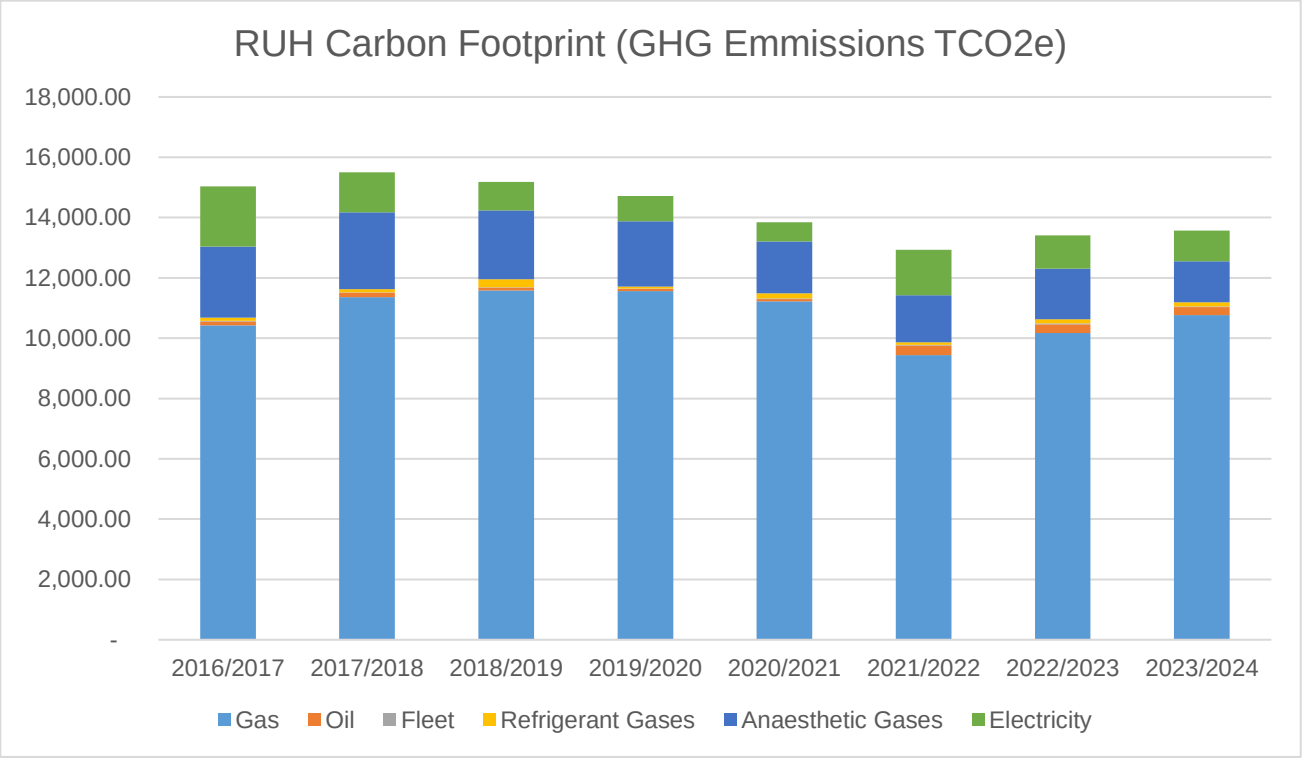



*Figure 1: The Trust's Carbon Footprint for Scope 1 and 2 emissions over the last 8 years.*

During the last year there have been increases and decreases in the carbon footprint as follows:

- Gas: There has been increased gas consumption onsite, however this is being addressed and there is a large project to de-steam the heating system on site and support the RUH in shifting away from fossil fuel reliance.
- Electricity: There was a significant reduction in the use of electricity on site, however the electricity grid carbon factor has increased this last year, leading to less of a drop.
- Anaesthetic gases: The overall carbon emissions of anaesthetic gases has decreased due to the decommissioning of the Nitrous Oxide manifolds as well as ceasing the use of Desflurane, one of the more potent gases.

- Oil: Consumption for oil will significantly drop next year due to the Cancer Centre Compound opening and therefore oil demand will reduce significantly. The RUH are targeting a complete phase out of oil boilers for heating by 2028 aligned to NHS wider targets.
- Fleet: emissions remain fairly static; however, the Trust continues to systematically transfer the fleet vehicles to electric when operationally possible.
- Refrigerant gases: remain fairly static, however this is dependent on leakages to the systems.

All emissions continually require ambitious and challenging targets to achieve net zero carbon by 2030.

**Improving Air Quality through Sustainable Travel**

Exposure to air pollution has significant impacts on our health. In particular, air pollution is most harmful to the most vulnerable among us such as, children, those with pre-existing respiratory conditions and the elderly.

> "It has become increasingly clear over the last few years that traffic-related air pollution can also have a toxic effect on the lungs – sadly a recent inquest concluded that air pollution had contributed to a young girl's death from asthma in London. Furthermore, many studies have now shown that over the longer-term pollution can adversely affect lung capacity and contribute to the development of certain respiratory diseases".
>
> Jay Suntharalingam, Respiratory Consultant, RUH

The Trust monitors the nitrogen dioxide ($NO_2$) levels – one of the most harmful pollutants – onsite in order to understand the air quality in the area. Diffusion tubes are placed across the site and are analysed monthly. In the UK, the law on nitrogen dioxide ($NO_2$) pollution says annual average concentrations cannot exceed 40 µg/m3 (micrograms per cubic metre of air). The latest figures show that annual site average for 2023/2024 is 14.49 ug/m3, substantially below this figure.

During 2023/24, the Sustainability Team continued to run initiatives to reduce air pollution on site including:

- Switch off when you drop off campaign in Estate's contractor's car park and across the main drop off points across the site.
- 85 new drivers using the electric vehicle chargers.
- Procurement of further electric vehicles as we transition our fleet.
- New and only electric bus in West of England servicing the RUH from Bath and surrounding villages.
- E-bike loan scheme has been extremely successful, with all bikes out on loan.

## Board oversight of climate-related issues

Sustainability reports to the Non-Clinical Governance Committee, a subcommittee of the Board of Directors chaired by a Non-Executive Director. The NED submits an upward report to the Board of Directors, providing an update and an assurance statement.

All Board reports are required to have a front sheet attached to them, there is a specific section on the front sheet that requires the author to consider the sustainability implications of the report, as shown below:

| 9. | Sustainability |
|---|---|
| The impact, positive or negative, that the report will have on the Trust's approach to environmental sustainability, including its commitment to achieve net zero carbon status by 2030, should be stated. Reference should be made to the BAF risk in this area. | |

One of our Executive deliverables on the RUH performance wall is delivering NZC (Net Zero Carbon) by 2030. Progress in delivering this priority is reported at every Management Board and Board of Directors meeting at the performance wall. The metric that is monitored to measure success is a reduction in our carbon emissions. We also use the sustainable development assessment tool (SDAT) to provide a metric and track performance in other sustainability disciplines outside of carbon, including adapting to climate change that aims to Develop our sites and services so that they are resilient to the adverse effects of climate change.

## Management's role in assessing and managing climate-related issues

The Trust employs the following members of staff:

- Sustainability Manager
- Sustainability Officer
- Sustainable Travel Officer (Shared with BANES and local universities)
- Energy Manager
- Energy Officer (Shared with SFT).

All these members of staff have specific climate-related managerial responsibilities. However, one of their key roles is to engage the rest of the organisation and make sustainable working practices everyone responsibility for and embed them into business as usual.

To support this, we are re-launching the sustainability steering group which will have the role of coordinating the work of the working groups including:

- Energy Working Group
- Theatre Working Group
- Endoscopy Working Group

These groups also act as a conduit for sharing information and best practice with the organisations.

## Tackling Health Inequalities

Overall, the communities within the Bath and North-East Somerset (BaNES), Swindon and Wiltshire remain some of the least deprived parts of the country. However, the average masks pockets of deep deprivation and inequality within each area, including two neighbourhoods which are within the 10% most deprived nationally. This wealth inequality has real impacts on health outcomes, the gap in life expectancy in BaNES between the ward with the highest and lowest expectancy is 10.1 years for females and 6.5 years in males.

In addition to the CORE 20, within BaNES the following PLUS population groups have been identified for whom we will drive targeted action in health inequalities improvement:

- people from ethnic minority backgrounds
- people experiencing homelessness
- people living with severe mental illness
- children eligible for free school meal

The key focuses for the Trust Health Inequalities Programme are:

1. **Ensuring datasets are timely and complete and utilised to inform targeted interventions**: initiating programme of improvement in recording of data aligned with national requirements.

2. **Accelerate Preventative Programmes and Promotion of Wellbeing**: Smoking continues to be identified as the single largest driver of health disparities between the most and least affluent quintiles. The Trust has a well-established programme to treat tobacco dependency amongst expectant parents and staff and is due to launch a Treating Tobacco Dependency programme for in-patients. Data for these services is included overleaf.

3. **Restore Services Inclusively**: we are working to develop a programme of work to understand the data available for the RUH (including services at Sulis Hospital) around emergency admissions and elective care, for both adults and children, to better understand the relationship between demand, activity and health inequalities and plan targeted actions. Data related to this domain is provided in Appendix 1.

4. **Awareness raising and training**: The Trust launched an awareness raising campaign, with dedicated capacity within our communication team, and a Health Inequalities communication strategy. New Health Inequalities e-learning modules have been uploaded to our training platform and are available to all staff members.

5. **Anchor institution**: the Trust is utilising its position as an “anchor” organisation to address some of the broader causes of health inequality, including:

    - Prioritising some of the more deprived local communities for employment and apprenticeship opportunities
    - Encouraging local businesses to become suppliers to the RUH, thereby increasing economic activity locally

- Reducing environmental impact through more sustainable practices
- Working with BaNES Council to help reduce vehicular traffic to and from the RUH sites, thereby improving air quality for local people and reducing respiratory illnesses
- Support our staff health & wellbeing through a series of opportunities and programmes such as our Employee Assistance Programme, Health Checks onsite and our staff networks

6. **Mitigating against digital exclusion**: a new project to reduce digital exclusion launched in May 2024. A team of digital inclusion navigators will be recruited to support patients with the adoption of digital health apps and promote patients' self-care and self-management of long-term conditions by supporting them with the uptake of digital interventions and use of technology.

7. **Leadership and Accountability**: the RUH has a dedicated Executive lead for Health Inequalities and has recruited a Health Inequalities lead in April 23. A steering Group has been established and clear governance and accountability has been described to support and enable the implementation of the Health Inequalities Programme.

The information below responds to the reporting requirements stated on 'NHS England's statement on information on health inequalities' (duty under section 13SA of the National Health Service Act 2006):

**Smoking Cessation**

| | |
|---|---|
| Proportion of adult acute inpatient settings offering smoking cessation services: | The Trust does not currently have a dedicated smoking cessation service for in-patients. This is due to launch in July 24. |
| Proportion of maternity inpatient settings offering smoking cessation services: | A total average of 95 % of maternity inpatients were offered smoking cessation services during April 23 and March 24 |

**Urgent and emergency care**

Emergency admissions for under 18s broken down by ethnicity and index of multiple deprivation (IMD, where 1 represents most deprived and 10 least deprived). The Index of Multiple Deprivation (IMD) datasets are small area measures of relative deprivation across each of the constituent nations of the United Kingdom.

The tables over the pages provide the total number and percentages of emergency admission for under 18s broken down by ethnicity (Tables 1&2) and by IMD (Tables 4&5) during April 23 and March 24. Tables 3&6 provide a demographic overview of the under 18s population in BSW by ethnicity (Table 3) and IMD (Table 6). The data source for tables 1, 2, 4, 5 is Secondary Uses Service (SUS), Children and Young People Transformation Dashboard (b). Table 3 and 6 use a different data source, therefore any comparison needs to consider the possibility of discrepancies in data recording.

**Table 1.** Number of emergency admissions for under 18s by ethnicity. Source: SUS data CYP Transformation Dashboard (b)

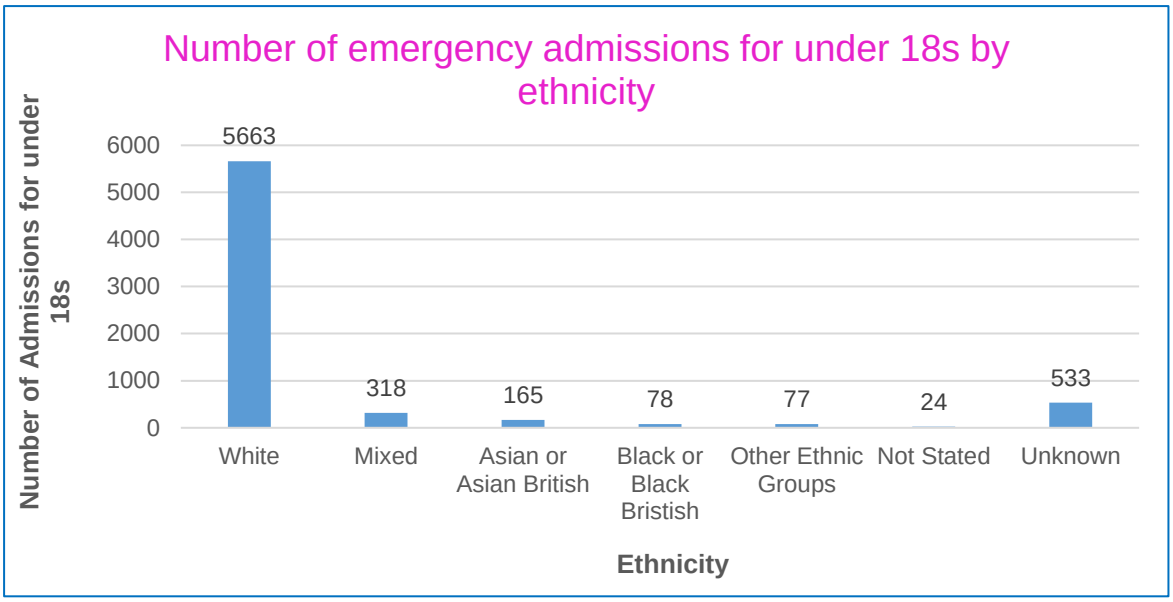



**Table 2.** Percentage of emergency admissions for under 18s by ethnicity. Source: SUS data CYP Transformation Dashboard (b)

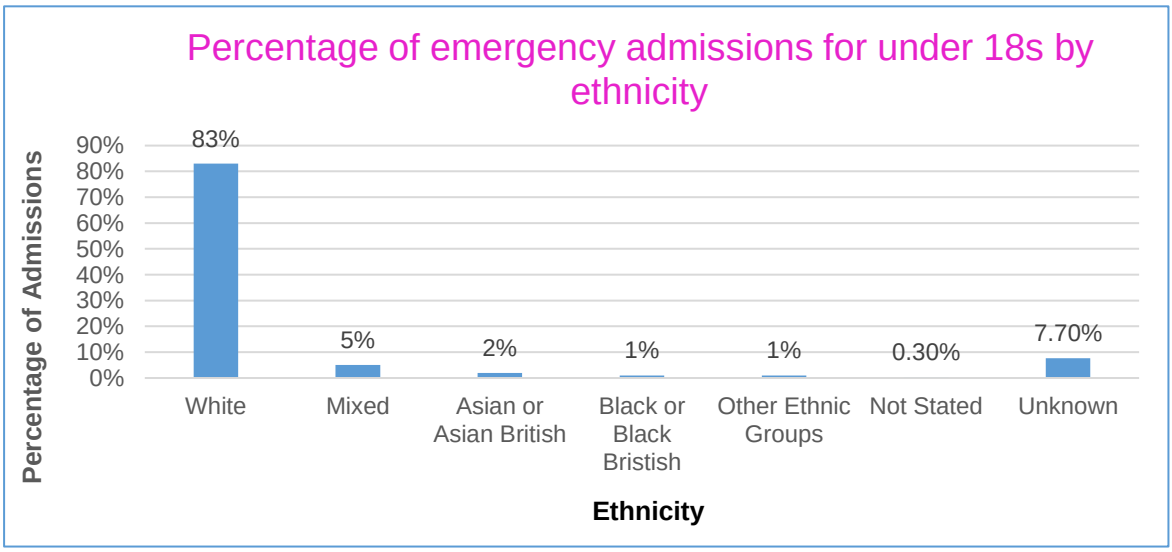



**Table 3.** Ethnicity data for under 18s in BSW. Source: BSW Population Insight Tool

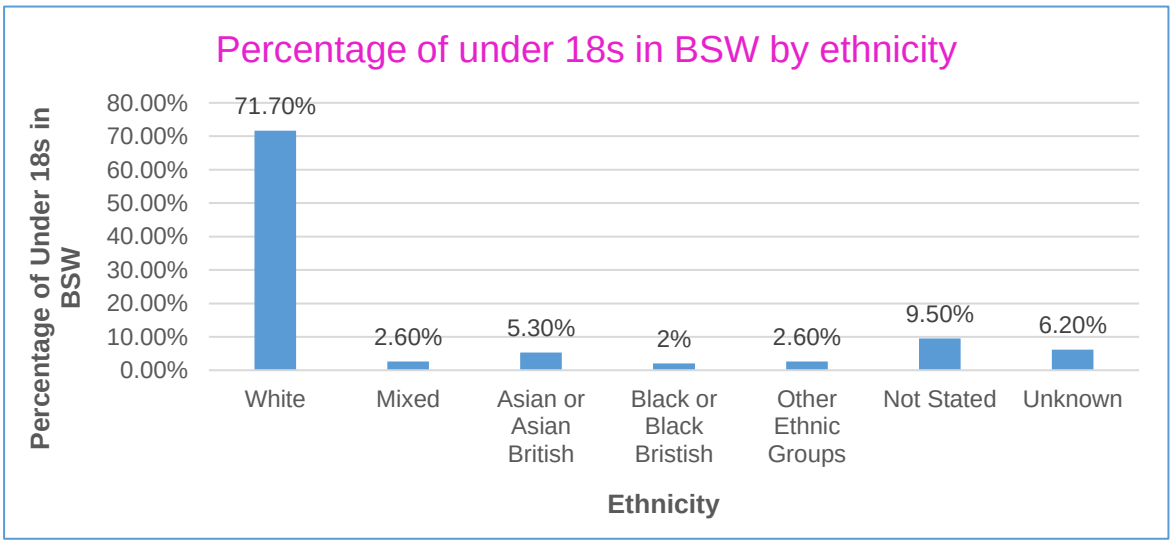


**Table 4.** Number of emergency admissions for under 18s by IMD. Source: SUS data CYP Transformation Dashboard (b). IMD 1: Most deprived, IMD 10: Least deprived.

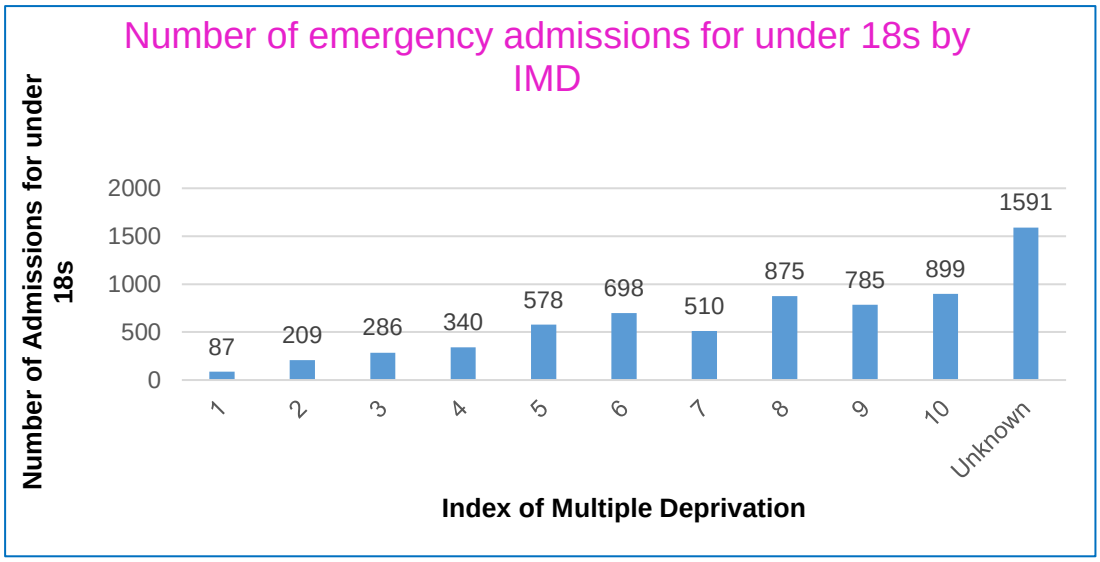



**Table 5.** Percentage of emergency admissions for under 18s by IMD. Source: SUS data CYP Transformation Dashboard (b)

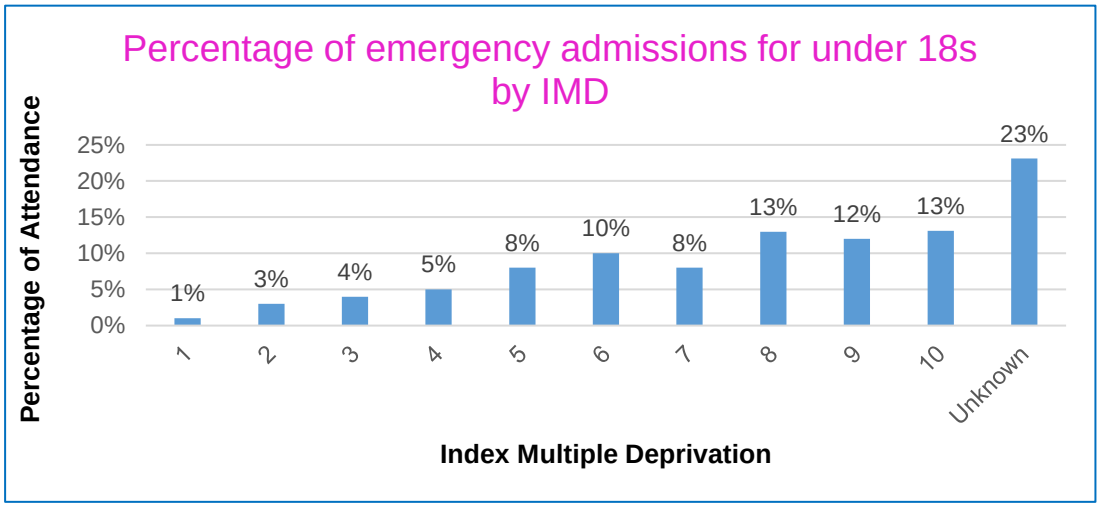
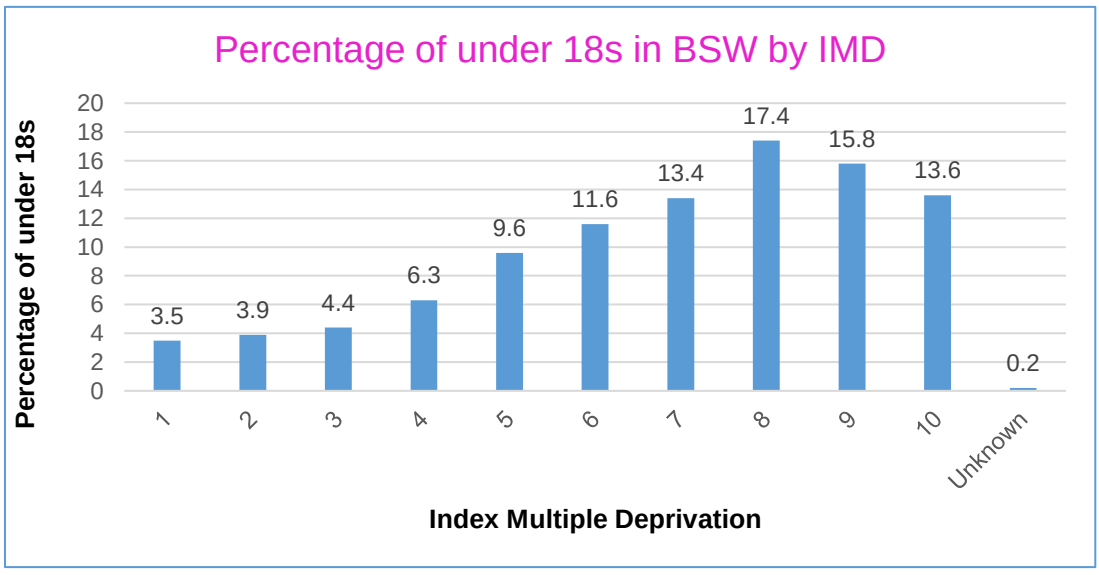



**Table 6.** IMD for under 18s in BSW. Source: BSW Population Insight Tool



## Elective Recovery

Elective activity vs pre-pandemic levels for under 18s and over 18s broken down by deprivation and ethnicity.

The Pre-pandemic numbers are the Monthly average of elective and outpatient activity at the RUH from Apr-18 until March-20 (the first Covid lockdown start). Then the percentages show how the activity levels change against that pre-pandemic baseline each financial year. The RAG scale is relative within each year's percentage change.

| | Deprivation, Under 18s: | | | | | Deprivation, Over 18s: | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Pre-Pandemic | 2020 / 2021 | 2021 / 2022 | 2022 / 2023 | 2023 / 2024 | Pre-Pandemic | 2020 / 2021 | 2021 / 2022 | 2022 / 2023 | 2023 / 2024 |
| IMD 1 | 66 | -41.0% | -10.9% | -7.5% | -4.1% | 303 | -17.7% | -4.2% | 7.4% | 0.1% |
| IMD 2 | 133 | -22.8% | -2.4% | -2.8% | 2.5% | 726 | -20.0% | -9.6% | -4.9% | 3.3% |
| IMD 3 | 161 | -27.0% | -14.8% | -7.8% | 10.9% | 928 | -18.9% | -3.6% | -0.1% | 12.0% |
| IMD 4 | 303 | -28.0% | -12.6% | -0.9% | 7.0% | 2,102 | -21.2% | -8.7% | -2.8% | 4.1% |
| IMD 5 | 371 | -24.2% | -3.4% | -4.8% | 2.9% | 2,760 | -22.2% | -4.8% | 0.7% | 4.3% |
| IMD 6 | 519 | -29.0% | -9.6% | -5.7% | 2.5% | 3,964 | -22.2% | -4.2% | 2.7% | 4.5% |
| IMD 7 | 338 | -27.1% | -0.3% | 5.1% | 8.4% | 2,528 | -19.1% | -2.3% | 7.7% | 12.7% |
| IMD 8 | 658 | -31.3% | -7.4% | 0.9% | 5.1% | 4,320 | -18.8% | -0.6% | 10.0% | 17.4% |
| IMD 9 | 557 | -29.3% | -5.9% | -0.7% | 6.8% | 3,982 | -19.0% | 0.0% | 7.2% | 12.4% |
| IMD 10 | 621 | -26.9% | -4.7% | 2.3% | 7.5% | 4,919 | -25.5% | -7.1% | 0.5% | 5.7% |

| | Ethnicity, Under 18s: | | | | | Ethnicity, Over 18s: | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Pre-Pandemic | 2020 / 21 | 2021 / 22 | 2022 / 23 | 2023 / 24 | Pre-Pandemic | 2020 / 21 | 2021 / 22 | 2022 / 23 | 2023 / 24 |
| African | 9 | -47.2% | -9.1% | 14.4% | 89.9% | 36 | -34.3% | -27.3% | -0.7% | 15.2% |
| Any other Asian background | 15 | -26.6% | -0.9% | 52.8% | 43.4% | 53 | -27.2% | 4.4% | 35.3% | 49.2% |
| Any other Black background | 6 | -40.8% | -11.2% | -13.8% | -32.6% | 34 | -37.1% | -17.8% | 29.5% | 31.7% |
| Any other ethnic group | 27 | -18.6% | 16.6% | 10.0% | 30.6% | 112 | -21.3% | 9.9% | 15.0% | 27.3% |
| Any other mixed background | 27 | -28.2% | -31.3% | 9.7% | 26.7% | 35 | -9.1% | -11.5% | 8.9% | 17.3% |
| Any other white background | 132 | -22.2% | 6.9% | 15.0% | 38.3% | 608 | -16.4% | 10.7% | 25.9% | 30.0% |
| Bangladeshi | 3 | -5.2% | 3.2% | 64.5% | 62.5% | 13 | -10.7% | 6.7% | 0.5% | 16.4% |
| British | 2,452 | -26.4% | -9.4% | -4.3% | 4.1% | 20,566 | -23.3% | -7.9% | -1.9% | 0.8% |
| Caribbean | 4 | -33.0% | 13.6% | 43.4% | 46.2% | 54 | -38.0% | -19.5% | -16.9% | -11.7% |
| Chinese | 8 | -48.1% | -3.6% | -24.8% | -20.3% | 41 | -21.4% | 0.4% | 41.8% | 20.0% |
| Indian | 11 | -42.2% | -23.2% | -16.8% | 44.3% | 49 | -25.5% | -27.7% | -14.6% | 15.0% |
| Irish | 7 | -58.2% | -19.8% | -24.5% | 17.9% | 110 | -17.0% | -20.7% | 1.1% | -13.0% |
| Not known | 856 | -32.1% | 1.2% | 4.7% | -0.3% | 3,571 | -7.4% | 17.7% | 31.4% | 47.4% |
| Not stated | 109 | -44.7% | -21.8% | -12.0% | -7.8% | 923 | -27.9% | -8.9% | 0.8% | 15.1% |
| Unknown | 30 | -39.1% | -29.6% | 4.9% | 24.7% | 321 | -17.2% | 20.1% | 36.3% | 51.0% |
| Pakistani | 2 | -3.2% | -1.4% | -19.3% | 48.0% | 8 | -6.2% | 9.1% | 18.3% | 16.8% |
| White and Asian | 18 | -6.2% | 15.3% | 14.4% | 47.7% | 20 | -35.8% | 19.2% | -5.0% | -19.1% |
| White and Black African | 10 | -24.5% | -15.9% | 20.6% | 74.1% | 6 | -15.2% | 33.3% | 39.4% | 28.9% |
| White & Black Caribbean | 15 | -13.4% | 6.7% | 22.4% | 53.0% | 20 | -33.6% | -2.7% | 11.1% | 32.1% |

## Oral health

Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions not number of teeth extracted) broken down by deprivation and ethnicity.

| Tooth Extractions with Tooth Decay Coded as K02 for Primary Diagnosis for children aged 10 or under, by IMD and Ethnicity | Most Deprived Decile | | | | | | | | | Least Deprived Decile | Null | Total: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | |
| African | | <5 | | | | | | | | | | <5 |
| British | 6 | 11 | 12 | 23 | 17 | 17 | 22 | 27 | 26 | 16 | <5 | 181 |
| Irish | | | | | | | | | <5 | | | <5 |
| White and Asian | | | | <5 | | <5 | | | <5 | | | <5 |
| White and Black African | | | | | | | <5 | | | | | <5 |
| White and Black Caribbean | <5 | | | | | | | | | | <5 | <5 |
| Any other Black background | | | | <5 | | | | | | | | <5 |
| Any other mixed background | | | | | | | <5 | | | | | <5 |
| Any other White background | <5 | <5 | <5 | <5 | <5 | 5 | <5 | 5 | <5 | <5 | | 24 |
| Any other ethnic group | | | | | <5 | | <5 | | <5 | | | 6 |
| Not Stated | <5 | <5 | | | <5 | <5 | <5 | <5 | <5 | <5 | <5 | 13 |
| Not Known | 7 | 7 | 7 | 7 | 8 | 11 | 5 | 15 | 11 | 9 | <5 | 90 |
| Total: | 16 | 23 | 20 | 33 | 31 | 35 | 32 | 49 | 46 | 30 | 9 | 324 |

**Table 7.** Number of admissions for tooth extraction for under 10s. Source: RUH Business Intelligence Unit

## Social, community, antibribery and human rights

All Group policies and procedures are based on national employment legislation, are in line with NHS constitutional commitments and include an equality and diversity impact assessment. The Trust's implementation of the Equality Delivery System 2, the Workplace Race and Disability Equality Standards, and reporting on the Gender Pay Gap, ensures that the organisation has a transparent approach to ensuring that the rights, interests and needs of all sections of the community are considered in terms of service delivery and development, and employment practices.

In June 2022, the RUH Board approved a revised People Plan to cover the period from 2022 to 2025. This focuses on three strategic themes: culture, capability, and capacity, and is underpinned by two key foundations: user friendly people processes (including recruitment, on-boarding, and appraisals) and creating an environment where everyone is respected and treated kindly.

Reporting on the gender pay gap at the RUH can be found within the Equality, Diversity and Human Rights section of the Trust website as below, and is reported within the Staff Report of this report:

https://www.ruh.nhs.uk/about/equality_diversity/gender_pay_gap.asp

This information may also be found on the Cabinet Office website (https://gender-pay-gap.service.gov.uk)

The Trust has in place an Anti-Fraud, Bribery and Corruption Policy and Response Plan, which complies with the provisions of the Bribery Act 2010 and takes account of best practice in this area.

During 2023/24, the Group had no social, community or human rights violation issues.

## Details of overseas and subsidiary operations

The Trust has no branches or offices outside the UK.

Sulis Hospital Bath Ltd, the private company that runs that hospital, is a wholly owned subsidiary of the RUH.

Royal United Hospital Charitable Fund (working name RUHX) Charity Commission No 1058323, is also a subsidiary of the RUH. The Board of Directors of the Trust is the Trustee of the Charity.

**Cara Charles-Barks**
**Chief Executive**
**27 June 2024**

# Accountability Report

## Directors' report

The Directors are responsible for preparing the annual report and accounts. The Directors consider that the annual report and accounts, taken as a whole, are fair, balanced, and understandable and provide the information necessary for patients, regulators, and other stakeholders to assess the Trust's performance and strategy.

Directors of the Royal United Hospitals Bath NHS Foundation Trust during 2023/24:

| Non-Executive Directors | | Appointed |
|---|---|---|
| Alison Ryan | Chair | 1 April 2019 |
| Nigel Stevens | Non-Executive Director | 1 April 2018 |
| Sumita Hutchison | Non-Executive Director | 1 September 2019 |
| Ian Orpen | Non-Executive Director | 7 September 2020 |
| Antony Durbacz | Non-Executive Director | 1 November 2020 |
| Paul Fairhurst | Non-Executive Director | 1 October 2022 |
| Hannah Morley | Non-Executive Director | 1 April 2023 |
| Paul Fox | Non-Executive Director | 1 April 2023 |

| Executive Directors | |
|---|---|
| Cara Charles-Barks | Chief Executive |
| Libby Walters | Chief Financial Officer,<br>Deputy Chief Executive (until November 2023) |
| Andrew Hollowood | Chief Medical Officer<br>Deputy Chief Executive (from November 2023) |
| Antonia Lynch | Chief Nursing Officer |
| Simon Sethi | Chief Operating Officer (until May 2023) |
| Niall Prosser | Interim Chief Operating Officer (from May – October 2023) |
| Paran Govender | Chief Operating Officer (from 2nd October 2023) |
| Alfredo Thompson | Chief People Officer |
| Jocelyn Foster | Chief Strategic Officer |
| Brian Johnson * | Director of Estates and Facilities (until February 2024)** |
| Christopher Brooks-Daw * | Director of Governance & Chief of Staff (from 5 January 2024) |

*Non-voting members

** Following the departure of the Director of Estates and Facilities, it was agreed that the role would be undertaken by the Chief Operating Officer (estates) and the Chief Nursing Officer (facilities).

The Trust considers each of the listed Non-Executive Directors to be independent.

Any Director who no longer meets the requirements of the Fit and Proper Persons Test will have their membership of the Board of Directors terminated.

**The Board of Directors**

| **Alison Ryan, Chair** |
| --- |
| Alison was previously a Non-Executive Director at the University Hospitals Bristol NHS Foundation Trust and has also held Non-Executive Director positions on the Boards of Somerset Partnership NHS Foundation Trust, NHS South West, and NHS South of England Strategic Health Authorities. Alison has had 30 years' strategic and executive experience in the health and social care sector as CEO of several national and local voluntary sector bodies working in health and social care. She has a MA (Oxon) in Philosophy, Politics and Economics and is a member of the Chartered Institute of Management. Alison Chairs the Board of Directors, the Board of Directors' Nominations and Remuneration Committee and the Council of Governors. She also sits on the Charities Committee. By way of interests, Alison continues in her role as South West Regional Chair for Organ Donation following her appointment in March 2022. |
| **Nigel Stevens, Non-Executive Director** |
| *Vice-Chair and Senior Independent Director from 1 April 2023<br>Nigel was previously Chair of the Quality Assurance Committee and remains Chair of the Subsidiary Oversight Committee. He is also a member of the Board of Directors' Nominations and Remuneration, Finance and Performance, and Audit and Risk Committees and is the Non-Executive Director champion for patient and families' experience. Nigel has a BA (Hons) in Politics and Geography and an MA in Defence Studies. After 20 years as a logistics officer in the Royal Air Force, Nigel moved into the commercial sector. Following eight years as Chief Executive Officer for the UK and Ireland Division of a major, global public transport group, he worked as Chief Operating Officer for Keolis UK, a role he combined with wider work in the commercial and public sectors on future transport solutions. He is the owner and sole trader of Raybarrow Consulting, a management consultancy business and was appointed as Chair of Transport Focus, a public funded watchdog in June 2022. |
| **Sumita Hutchison, Non-Executive Director** |
| Sumita is Chair of the Non-Clinical Governance Committee and Charities Committee and sits on the People and Audit and Risk Committees, as well as the Board of Directors' Nomination and Remuneration Committee. She is the Board lead for equality, diversity and inclusion and health and wellbeing. Sumita has an LLB (Hons) and has practised as a solicitor specialising in employment law. She has also worked as Engagement Development Manager at the Avon and Somerset Constabulary, leading on diversity and inclusion initiatives across the organisation. Sumita has been heavily involved in promoting race, disability, and gender equality in the Bristol area, serving as Commissioner for Adult Social Care at both South Gloucestershire and Bristol City Councils and as a member of the Women's and Race Equality Commissions in Bristol. In addition to her role at the RUH, she also currently serves as a Non-Executive Director of the Gloucestershire Health and Care NHS Foundation Trust and volunteers for the Save the Soil movement, which aims to create awareness about soil degradation bring policies to safeguard soil heath. |

| Ian Orpen, Non-Executive Director |
| --- |
| Ian joined the Board in September 2020 as the Trust's first clinically qualified Non-Executive Director. He previously worked as a General Practitioner in the Bath area and served as Clinical Chair at the Bath and North East Somerset Clinical Commissioning Group from 2013 to 2020. In that capacity, Ian held the role of Stakeholder Governor on the RUH's Council of Governors right from the Trust's authorisation as a Foundation Trust in 2014. Ian now chairs the Quality Governance Committee, and sits on the People, Non-Clinical Governance and Subsidiary Oversight Committees. He is the Board's Maternity Safety Champion, and he leads on Children and Young People. In terms of declared interests, Ian is an investor in tem.energy which operates a platform to connect suppliers of renewable energy with business consumers. |
| **Antony Durbacz, Non-Executive Director** |
| Antony is a chartered accountant by background and an experienced Non-Executive Director. Before he joined the RUH Board in September 2020, he had previously served as a Non-Executive Director and Chair of the Audit Committee at Taunton and Somerset NHS Foundation Trust. He is also Chair of the Audit Committee at LiveWest, one of the largest housing associations in the South West. Antony has held a number of senior finance roles, mainly in the manufacturing sector. On the RUH Board, he has been Chair of the Finance and Performance Committee since October 2023 and sits on the Audit and Risk and Subsidiary Oversight Committees. He was also Chair of the Audit and Risk Committee until September 2023 and a member of the Non-Clinical Governance Committee until October 2023. In addition to his membership of the LiveWest Board, Antony is also a Governor at Bath Spa University. His daughter is a specialist trainee in Obstetrics and Gynaecology in the Severn Deanery and is currently on rotation as a registrar in Obstetrics and Gynaecology at the RUH. |
| **Paul Fairhurst, Non-Executive Director** |
| Paul has professional backgrounds in corporate law and strategic business development. He started his career at the international law firm, Simmons & Simmons, working on mergers and acquisitions, and subsequently took on a variety of senior roles in a range of international organisations such as Intercontinental Hotels Group PLC and Diageo PLC. His more recent full-time role was as Strategy, Planning and Policy Director at UK charity Jubilee Sailing Trust. Paul Chairs the People Committee and is a member of the Finance and Performance and Quality Assurance Committees. He also sits on the Vulnerable Persons Assurance Committee, and he is the Non-Executive lead on safeguarding, security, staff inequalities and Improving Together. By way of declared interests, Paul acts of a Trustee for two charities: Designability, a Bath-based national charity that creates products with and for disabled people to enable them to live with greater independence, and Back Up Trust, which is dedicated to supporting and inspiring people affected by spinal cord injury to get the most out of life. |

| Hannah Morley, Non-Executive Director |
| --- |
| Hannah has a Clinical background, having gained her undergraduate degree from the University of Cardiff in 2010, before completing her Masters in 2018. She started her career at the Aneurin Bevan University Health Board in 2010 before progressing to the Fraser Health Authority in 2013. Hannah spent time overseas before coming back to the UK in 2015. Hannah has taken on a variety of roles in the healthcare sector since returning to the UK and is currently a Senior Planning and Service Development Manager at Aneurin Bevan University Health Board. She is a member of the Non-Clinical Governance, Quality Assurance and People Committees. In terms of declared interests, Hannah is a member of the Chartered Society of Physiotherapists, the Canadian Alliance Physiotherapy, the College of Physiotherapy British Columbia, the Royal Society of Arts, and the Health and Care Professions Council. |
| **Paul Fox, Non-Executive Director** |
| Paul has a financial background. He has an MA in Modern History and Economics from Oxford University and has since worked as Finance Director / Chief Operating Officer in a range of complex organisations, including Bath & NE Somerset Council, the Natural Environment Research Council and Bath Spa University. He was awarded an OBE in 2022 for services to scientific research. On the RUH Board, he has been Chair of the Audit and Risk Committee since October 2023 and sits on the Finance and Performance and Subsidiary Oversight Committees. In terms of declared interests, Paul is a member of UKRI Financial Sustainability of Research Committee and the Chartered Institute of Public Finance and Accountancy. He is also a Governor at Wiltshire College and University Centre, Treasurer of the Liberal Democrat History Group, and Chair of the Western Counties Liberal Democrats. His wife works at University Hospitals Bristol NHS Foundation Trust and is registered with the NHS bank. |

## Executive Directors - Voting

### Cara Charles-Barks, Chief Executive

Cara has worked at board level within the NHS since 2008, including as Chief Operating Officer and Deputy CEO at Hinchingbrooke Healthcare NHS Trust, and more latterly as CEO at Salisbury Foundation Trust between 2017 and 2020. Before that, Cara held senior healthcare management roles in her native Australia, including as Nursing Director at the Queen Elizabeth Hospital in Adelaide, South Australia. She holds Bachelor's and Master's Degrees in Nursing as well as an MBA from the University of Adelaide. Cara is Vice Chair of the Health Innovation West of England on behalf of the RUH. She is also a Visiting Professor of the Faculty of Health and Applied Sciences at the University of the West of England, and Deputy Chair of NHS Quest, a leadership and development service provider.

### Libby Walters, Chief Financial Officer

Libby has worked in the NHS for 25 years and prior to joining the RUH held positions as the Director of Finance and Resources at Dorset County Hospital NHS Foundation Trust and as the Director of Finance and Deputy Chief Executive at Yeovil District Hospital NHS Foundation Trust. She is a member of the Chartered Institute of Public Finance and Accountancy and has a particular interest in ensuring the focus on use of resources is intrinsically linked with improving the quality of care provided. Libby is also an active member of the Healthcare Financial Management Association South West Branch and served as Interim Chief Executive of the Trust between 1 June and 7 September 2020. By way of declared interests, her husband works on the radiology portering bank, and her daughter holds a bank portering contract with the RUH. Her daughter is also a student midwife, undertaking clinical placements at the Trust.

### Andrew Hollowood, Deputy Chief Executive & Chief Medical Officer

Andy joined the RUH on 15th September 2022. He is a cancer surgeon by background, specialising in gastric cancer, and he previously worked as Deputy Medical Director at the University Hospitals Bristol and Weston NHS Foundation Trust, covering the Weston site. Andy is passionate about taking positive action to reduce the impact of health inequalities, and he is committed to creating a listening culture to support staff in problem solving and creating solutions. In terms of declared interests, Andy is a director of Andrew Hollowood Ltd., FH Intuition Ltd and a Bristol based charity called Boomsatsuma, which provides young people with opportunities to work in the creative industries. He is also a director of Sulis Hospital Bath Ltd., and his wife is a general practitioner at Hartcliffe Surgery in Bristol.

### Antonia (Toni) Lynch, Chief Nursing Officer

Toni joined the RUH in April 2021 from Guy's and St Thomas' NHS Foundation Trust, where she was the Deputy Chief Nurse and acting Chief Nurse providing leadership to 7000 nurses and midwives through the first two waves of the COVID-19 pandemic. She previously held senior roles both in clinical and operational management. Toni holds a Masters' degree in Advanced Nursing Practice and has completed the Nye Bevan Executive Leadership programme. In terms of declared interests, her spouse is a Matron at the Great Western Hospitals NHS Foundation Trust.

| Simon Sethi, Chief Operating Officer (until May 2023) |
| --- |
| Simon joined the RUH in January 2021 from Yeovil Hospital NHS Foundation Trust, where he was Chief Operating Officer and helped that trust develop its reputation for the quality and efficiency of its emergency services. He had previously held senior roles both in operational management and commissioning. Simon holds a Masters' degree in healthcare management and leadership as well as an MBA. He is an Honorary Senior Research Fellow at the University of Bath, and his wife is Associate Director of Culture, Leadership and Development at North Bristol NHS Trust. Simon took a sabbatical in May 2023 and is now Director of Future Community Services for the BSW Communities Together Programme and Director of Recovery at Wiltshire Health and Care. |
| **Niall Prosser, Interim Chief Operating Officer (May 2023 – October 2023)** |
| Niall Prosser joined the Executive Team for an interim period in May 2023. He has over 16 years of NHS operational management experience working within the Bath, Swindon and Wiltshire and Bristol systems. Over the last three years this has included undertaking the Interim Chief Operating Officer and Deputy Chief Operating Officer roles at the Trust. Prior to working within Bath, he has also undertaken senior transformation, commissioning, and divisional director roles. Niall has a strong track record of helping services to innovate through clinically led service developments. |
| **Paran Govender, Chief Operating Officer (From October 2023)** |
| Paran joined the Trust in October 2023 from Guy's and St Thomas' NHS Foundation Trust. She has worked in a number of NHS organisations, including King's College NHS Foundation Trust where she held a number of clinical and operational roles. She has extensive clinical and leadership experience as an Occupational Therapist, Chief Therapist and Director of Operations and Partnerships in South East London. Paran grew up in South Africa and was influenced by the political and economic challenges and disproportionate socio-economic climate. She is committed to supporting those in need and works tirelessly to champion basic rights including health and care. Paran has no declared interests. |
| **Jocelyn Foster, Chief Strategic Officer** |
| Joss was previously Director of Business Strategy for Kent County Council, Strategy Director at (Parcelforce) Royal Mail, Strategic and Corporate Development Director at Leicestershire Partnership NHS Trust and has previous public and private sector experience in business strategy, planning, transformation, and new business development. Joss has an MBA, DPhil, and BSc (Hons) in Biological Sciences. Her declared interests include a financial interest in Veloscient Ltd, a company dedicated to facilitating structured data capture for a range of markets, including healthcare, and work as a complaint's panellist for the Dental Complaints Service. |
| **Alfredo Thompson, Chief People Officer** |
| Alfredo joined the Trust at the end of January 2022 from North Middlesex University Hospital NHS Trust where he had led the culture change and leadership programmes. He has held a number of senior roles both within the NHS and in other sectors and is passionate about organisational culture, staff experience and inclusion. In terms of declared interests, Alfredo attends Locum's Nest Special Interest Group Meetings. This is a private organisation that the Trust uses to book medical locums. |

| Executive Directors – Non-Voting |
| --- |
| **Brian Johnson, Director of Estates and Facilities (until February 2024)** |
| Brian has over 30 years' experience working nationally and internationally across a broad range of technically challenging, high-profile projects in a number of sectors, with a focus on health, education, and sport. He has a wealth of design and construction delivery experience, including in his previous role was as Head of Capital Projects at the RUH, before which he was Regional Operations Director at Capita Health Partners. As part of the NHS response to the COVID-19 pandemic in the South-West, Brian took on the additional role of Director of Estates and Facilities for the Bristol Nightingale Hospital. He then shared his time at the RUH with a role as Director of Estates for Salisbury NHS Foundation Trust under an agreement between both organisations. Brian left the Trust in February 2024 to take up the role of Director of Estates and Facilities at the Royal Cornwall Hospitals NHS Trust. |
| **Christopher Brooks-Daw, Director of Governance & Chief of Staff** |
| Christopher became the Director of Governance & Chief of Staff in January 2024, having worked in many roles in healthcare for over 30 years beforehand. He has had a varied career spanning clinical and corporate roles in both the NHS, overseas and the independent healthcare sector. His previous roles have included senior positions in nursing, governance and risk, leadership, and organisational change. Christopher's motivation centres on continuous learning, bringing simplicity and clarity, fostering a positive organisational culture, and advocating for both staff and patients. He enjoys working with colleagues to find creative ways to solve problems and design better ways of working. He has no declarations of interest. |

### Contact with the Directors

Information on how to contact the Chair and the Chief Executive is available on the Trust's website. In addition, all Directors can be contacted at ruh-tr.trustboard@nhs.net

### Register of interests

The Trust's Chair, Non-Executive Directors, Executive Directors, and Governors are required to comply with the Trust's Code of Conduct and Declarations of Interests Policy and declare any interests that may result in a potential conflict with their role at the Trust; they do this during each of their public meetings. The register of interests of Governors can be obtained by writing to the Membership Office at RUHmembership@nhs.net.The Directors' declared interests are listed on the Trust's website.

## Additional Directors' report disclosure

### Cost Allocation and Charging Requirements

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

### Political and Charitable Donations

The Trust has made no political or charitable donations over the course of the year. No political or charitable donations were made during 2022/23.

### External Consultancy

During 2023/24, the Trust commissioned Linea to provide advice and guidance on financial stewardship.

Aqua were commissioned to support the Trust with quality governance assurance as part of an ongoing developmental well-led process. Additionally, they supported an organisational development intervention. Aqua were also commissioned to undertake the Trust's external well-led review which was due to start in July 2023 for a period of 3 months but began in May 2024.

The Trust did not use any external consultancy in 2022/23

### Better Payment Practice Code

The Trust is required, by the national "better payment practice code", to aim to pay all valid invoices within 30 days of receipt, or the due date, whichever is the later. The table below includes the position for both the Trust and Sulis Hospital. Over the 12 months to 31 March 2024, the Group achieved the following performance:

| | 2023/24 | | | 2022/23 | |
|---|---|---|---|---|---|
| **Better payment practice code** | **Actual Foundation Trust Number** | **Actual Foundation Trust £'000** | | **Actual Foundation Trust Number** | **Actual Foundation Trust £'000** |
| **Non-NHS** | | | | | |
| Total bills paid in the year | 88,907 | 352,808 | | 93,791 | 343,672 |
| Total bills paid within target | 82,816 | 322,555 | | 89,229 | 323.968 |
| Percentage of bills paid within target | **93.1%** | **91.4%** | | **95.1%** | **94.3%** |
| | | | | | |
| **NHS** | | | | | |
| Total bills paid in the year | 1,451 | 25,860 | | 1,433 | 16,846 |
| Total bills paid within target | 1,131 | 18,673 | | 1,158 | 12,284 |
| Percentage of bills paid within target | **77.9%** | **72.2%** | | **80.8%** | **72.9%** |
| | | | | | |
| **Total** | | | | | |
| Total bills paid in the year | **90,358** | **378,668** | | **95,224** | **360,518** |
| Total bills paid within target | **83,947** | **341,228** | | **90,387** | **336,252** |
| Percentage of bills paid within target | **92.9%** | **90.1%** | | **94.9%** | **93.3%** |

Total interest paid to suppliers under the Late Payment of Commercial Debts Act 1998 was £0k (£0k in 2022-23).

## NHS Improvement's Well Led Framework

The Trust has considered NHS Improvement's well-led framework in arriving at its overall evaluation of the organisation's performance and in developing its approach to internal control, board assurance framework and the governance of quality.

An external well-led review was commissioned to start in July 2023 for a period of 3 months but was rearranged due to other emerging priorities. The review began in May 2024 and will conclude in June 2024. This developmental review has the key aim to understand our strengths and also areas that require improvement from a well-led perspective. The Annual Governance Statement describes in further detail the Trust's approach to ensuring services are well-led and quality governance. The Quality Account describes quality improvements in more detail and can be found on the Trust's website which is published on the Trust's website in June 2024.

## Modern Slavery Act 2023-24 annual statement

The Group is committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. We are fully aware of the responsibilities we hold towards our service users, employees, and local communities. We are guided by a strict set of ethical values in all our business dealings and expect our suppliers (i.e., all companies that we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking.

## Enhanced quality governance reporting

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The accuracy of the Trust's Quality Account and an assessment of whether this presents a balanced view of controls in place is provided through internal review, stakeholder engagement and consultation. The report for 2023/24 will be published on the Trust's website in June 2024.

Quality is embedded in the Trust's overall strategy – *The people we care for.* Quality targets are linked to clinical divisions and the Trust's performance against the quality priorities and targets is included in the Trust-wide Integrated Performance Report (IPR) report which is reviewed monthly by various committees and ultimately by the Board of Directors. During 2023/24 the Board continued to receive regular performance information on key quality indicators including patient safety, patient experience, and clinical effectiveness.

### Quality Indicators Performance 2023/24

We successfully delivered our quality priorities in 2023/24, which were:

- Reducing health inequalities in maternity
- Reducing length of stay in the neonatal intensive care unit
- Opening a dedicated Day Surgery Unit
- Embedding our Family Liaison Officers

### Quality Priorities 2024/25

We have set the following quality priorities for 2024/25:

- Improving learning from patient safety events
- Developing our safety culture
- Improving communication access with patients, their carers, and families

These will be reported in full in the 2023-24 Quality Account which is published on the Trust's website in June 2024.

### Improving Patient and Carer Experience at the RUH

Patients tell us that they appreciate the importance of staff kindness and understanding and especially that they are treated as an individual.

We also hear that we need to improve how we communicate with patients and provide information in a way they can understand and at the right time for them. We know that feeling heard and valued has a positive impact on patients' experience of the hospital.

In partnership with patients, families and the local community, the Trust developed a patient and carer engagement and experience strategy, which aligns with the Trust goal for the 'people we care for'. The strategy supports staff to work with patients and their families/carers to develop

and design new services, improve existing services, and improve overall patient and family experience.

Patients, families, and the local community helped develop our three commitments to improving patient experience. These are:

- We will involve and engage with you in a purposeful, meaningful, and inclusive way.
- We will listen, hear, and act on what you tell us to improve your experience.
- We will communicate with you in a clear and understandable way at the right time.

This year, in working towards achieving these commitments we have focused on the following:

**Patient Safety Partners (PSP)**

In May 2023 we recruited Patient Safety Partners to be actively involved in developing improvements in patient safety and the quality of care we provide at the RUH. The PSP's, who are volunteers, ensure that the voices of patients, carers, families and hard to hear groups are represented in how we learn from patient safety events.

**Patient representatives**

Patient representatives bring a unique perspective to our Boards, Committees and Groups. People who have experience of being a patient or a patient's carer/ family member are 'experts by experience.' We believe these experiences empower patients to be meaningfully engaged in discussions around quality, service improvement and design. For example, the RUH has recruited patient representatives to the Medicine Divisional Board, Dementia and Strategy group and the Palliative and End of Life Care steering group.

**DrDoctor**

DrDoctor is a patient engagement platform that helps the hospital to communicate effectively with patients. This is part of our ongoing commitment to provide the right care at the right time.

The RUH has partnered with DrDoctor to introduce video consultations, digital appointment reminders and digital letters.  Patients tell us they find video consultations more convenient than attending the hospital. Patients do not have to allow significant extra time before and after appointments, only needed to take minimal time off work, have a more comfortable and shorter waiting experience, have a less stressful experience, and feel it to be safer/easier where their condition reduced their ability to travel.

Patients receive up to three text and/or email reminders about their upcoming hospital outpatient appointment. This reduces non-attendance (DNAs), the reduction in unused clinic slots due to DNAs means more patients can be seen sooner, booking teams do not need to rearrange appointments due to non-attendance, and personalised messages support empowerment of the patients' own care.

Switching from printing and posting appointment letters to digital has improved patient experience, saved money, and promoted environmental sustainability. Patients receive their letters faster and they are more readily accessible on the patient portal. Patients view and download their letters online with the option as well to receive letters in their preferred way.

**Call for Concern**

Call for Concern provides patients, their families, carers, and advocates with access to 24/7 rapid review from a critical care outreach team if they are worried about the patient's condition. A pilot has commenced on 3 wards with a plan to roll this out Trust wide. This service is known nationally as "Martha's Rule".

The Critical Care Outreach team, a team of specialist nurses, provides the service at the RUH. They are available 24 hours a day to help support ward staff in the care of acutely ill patients. They can offer advice over the telephone or see the patient on the ward to review their condition.

**Bob's Boxes**

Bob's boxes were introduced to improve the experience of inpatients who are registered blind/partially sighted. Bob was a patient who was diagnosed with a serious eye condition and lost all vision when he was 67. We learnt from Bob how stays in hospital could feel lonely and isolating. With the support of Bob's family, the Trust has created boxes with contents to support patients who have visual impairment. The content includes a magnifying glass, radio, talking clock, memo recorder, non-slip plate pad, non-slip cup holder, plate/bowl guard and velcro-dots for call buttons.

**Involving patients in planning future services**

Our aim is to continuously improve patient and family experience and strengthen the patient voice in every service across the hospital. The RUH is committed to ensuring that the Trust's priorities reflect what patients, their families/carers and the local community tell us is important to them. This year we have involved members of the local community in developing the Vulnerable People Strategy, which will be launched later this year.

We are committed to creating opportunities for patients, and their families and carers, with lived experience to be involved and work with staff in developing and improving the service, we provide.

This year, the Patient Experience Team supported 73 teams to collect patient and carer feedback (via questionnaires, telephone interviews and focus group meetings) and to use the information to improve their service. This is an increase from the 60 teams supported the previous year.

Some of these projects were nominated for the Improving Patient Experience Awards 2023-24, which provided an opportunity to celebrate the good practice:

The winner of this year's award was the Trauma Assessment Unit for the work they have done to perform hand surgery in their procedure room which has resulted in reducing waiting times for patients.

Patients have fed back positively, saying, "staff were very informative of the procedure which made me feel calm and relaxed throughout". "I was treated extremely well, and every step of the process was explained as it was happening". "I was given clear and detailed information regarding the procedure, including the benefits and risks"

**Collecting patient feedback to improve our services**

Patients, families, and carers, regularly share their experiences of the hospital. This information is collected through a variety of ways, for example:

- Patient stories
- 'See It My Way' films
- Mealtime observations
- Patient Readers Panel
- Patient Experience Volunteers
- Social media
- Friends and Family Test (FFT) cards and online feedback
- Patient Support and Complaints Team (PSCT)
- Hospital questionnaires, telephone interviews, focus groups
- Ward and outpatient observations as part of the Trust Accreditation standards
- Patient Led Assessment of Clinical Environments (PLACE)
- Annual and bi-annual National Patient Experience Surveys – Inpatient/Maternity/Emergency Department/Cancer

**Friends and Family Test (FFT)**

The response to the national FFT question helps us to understand patient experience across the hospital. The question asks, *'overall how was your experience of our service?'*

To support us to understand patient experience the FFT question is now asked by text message. The text is sent to patients who have provided us with their mobile phone number. Feedback via a text messaging service was introduced on 1st October 2023. This has led to a significant rise in responses from 4,071 in July- September to 23,161 between October – December 2023.

On average 96% of patients who completed the questionnaire in 2023/24 responded positively about their experience of the hospital. Patients have the opportunity to tell us why they rate their experience positively. The top reason for positive feedback is the attitude and behaviour of staff, kindness, compassion, respect.

**Patient Stories**

A Patient Story is presented to each public meeting of the Board of Directors. The patient story aims to set a patient focussed context to the meeting. The story is either filmed, voice-recorded or the patient/family member shares their experience in person. Listening to patient/ family stories provides a unique insight into their experience of the hospital and helps staff to acknowledge and celebrate what we do well and recognise where we need to improve care. Patient/family and staff stories are shared on the Trust internal web pages and used for training and education.

In July 2023, the Board heard from the Homeless Hospital Discharge Team (HHDT), who shared a very positive patient story, highlighting the joined-up work between the hospital and the community.

In September 2023, the Board heard from a family member whose wife sadly died at the hospital in December 2022. Her husband contacted the Trust to provide feedback on his experience as a relative. Feedback was received regarding the bereavement booklet, which he was unable to read due to his sight loss. Following his feedback changes have been made to the bereavement booklet so it is accessible for people who are blind or partially sighted and can be available in braille or read through a computer. The Palliative Care team has provided training to ward staff around 'care after death' and produced a video, which is available for all staff on the Intranet.

In November 2023, a mum who had given birth just over a year ago shared her experience of the maternity and high care dependency unit. She spoke movingly about her experience of the birth and the subsequent impact that this had on her ability to care for her baby and the support she needed to breastfeed. Her story was recorded and is used in staff training and education highlighting the importance of staff identifying the emotional side of parenthood in the core training of midwives and asking the parent 'what matters to you/how can I help you?'. The parent had also used the birth reflections service, which she said had helped her to share her experience in a supportive way.

In January 2024, the Board heard from a patient who had been diagnosed with and treated for ovarian cancer at the hospital in 2019. In 2022, the patient was invited to be a member of a Patient Advisory Group (PAG) and provide feedback on her experience of care at the hospital, as part of the Holistic Integrated Care for Ovarian Cancer (HICO) project. As a black Afro-Caribbean woman, the patient shared some of the additional difficulties she faced in coming to terms with her cancer and in particular the impact of chemotherapy on losing her hair. She was distressed to find that the wigs provided for women did not include any for Afro-Caribbean women. As a result of this story, the Trust does now have wigs for Afro-Caribbean women. This has also led to raised awareness about the personal care of patients from a different ethnic background to be able to care for their hair and skin whilst in hospital.

**See It My Way**

This year we continued with our very successful 'See it my Way' programme and recorded a film during Dementia Action week in May. The film called *'See it my Way – living with Dementia'* highlighted the importance of person-centred care. It reminds staff that the family and carers of loved ones with Dementia are experts in their care and that it is important for staff to listen to them and involved them in their loved one's care and treatment. The film is used for staff education and training.

To celebrate Experience of Care week in April, we produced a short film with a number of staff from across the hospital who shared what they all do to make a difference to patient and family experience. Called 'Small things, big difference' it is used at all staff induction and in training and education.

**Written Patient Information Leaflets**

This year the Patient Readers Panel reviewed 102 written patient information leaflets from across the hospital. The leaflets written by staff for patients and shared with panel who review the leaflets to ensure they can be understood by patients and their families and carers, that there are no gaps in information and that the information is relevant to patients.

**Complaint's handling**

Our Patient Support and Complaints Team (PCST) works to achieve early resolution for patient and carer concerns and facilitate the answer to questions regarding treatment and care as soon as possible. We aim to acknowledge all contacts within 2 working days and options for resolution are offered in order to resolve concerns in a way that works best for the patient and their family.

The Trust is committed to ensuring that our feedback is responsive and compassionate; to achieve this we have been exploring the best option for providing feedback or resolving concerns or complaints. Some patients told us that they had concerns about the care of their loved one but did not want to make a formal complaint. As a result, we introduced a single point of access for patients and families, which provides patients and their families with a range of options for addressing their concerns with an emphasis on early resolution.

- Log the case as a concern and ask that someone from the department contact the person by phone or email or in person to discuss their experience. The patient will not receive a written response unless requested.
- Log experience as a complaint, this is an investigation with an agreed timeframe. At the end of the formal complaint investigation, the person will receive an investigation report and/or the offer of a meeting with the clinicians involved.
- Log the concerns as feedback for the department, this will be seen by the team leaders in the department and the Trust Management team, but the person does not receive a response.
- Arrange a bereavement meeting for families who have questions about the loss of their family member.
- Listening Service, this is an opportunity for the patient and their family to discuss your experience with an experienced member of staff from outside of the department. Following this the feedback and actions are shared with the department and the patient is updated when the actions have been completed.

This approach is in line with the NHS Complaints Standards. This highlights the importance of welcoming complaints in a positive way ensuring that the process is 'responsive to the needs of each individual'. Prompt engagement by Matrons or other senior staff to listen and resolve complaints at the earliest opportunity has also supported the Trust commitment to promote a learning culture and welcome complaints in a positive way.

This year the Trust received 266 complaints compared to 326 in the previous year. The majority of complaints related to communication issues, clinical care, and concerns.

Full details of the number, type and resolution of complaints received at Sulis Hospital during 2023/24 will be reported within their Quality Account.

## Stakeholder relations

### Anchor organisations

The term anchor institutions refer to large, typically non-profit, public-sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities.

Over the past couple of years, the RUH and other anchor organisations within the B&NES area have been working together to support the development and achievement of a “Future Ambition” for B&NES as particularly embodied in its Economic and Health and Wellbeing Strategies. Our shared and long-term commitment to civic responsibility of this kind has now been formally set out in the B&NES Civic Agreement, signed by the RUH Board of Directors in January 2024. This document will form an important foundation upon which the RUH will continue to develop its role as an anchor within B&NES as well as strengthening our working relationships with other anchors. The other signatories to the Future Ambition Civic Agreement are the University of Bath, Bath Spa University and Bath & North East Somerset Council.

In addition, the RUH and University of Bath agreed a civic partnership in 2023/24, building on four areas of shared interest: education, research, shared strengths, and community.

### Third Sector

The RUH works closely with a variety of third sector partners for the benefit of current patients and research for the future. These include partner’s resident on its site: Research Institute for the Care of the Elderly (RICE), Designability, Bath Radio and Friends of the RUH whose passionate volunteers contribute a huge amount of value through their many activities on wards and generating funds which are used to enhance patient experience.

Recognising the importance of our third sector partners, we have spent time in 2023 looking to formalise our relationships. For example, Dorothy House, our local end of life and hospice care provider, joined the RUH’s Trust Management Executive’s monthly meeting in September 2023 to lead a discussion on how both organisations could build on our close working relationship; we anticipate formalising this as a strategic partnership in early 2024/25.

A key focus of our work with third sector providers in 2023 has been through the BaNES Home is Best programme. A team made up of staff from B&NES Council, BSW Integrated Care Board, HCRG Care Group (the local community services provider) and 3SG (BaNES third sector members network) and led by the RUH Transformation team, came together to consider how to reduce the number of patients in beds at the RUH who do not need secondary care. The team used A3 problem solving methodology to develop a collective understanding of the need for improvement, using a range of investigations including engagement sessions and service user feedback. From this, the team was able to develop an overarching vision for the programme.

One of the most innovative projects within the Home is Best programme is the Community Wellbeing Hub (CWH). We know that patients who wait longer in hospital are often those who experience health inequalities, and that working across sectors can be an effective way to address these disadvantages. Bringing together teams from the local authority, RUH, and local third sector providers, the Hub aims to move away from the historic gap between commissioned services and the third sector:

In June 2023, the CWH team launched a new referral process for RUH inpatients. The process is designed to assist a two-way conversation as a patient prepares to be discharged home from hospital. The form focusses on eight areas of need; priority is given to discharge dependent services, and response are routed to the relevant CWH partner organisation as a referral based on the individual's needs. A patient dashboard supports the process, giving all teams the information, they need to best support patients.

RUHX, the RUH charity, worked closely with partners including the James Dyson Foundation, Medlock Charitable Trust, and Macmillan Cancer Support to raise funds for the new Dyson Cancer Centre, opening in 2024 and providing a cancer services hub for over 500,000 people in the South West. Macmillan's funding will support the Macmillan Wellbeing Hub, one of the ways in which the building is designed to support holistic care for patients, their loved ones, and the wider community.

**Training and development**

Undergraduate medical students: The RUH hosts Bath Academy as a teaching hub for Bristol University Medical School, supporting the education and training of nearly 400 medical students, equating to 9,000 student weeks, per year. Around 25 Consultants act as Coordinators and Tutors providing and organising the teaching of medical students. They work alongside eight Clinical Teaching Fellows (Junior Doctors) as the keystone to providing the teaching both on the wards and in the classroom.

The Bath Academy goes from strength-to-strength as our reputation as the most popular Academy for Bristol medical students continues to grow. This reputation is enhanced by further improving our Simulation Suite where we can teach medical students how to deal with a multitude of clinical situations in a controlled environment.

Postgraduate Doctors: The RUH continues to respond to and embed the changes in Post-Graduate Medical Education precipitated by the 2016 Junior Doctors Contract. Results from the National Training Survey and Quality Panels have shown the RUH continues to offer excellent training. The pioneering Local Trainee Support Faculty run by the Associate Director of Medical Education for Support is in place to help those trainees who need additional advice and guidance.

The General Medical Council and Health Education England are moving forward on a multi-professional education agenda. At the RUH, we continue to explore non-medical workforce options, such as Physician Associates and Advanced Nurse and Physiotherapy Practitioners. The Trust Education Group has continued to help facilitate successful multi-professional skills days to further integrate training and development across the various professional groups.

Our Widening Participation programme offers a wide range of opportunities to support people into work. These include careers evenings for students to talk to hospital staff, a Careers Ambassadors programme to support RUH staff going in to local schools and colleges to support mock interviews and talk about their NHS career, virtual work experience to shine a spotlight on different roles, and the Project SEARCH supported internship programme for young people with a learning disability or autism. Our work experience programme received a gold award under the Work Experience Quality Standard, a national accreditation run by NHS England.

**Primary care services**

During 2023/24, the Trust continued to work closely with 22 Primary Care Networks across BSW to support them both in their short-term aim of making general practice financially sustainable and their longer-term goal of improving access and care. This work has this year included a focus on the RUH's relationship with Frome Medical Practice, the largest (by registered patient list) Practice within the RUH catchment. The RUH has run outpatient services at Frome for over 10 years, and in early 2024 agreed at the request of the Practice to take on responsibility for running the dedicated secondary care outpatient and theatre service at the Practice. In the short term this will allow us to consolidate our relationship with Frome and continue provision of vital secondary care services within Mendip. In 2024/25 we intend to develop further services at Frome, working hand in hand with primary care to deliver care closer to people's home.

**Community services**

In July 2016, Wiltshire Health and Care (a limited liability partnership (LLP) and joint venture created between Great Western Hospitals Foundation Trust, Salisbury Foundation Trust and the RUH) commenced its £40 million a year contract to deliver seamless and improved community services across Wiltshire. The RUH, along with our Acute Hospital Alliance partners Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust, are working with local third sector, end of life, primary care, community services and mental health services to consider how we can work together to support transformation of community services in future.

**Learning from best practice networks**

The RUH remains a member of NHS Quest and NHS Providers. These membership organisations retain a relentless focus on the sharing of best practice. Across both organisations, members work together to share challenges, benchmark, peer review and design innovative solutions to provide the best care possible for patients and staff. A small annual membership fee is paid by the Trust towards the running costs of these networks.

We are continuing roll out of our Improving Together methodology; this framework provides an operating framework through which we will deliver our Trust You Matter vision and strategy. As part of the BSW Acute Hospital Alliance, all three NHS Trusts in BSW have adopted the same methodology, and a key element of our work in 2023/24 has been building links between our respective improvement teams and collaborating on development and roll out of best practice within our respective Trusts.

**Health Innovation West of England**

The Government established Health Innovation Networks, previously known as Academic Health Science Networks (AHSNs), in 2013 as alliances between education, clinical research, informatics, innovation, training and education and healthcare delivery, with the goal of improving patient and population health outcomes by translating research into practice and developing and implementing integrated healthcare.

The RUH hosts and continues to work in partnership with Health Innovation West of England to explore new opportunities for collaboration and innovation, further improve patient safety and quality of care, and share best practice across the South West. A number of our clinical teams have been participating in specific work streams to support the rapid implementation of

innovation and service improvement and share best practice across the NHS, including roll out of the Supporting High impact users in Emergency Departments (SHarED) programme, recognised with at the 2023 HSJ Patient Safety Awards, at the RUH. Our work as part of the Maternity and Neonatal Patient Safety Network to improve safety and outcomes of maternal and neonatal care by reducing unwarranted variation and providing high quality healthcare experience to all women, babies and families was also noted by the CQC during their 2023 inspection of RUH Maternity services.

**Consultation with local groups and organisations**

New approaches to engagement through virtual platforms developed during the COVID-19 pandemic have informed much of our engagement work this year, for example the use of online patient engagement workshops to develop our thinking for a new Vulnerable Persons strategy, due to launch in 2024/25. We have also reinstated many of our previous activities, for example the face-to-face Annual General Meeting and Annual Members' Meeting in September 2024, which saw over 100 members of the public, Trust members and governors and local organisations come together to hear updates on key RUH projects and ask questions of our Board of Directors.

Our You Matter strategy puts the voice of our people at the heart of everything that we do. Our work with local partners plays a key role in this. For example, our maternity matrons run a quarterly forum with the BSW Maternity & Neonatal Voices Partnership and local birth doula's, antenatal teachers, hypnobirthing teachers and yoga teachers to provide communication within the wider birthing community, with a shared vision of personalised care and support for women and birthing people.  Within BSW Integrated Care System, we have sought feedback from patients and families who have recently been discharges from hospital on their experience, as part of a wider programme to improve the process of leaving hospital.

## Statement as to disclose to the auditor

The Board of Directors can confirm that each individual who was a Director at the time this report was approved has certified that:

- So far as the Director is aware, there is no relevant audit information of which the Trust's auditor is unaware and,
- The Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust auditor is aware of that information.

## Income Disclosures

Income from the provision of goods and services for the purposes of health services in England is greater than the income from the provision of goods and services for any other purpose for Royal United Hospitals Bath NHS Foundation Trust. Income was received from other sources including private patients and catering, and details of these are provided in the accounts. Any net surplus generated from these additional activities serves to enhance patient care and further knowledge and understanding of the conditions treated at the Trust.

## Joint ventures

The Trust has a one-third controlling interest in Wiltshire Health and Care LLP, in partnership with Salisbury NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust.

Wiltshire Health and Care LLP, from July 2016, became responsible for the delivery of adult community healthcare across Wiltshire for at least the next five years. The LLP has a separate Board, but strategic control of the organisation remains with the partners as detailed in the Members' Agreement signed by the three NHS Foundation Trusts.

The Trust provides financial services to Wiltshire Health and Care managed through a Service Level Agreement.

## Subsidiaries

### Sulis Hospital Bath Ltd

Sulis Hospital Bath Ltd, the limited liability company that runs Sulis Hospital, is a wholly owned subsidiary of the RUH. The Trust is the sole shareholder in the company, having acquired it from Circle Holdings in June 2021. The Board of Sulis Hospital Bath Ltd is chaired by Jeremy Boss, who was until 31 March 2023, the Vice Chair and Senior Independent Director of the RUH. Two of the other three directors, Simon Sethi and Andrew Hollowood also sit on the RUH Board. All three directors have declared their respective interests to both boards.

The RUH Board has established a committee, the Subsidiary Oversight Committee, to help ensure that the Trust's objectives in making the acquisition are being met, and to gain assurance around the hospital's performance, the quality of the care that it provides, that it is complying with its regulatory requirements and managing its finances appropriately.

## RUH Charitable Funds

The RUH Charitable Funds are managed and operated separately from the main services provided by the Trust. Income for the Charitable Funds are made up of donations, mainly from individuals and local organisations. The activities of the hospital's main charity, RUHX (formerly the Forever Friends Appeal), are focused on improving the environment within the hospital for staff and patients and supporting innovative developments not funded by the NHS. The financial position of the charity is reported within the Trust's accounts and forms part of the Group accounts.

## Remuneration Report

In accordance with the requirements of NHS England and NHS Improvement, this remuneration report consists of the following parts:

- An Annual Statement on remuneration
- The Senior Manager Remuneration Policy
- The Annual Report on remuneration

The following report details how the remuneration of senior managers is determined. A 'senior manager' is defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust'. This has been concluded to relate to the Executive and Non-Executive members of the Board of Directors as those responsible for the group as a whole.

### Annual Statement on Remuneration

### Chair of the Remuneration Committee's annual statement on remuneration

Upon authorisation as an NHS Foundation Trust on 1 November 2014, the Board of Directors established a Nominations and Remuneration Committee with responsibility for the nomination and selection of candidates for appointment as Chief Executive or Executive Directors, as well as in respect of issues concerning Executive remuneration.

The Nominations and Remuneration Committee is chaired by the Trust Chair and has delegated responsibility for the remuneration and terms of service for the Chief Executive and Executive Directors of the Trust. Its responsibility includes all aspects of salary, provision of other benefits, and arrangements for termination of employment and other contractual terms. The membership of the Committee consists of all the Non-Executive Directors. The Chief Executive and the Chief People Officer attend meetings of the Committee to provide advice but are not present during any discussions relating to their own remuneration.

The Committee is also responsible for agreeing the remuneration of the Chair of the Sulis Board. At present the other RUH Directors who sit on that Board are not separately remunerated for that role. The remuneration of the Sulis Hospital Director is agreed and set by the RUH Chief Executive in conjunction with the other members of the Sulis Board.

The Committee reviewed the salaries of the Executive Directors for 2023-24. Salaries are set in comparison with those given to holders of equivalent posts within the NHS.

The Committee works closely with the Chief Executive in reviewing each Executive Director's performance and the Chair advises the committee on the performance of the Chief Executive.

The Committee follow the Trust's Equality, Diversity, and Inclusion Policy as detailed within the Equality Report.

## 2023/24 decisions on remuneration

During 2023/24, the Nominations and Remuneration Committee recognised the annual pay increase for Very Senior Managers as laid out in guidance shared from NHS England by 5% with effect from 1 April 2023.

A new Executive Director post was created, and one Executive Director received an uplift in pay in 2023/24 in consideration of national benchmarking and guidance. The Committee noted that the tenure of any Executive taking on the Deputy Chief Executive role would be for a maximum period of two years.

The changes to the Trust's Executive team during 2023/24 were:

- Simon Sethi left his post as Chief Operating Officer in May 2023.
- Niall Prosser commenced a secondment as interim Chief Operating Officer in May 2023.
- Paran Govender was appointed as Chief Operating Officer in October 2023.
- Joss Foster's job title changed from Director of Strategy to Chief Strategic Officer in November 2023.
- Libby Walter's job title changed from Director of Finance to Chief Financial Officer in November 2023.
- Alfredo Thompson's job title changed from Director for People and Culture to Chief People Officer in November 2023.
- Andrew Hollowood was appointed as the Deputy Chief Executive in November 2023 for a two-year term.
- Christopher Brooks-Daw was appointed as Director of Governance and Chief of Staff in January 2024.
- Brian Johnson left his post as Director of Estates and Facilities in February 2024.

## Senior Managers' Remuneration Policy

With the exception of the Chief Executive and Executive Directors, all non-medical employees of the Trust are remunerated in accordance with the national NHS Agenda for Change pay structure. Medical staff are remunerated in accordance with national terms and conditions of service for doctors and dentists. The pay and terms and conditions for the Chief Medical Officer are determined by the national Consultant Contract and the associated Medical Terms and Conditions. An additional payment is made which reflects the additional responsibilities for the role of Chief Medical Officer.

The remuneration of the Chief Executive and Executive Directors is determined by the Board of Directors' Nominations and Remuneration Committee considering market levels, key skills, performance, and responsibilities. In reviewing remuneration, including making decisions about whether to pay the Chief Executive and any of the individual Executive Directors more than £150,000 per annum, as outlined in the guidance issued by the Cabinet Office, the Committee has regard to the Group's overall performance, delivery of agreed objectives, remuneration benchmarking data in relation to similar NHS Foundation Trusts and the wider NHS, and the

individual Director's level of experience and development of the role. However, the Trust has not directly consulted with the wider employee body in setting the remuneration policy for senior managers.

**Remuneration of Senior Managers (Executive Directors)**

The Board of Directors' Nomination and Remuneration Committee considers market levels, key skills, performance, and responsibilities. In reviewing remuneration, including making decisions about whether to pay the Chief Executive and any of the individual Executive Directors more than £150,000 per annum, as outlined in the guidance issued by the Cabinet Office, the Committee has regard to the Trust's overall performance, delivery of agreed objectives, remuneration benchmarking data in relation to similar NHS Foundation Trusts and the wider NHS and the individual Director's level of experience and development of the role.

*The pay, terms and conditions for the Chief Medical Officer are determined by the national Consultant Contract and the associated Medical Terms and Conditions. An additional payment is made which reflects the additional responsibilities for the role of Chief Medical Officer. The Chief Medical Officer is eligible to apply for discretionary performance-related pay under Medical Terms and Conditions.

| Pay component | Cost of Living uplift (annual) | Relevant Senior Managers |
|---|---|---|
| Basic pay, agreed through the Nominations and Remuneration Committee and benchmarked against the 'NHSI Guidance for pay for very senior managers.' | Application of nationally recommended uplift reviewed and determined by Nominations and Remuneration Committee. | All Executive Directors of the Trust including the Chief Executive. |

**Performance Assessment of Chief Executive and Executive Directors**

Individual performance is reviewed through the Trust's appraisal process to evaluate the extent to which the Chief Executive and Executive Directors have met their objectives and contributed to the delivery of the Trust's strategic objectives. The annual review comprises, where applicable, a cost-of-living uplift (offered in line with any guidance from NHS England) and, a review of national benchmarking pay data. The performance of the Chief Executive and Executive Directors is assessed on a continuing basis via formal appraisal and unsatisfactory performance may provide grounds for termination of contract.

Objectives for each Executive Director are set at the start of the financial year and are linked to the Trust's Vision as well as the agreed Breakthrough Objectives for that year. These SMART objectives are the performance measures for the individual Executives. Performance against these objectives is reviewed during the year and a quarterly progress update is provided to the Board in private session.

The Board of Directors' Nominations and Remuneration Committee met on 4 October 2023 to consider among other items the total remuneration package for the Chief Executive and

Executive Directors, taking account of the Senior Salaries Review Body's recommendation to apply a 5% increase for all Very Senior Managers (VSMs). The meeting was chaired by Alison Ryan, Chair, and was attended by Ian Orpen, Hannah Morley, Paul Fairhurst and Sumita Hutchison.

The Chief People Officer attended the meeting but withdrew during the discussion about Executive Directors' pay. The Deputy Head of Corporate Governance was in attendance and recorded the Committee's discussions and decisions.

### Remuneration of the Chair and Non-Executive Directors

Upon authorisation as an NHS Foundation Trust, the Council of Governors has established a Nominations and Remuneration Committee. This Committee is responsible for the appointment, remuneration and appraisal of the Trust Chair and Non-Executive Directors.

In 2023/24 there continued to be additional allowances for the Chairs of the Board committees and Senior Independent Director. The additional allowances reflect the continued complexities and challenges of the Group, particularly around the financial position and the creation of an integrated healthcare system.

The Non-Executive Directors are paid an annual allowance, together with responsibility allowances for specific roles as set out below:

- Base fee for all NEDs - £13,000
- Extra payment for Senior Independent Director (SID) - £1,500
- Extra payment for Chair of Audit and Risk Committee - £1,500
- Extra payment for Chair of the other Committees - £1,000 (only paid once even if a particular NED chairs more than one committee)
- Extra payment for Board Maternity Champion - £500 (only paid if the particular NED does not receive an extra payment as a Committee Chair).

Details of all directors' attendance at Board and Board Committee meetings are set out within the "Governance of the Trust" section of this report.

### Annual Report on Remuneration

### Service Contracts obligations

None of the current substantive Executive Directors is subject to an employment contract that stipulates a length of appointment. The appointment of the Chief Executive is made by the Non-Executive Directors and approved by the Council of Governors. The Chief Executive and Executive Directors have a permanent employment contract, and the contract can be terminated by either party with six months' notice. The contract is subject to normal employment legislation. Executive Directors are appointed by a committee consisting of the Chair, Chief Executive and Non-Executive Directors. The Trust's Constitution sets out the circumstances in which a Director will be disqualified from office and employment terminated.

The Service Contract for Non-Executive Directors is not an employment contract. Non-Executive Directors are appointed for an initial term of up to three years and are eligible for further terms of appointment of up to three terms or nine years in total. The Council of Governors is responsible for appointing, suspending, and dismissing the Chair and Non-Executive Directors as set out in the Trust's Constitution.

| Name | Role | Current term of office (commenced) | Notice Period (months) |
|---|---|---|---|
| Alison Ryan | Chair | 1 April 2019 | 3 |
| Nigel Stevens | Non-Executive Director | 1 April 2018 | 3 |
| Sumita Hutchison | Non-Executive Director | 4 September 2019 | 3 |
| Ian Orpen | Non-Executive Director | 7 September 2020 | 3 |
| Antony Durbacz | Non-Executive Director | 7 September 2020 | 3 |
| Paul Fairhurst | Non-Executive Director | 1 October 2023 | 3 |
| Hannah Morley | Non-Executive Director | 1 April 2023 | 3 |
| Paul Fox | Non-Executive Director | 1 April 2023 | 3 |
| Cara Charles-Barks | Chief Executive | 1 September 2020 | 6 |
| Libby Walters | Chief Financial Officer | 4 June 2018 | 6 |
| Joss Foster | Chief Strategic Officer | 30 July 2012 | 6 |
| Toni Lynch | Chief Nursing Officer | 1 May 2021 | 6 |
| Alfredo Thompson | Chief People Officer | 31 January 2022 | 6 |
| Andrew Hollowood | Chief Medical Officer & Deputy Chief Executive | 15 September 2022 | 6 |
| Paran Govender | Chief Operating Officer | 2 October 2023 | 6 |
| Christopher Brooks-Daw* | Director of Governance & Chief of Staff | 5 January 2024 | 6 |
| Brian Johnson* | Director of Estates and Facilities | left February 2024 | 6 |

*Indicates non-voting members of the Board of Directors

## Disclosures in accordance with the Health and Social Care Act

### Director and Governor expenses etc

Information regarding Director and governor expenses during the reporting period is outlined below:

### Directors' expenses

£ 6,292.53 worth of taxable expenses were paid to 9 Executive Directors and £1,381.78 to 4 Non-Executive Directors during the reporting period. The full list of Executive and Non-Executive Directors who served during 2023/24 is set out within the Accountability Report.

£4,000 worth of taxable expenses were paid to 6 Executive Directors and £1,300 to 4 Non-Executive Directors during the period 1 April 2022 to 31 March 2023.

### Governors' Expenses

Governors are not remunerated but are entitled to claim expenses for costs incurred whilst undertaking duties for the Trust as a Governor (for example, travel expenses to attend Council of Governors' meetings). A total of £1,374.53 was paid to 13 Governors in the period from 1 April 2023 – 31 March 2024.

£921.10 was paid to 11 out of the 25 governors in the period 1 April 2022 to 31 March 2023.

### Senior Managers' Remuneration (subject to audit)

The definition of "Senior Managers" is 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Royal United Hospitals Bath NHS Foundation Trust.' This is exclusive to the Chair, Non-Executive Directors and Executive Directors.

## Salary and Pension Entitlement

| Remuneration for Senior Managers for 2023-24: | Salary and Fees (bands of £5,000) | Salary and fees for clinical duties (bands of £5,000) | Annual performance related bonuses (bands of £5,000) | Pension related benefits (bands of £2,500) | Total (bands of £5,000) |
|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| Cara Charles-Barks<br>Chief Executive | 230 - 235 | - | - | 0 - 2.5 | 230 - 235 |
| Libby Walters<br>Chief Financial Officer | 170 - 175 | - | - | 0 - 2.5 | 170 - 175 |
| Andrew Hollowood<br>Chief Medical Officer | 195 - 200 | - | - | 0 - 2.5 | 195 - 200 |
| Jocelyn Foster<br>Chief Strategic Officer | 140 - 145 | - | - | 0 - 2.5 | 140 - 145 |
| Antonia Lynch<br>Chief Nurse | 145 - 150 | - | - | 0 - 2.5 | 145 - 150 |
| Alfredo Thompson<br>Chief People Officer | 135 - 140 | - | - | 7.5 - 10 | 145 - 150 |
| Brian Johnson<br>Director of Estates and Facilities (until 29 February 2024) | 120 - 125 | - | - | 30 - 32.5 | 150 - 155 |
| Simon Sethi<br>Chief Operating Officer (until May 2023) | 15 – 20 | - | - | 0 - 2.5 | 15 – 20 |
| Niall Prosser<br>Interim Chief Operating Officer (from May – Oct 23) | 45 - 50 | - | - | 75 - 77.5 | 120 - 125 |
| Paran Govender<br>Chief Operating Officer (from 2 October 2023) | 75 - 80 | - | - | 57.5 - 60 | 135 - 140 |
| Christopher Brooks-Daw<br>Director of Governance & Chief of Staff (from 5 January 2024) | 25 - 30 | - | - | 5.0 – 7.5 | 30 - 35 |
| | | | | | |
| Alison Ryan<br>Chair | 45 - 50 | - | - | - | 45 - 50 |
| Nigel Stevens<br>Non-Executive Director | 15 – 20 | | | | 15 – 20 |
| Sumita Hutchinson<br>Non-Executive Director | 10 - 15 | - | - | - | 10 - 15 |
| Ian Orpen<br>Non-Executive Director | 10 - 15 | - | - | - | 10 - 15 |
| Antony Durbacz<br>Non-Executive Director | 10 - 15 | - | - | - | 10 - 15 |
| Paul Fairhurst<br>Non-Executive Director | 10 - 15 | - | - | - | 10 - 15 |
| Hannah Morley<br>Non-Executive Director | 10 - 15 | - | - | - | 10 - 15 |
| Paul Fox<br>Non-Executive Director | 10 - 15 | - | - | - | 10 - 15 |

- Hannah Morley was appointed as Non-Executive Director from 1 April 2023.
- Paul Fox was appointed as Non-Executive Director from 1 April 2023.
- Simon Sethi left the role of Chief Operating Officer on 14 May 2023.
- Niall Prosser was appointed as Interim Chief Operating Officer on 15 May 2023, prior to this, Niall was Deputy Chief Operating Officer. This interim opportunity ended on 1st October 2023.
- Paran Govender was appointed as Chief Operating Officer from 2nd October 2023.
- Andrew Hollowood became Deputy Chief Executive on 14 November 2023.
- Christopher Brooks-Daw was appointed Director of Governance & Chief of Staff from 5 January 2024.
- Brian Johnson left the Trust on 29 February 2024.

There were no taxable benefits paid to Directors in the year.

There is no additional benefit that will become receivable by a Director in the event that a senior manager retires early.

Andrew Hollowood received an additional responsibility allowance of £10k per annum (pro-rata from 1 November 2023) in the role of Deputy Chief Executive. This will be for a two-year period until 31 October 2025.

Remuneration of 0.4 WTE was received from Salisbury NHS Foundation Trust for the Directors of Estates and Facilities during 2023/24, in recognition of shared Director.

No severance payments were made within the year.

In considering senior manager pay, the Nominations and Remuneration Committee is mindful of the content of the Trust's Equality, Diversity and Inclusion Policy which clearly articulates the Trust's goal of creating a workplace in which all staff feel valued. One of the ways by which the Committee seeks to ensure progress towards realising this goal in the context of senior manager pay is testing the impact that such pay has on the narrowing or widening of the gender pay gap. The Trust publishes its audit of this gap each year, and the Committee ensures that the setting of senior manager pay does not hamper efforts to narrow the gender pay gap.

## Remuneration 2022/23

| Remuneration for Senior Managers for 2022-23: | Salary and Fees (bands of £5,000) | Salary and fees for clinical duties (bands of £5,000) | Annual performance related bonuses (bands of £5,000) | Pension related benefits (bands of £2,500) | Total (bands of £5,000) |
|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| Cara Charles-Barks<br>Chief Executive | 220-225 | - | - | 52.5-55 | 270-275 |
| Libby Walters<br>Director of Finance & Deputy Chief Executive | 165-170 | - | - | 37.5-40 | 205-210 |
| Bernie Marden<br>Medical Director (departed 01/09/2022) | 40-45 | 35-40 | - | 25-27.5 | 105-110 |
| Richard Graham<br>Acting Chief Medical Officer (01/09/2022 – 31/12/2022) | 50-55 | 10-15 | - | 37.5-40 | 105-110 |
| Jocelyn Foster<br>Director of Strategy | 135-140 | - | - | 32.5-35 | 165-170 |
| Brian Johnson<br>Director of Estates and Facilities | 125-130 | - | - | 30-32.5 | 155-160 |
| Simon Sethi<br>Chief Operating Officer | 125-130 | - | - | 35-37.5 | 165-170 |
| Antonia Lynch<br>Chief Nurse | 135-140 | - | - | 32.5-35 | 170-175 |
| Alfredo Thompson<br>Director for People and Culture | 130-135 | - | - | 7.5 - 10 | 145-150 |
| Andrew Hollowood<br>Chief Medical Officer (started 14/11/2022) | 45-50 | 20-25 | - | 5-7.5 | 75-80 |
| Alison Ryan<br>Chair | 45-50 | - | - | - | 45-50 |
| Jeremy Boss<br>Non-Executive Director | 15-20 | - | - | - | 15-20 |
| Nigel Stevens<br>Non-Executive Director | 10-15 | - | - | - | 10-15 |
| Sumita Hutchinson<br>Non-Executive Director | 10-15 | - | - | - | 10-15 |
| Anna Mealings<br>Non-Executive Director (left 31/10/2022) | 10-15 | - | - | - | 10-15 |
| Ian Orpen<br>Non-Executive Director | 10-15 | - | - | - | 10-15 |
| Antony Durbacz<br>Non-Executive Director | 10-15 | - | - | - | 10-15 |
| Paul Fairhurst<br>Non-Executive Director (started 01/10/2022 | 10-15 | - | - | - | 10-15 |

- Bernie Marden left the Trust on 1 September 2022.
- Richard Graham was appointed as Interim Chief Medical Officer on 1 September 2022 until 31 December 2022.
- Paul Fairhurst was appointed as Non-Executive Director from 1 October 2023.
- Anna Mealings left the Trust on 31 October 2022.
- Andrew Hollowood was appointed as Chief Medical Officer on 14 November 2022.
- Jeremy Boss left the Trust on 31 March 2023.

There were no taxable benefits paid to Directors in the year.

There is no additional benefit that will become receivable by a director in the event that that senior manager retires early.

No member above received remuneration for additional duties. No remuneration was received from another body and no severance payments were made within the year.

## Pension Benefits

| Pension for Senior Managers for 2023-24: | Real increase in pension at pension age (bands of £2,500) | Real increase in pension lump sum at pension age (bands of £2,500) | Total accrued pension at pension age at 31 March 2024 (bands of £5,000) | Lump sum at pension age, related to accrued pension at 31 March 2024 (bands of £5,000) | Cash Equivalent Transfer Value at 1 April 2023 | Real increase in Cash Equivalent Value Transfer | Cash Equivalent Transfer Value at 31 March 2024 | Employer's Contribution to Stakeholder Pension |
|---|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Cara Charles-Barks Chief Executive | 0 – 2.5 | 52.5 - 55 | 45 – 50 | 110 – 115 | 779 | 174 | 982 | 30 |
| Libby Walters Chief Financial Officer | 0 – 2.5 | 27.5 - 30 | 55 - 60 | 155 - 160 | 1,152 | 120 | 1,293 | 22 |
| Andrew Hollowood Chief Medical Officer | 0 – 2.5 | 20 - 22.5 | 85 - 90 | 240 - 245 | 1,929 | 116 | 2,071 | 28 |
| Jocelyn Foster Chief Strategic Officer | 0 – 2.5 | 32.5 - 35 | 20 - 25 | 55 - 60 | 476 | 64 | 557 | 19 |
| Antonia Lynch Chief Nurse | 0 – 2.5 | 30 – 32.5 | 45 - 50 | 130 - 135 | 1,013 | 136 | 1,168 | 19 |
| Alfredo Thompson Chief People Officer | 0 – 2.5 | 0 – 2.5 | 35 - 40 | 0 - 5 | 417 | 108 | 543 | 20 |
| Brian Johnson Director of Estates and Facilities * | 0 – 2.5 | 0 – 2.5 | 10 - 15 | 0 - 5 | 130 | 38 | 189 | 18 |
| Simon Sethi Chief Operating Officer * | 0 – 2.5 | 2.5 - 5 | 30 - 35 | 80 - 85 | 467 | 11 | 580 | 3 |
| Niall Prosser Interim Chief Operating Officer * | 2.5 - 5 | 7.5 - 10 | 30 - 35 | 85 - 90 | 417 | 61 | 593 | 7 |
| Paran Govender Chief Operating Officer * | 2.5 – 5 | 5 – 7.5 | 40 - 45 | 110 - 115 | 767 | 56 | 901 | 11 |
| Christopher Brooks-Daw Director of Governance & Chief of Staff * | 0 – 2.5 | 0 – 2.5 | 20 - 25 | 30 - 35 | 411 | 4 | 446 | 4 |

*Not in post for full year

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

### Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

### Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

### Statement of consideration of employment conditions elsewhere in the Trust

Pay and conditions of employees are considered when setting the remuneration policy for senior managers. The nationally recommended annual cost of living allowance for NHS Very Senior Managers (executive directors) is the figure that is considered by the Nominations and Remuneration Committee. Executive pay does not include annually agreed increments or pay stops – spot salaries for executives are supported, where applicable, by non-consolidated allowances.

**Fair Pay Multiple – this is subject to audit**

NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration for the highest paid Director in the Royal United Hospitals Bath NHS Foundation Trust for the financial year 2023-24 was £230,000 - £235,000 (2022-23 £220,000 - £225,000). This is a change between years of 5.00% (2022-23 4.88%).

Total remuneration includes salary, non-consolidated performance-related pay and benefits in kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2023-24 was from £27 to £462,564 (2022-23 £26 to £317,273). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 7.98%. 12 employees received remuneration in excess of the highest-paid director in 2023-24 (2022-23 7).

| | 2022/23 | 2023/24 | %age difference |
|---|---|---|---|
| Salary of highest paid director | £220,351.51 | £231,369.96 | 5.0 |
| Bonus of the highest paid director | £ - | £ - | 0.0 |
| Total of annualised pay – the highest paid director / FTE employees | £48,734.29 | £52,621.87 | 7.98 |
| Total of performance pay and bonus' – highest paid director / FTE employees | £ - | £ - | 0.0 |

Highest Paid Director Bonus – No Director bonus payments were made in 2023-24.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

| 2023/24 | 25th Percentile | Median | 75th Percentile |
|---|---|---|---|
| Salary component of pay | £22,131.84 | £28,031.36 | £37,350.00 |
| Total pay and benefits excluding pension benefits | £27,288.99 | £38,106.35 | £50,056.00 |
| Pay and benefits excluding pension: pay ratio for highest paid director (%) | 8.48 | 6.07 | 4.62 |

| 2022/23 | 25th Percentile | Median | 75th Percentile |
|---|---|---|---|
| Salary component of pay | £18,912.43 | £25,933.41 | £34,380.12 |
| Total pay and benefits excluding pension benefits | £24,997.43 | £35,255.33 | £47,293.98 |
| Pay and benefits excluding pension: pay ratio for highest paid director (%) | 8.81 | 6.25 | 4.66 |

**Payments for loss of office**

There have been no payments made to any senior manager during 2022-23 or 2023-24 for loss of office. Any compensation payable for loss of office is conducted under the terms and conditions of the appropriate contract of employment.

**Payments to past senior managers (on exit payments)**

There were no payments to past senior managers during the reporting period 2023-24.

**Cara Charles-Barks**
**Chief Executive (Accounting Officer)**
**27 June 2024**

## Staff report

### Analysis of staff numbers

An analysis of average 2023/24 staff numbers for the group is outlined below:

| Group | | | | | | |
|---|---|---|---|---|---|---|
| | Permanent number | Other number | 2023/24 total number | Permanent Number | Other Number | 2022/23 total number |
| Medical and dental | 732 | 8 | **740** | 577 | 18 | 595 |
| Ambulance staff | 4 | 1 | **5** | 2 | 1 | 3 |
| Administration and estates | 916 | 114 | **1,030** | 845 | 123 | 968 |
| Healthcare assistants & other support staff | 1,577 | 133 | **1,710** | 1,570 | 153 | 1,723 |
| Nursing, midwifery & health visiting staff | 1,788 | 166 | **1,954** | 1,611 | 175 | 1,786 |
| Nursing, midwifery & health visiting learners | - | - | **-** | - | - | - |
| Scientific, therapeutic, and technical staff | 522 | 12 | **534** | 492 | 12 | 504 |
| Healthcare science staff | 159 | 2 | **161** | 151 | 2 | 153 |
| Social care staff | - | - | **-** | - | - | - |
| Other | - | - | **-** | - | 7 | 7 |
| **Total average numbers** | **5,698** | **436** | **6,134** | **5,248** | **491** | **5,739** |
| Of which: Number of employees (WTE) engaged on capital projects | 14 | 3 | **17** | 13 | 2 | 15 |

## Analysis of staff costs for 2023/24

| | Permanent £000 | Other £000 | 2023/24 total £000 | Permanent £000 | Other £000 | 2022/23 total £000 |
|---|---|---|---|---|---|---|
| Salaries and wages | 276,738 | 679 | **277,417** | 256,950 | 598 | 257,548 |
| Social security costs | 28,950 | - | **28,950** | 26,092 | - | 26,092 |
| Apprenticeship levy | 1,363 | - | **1,363** | 1,166 | - | 1,166 |
| Employer's contributions to NHS pension scheme | 44,408 | - | **44,408** | 39,640 | - | 39,640 |
| Pension cost - other | 71 | - | **71** | 99 | - | 99 |
| Other post-employment benefits | - | - | **-** | - | - | - |
| Other employment benefits | - | - | **-** | - | - | - |
| Termination benefits | - | - | **-** | - | - | - |
| Temporary staff | - | 10,113 | **10,113** | - | 14,192 | 14,192 |
| NHS charitable funds staff | 892 | - | **892** | 767 | | 767 |
| **Total gross staff costs** | **352,422** | **10,792** | **363,214** | **324,714** | **14,790** | **339,504** |
| Recoveries in respect of seconded staff | - | - | **-** | - | - | - |
| **Total staff costs** | **352,422** | **10,792** | **363,214** | **324,714** | **14,790** | **339,504** |
| Of which: Costs capitalised as part of assets | 940 | 832 | **1,772** | - | 1,153 | 1,153 |

## Sickness absence data

| Figures Converted by DH to Best Estimates of Required Data Items | | | Statistics Produced by NHS Digital from ESR Data Warehouse | | |
|---|---|---|---|---|---|
| Average FTE 2023 | Adjusted FTE days lost to Cabinet Office definitions | | FTE - days available | FTE-Days lost to sickness absence | Average sick days per FTE |
| 5,654 | 55,944 | | 2,063,658 | 90,754 | 9.9 |

### NHS Sickness Absence Figures for NHS 2023-24 Annual Report and Accounts

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse

Period covered: January to December 2023

Data items: ESR does not hold details of the planned working/non-working days for employees, so days lost and days available are reported based upon a 365-day year. For the Annual Report and Accounts the following figures are used:

The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.

The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.

The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

**Staff Turnover**

Information on staff turnover can be found via NHS workforce figures published by NHS Digital and can be accessed via this link: NHS workforce statistics - NHS Digital

**Staff policies and actions applied during 2023/24**

The People Plan was agreed by the RUH Board in July 2022 and outlines the people strategy and agenda for the next three to five years, with refreshes as required. Throughout 2023/2024 the People Directorate has restructured to align resources to deliver the People Plan.
Within the People Plan there are three main themes: Culture, Capability and Capacity. Each theme has three associated programmes of work, with two further foundational programmes of work supporting these.

The People Plan is the primary vehicle through which the Directorate supports the organisation to manage and mitigate workforce risk.

**People Plan Portfolio**

The People Plan, as a portfolio of work, has been captured in eleven programmes, spanning a three-to-five-year period, with associated projects. The eleven programmes are:

1. Foundations (incorporating Basics Matter).
2. Restorative, Just and Learning.
3. Culture: Employee Experience.
4. Culture: Equality, Diversity, and Inclusion.
5. Culture: Leadership
6. Capability: Wellbeing
7. Capability: Learning and Development.
8. Capability: Workforce Planning.
9. Capacity: Talent Acquisition.
10. Capacity: Temporary Workforce and Workforce Systems
11. Capacity: Improvement; workforce cost and productivity.

Programme governance is managed through the People Programme Board and People Committee.

## The people we work with

In this financial year, turnover has decreased, and staff vacancies have fallen. Agency and overtime spend have reduced considerably through the Temporary Workforce and Workforce Systems Programmes.

Our Basics Matter projects are prompted by employee feedback through the Staff Survey, the Culture Change Team, the Employee Networks, and direct feedback. Colleagues told us how important nutrition is to them, food and drink initiatives featured heavily in our Basics Matter Programme this year.

The Dignity at Work programme has increased the reporting of violence, aggression, harassment, and bullying, and will continue to do so as the policy becomes embedded.

As part of our productivity improvement work, we launched a new medical job planning system (L2P). A vacancy control process was introduced, improving the governance around requests for vacancies, overtime, bank and change in hours.

The first cohort of our positive action programme called Routes to Success launched, aimed at global majority colleagues (21 successfully completed the programme). We have seen increased career progression for colleagues from the global majority.

Our Anti-Racism statement went live, following engagement work with the organisation and Board, with each Board member having an EDI objective.

Staff networks have been re-established; we now have five active networks.

Work continued with our compassionate leadership approach. The launch of the You Matter Leadership programme aimed at anyone reporting to Executive and other senior managers.

Our well-being work focussed on prevention, supporting people to avoid burnout. The occupational health team also delivered the 3rd best results nationally for vaccination uptake.

There has been a focus on 'building the pipeline', increasing the numbers of Trainee Nurse Associates and Registered Degree Nurse Apprenticeships.

### Gender Analysis

A breakdown at the year end of the number of each gender who were:

- Directors
- Other Senior Managers
- Employees

**Position as at 31 March 2024**

| | Female | Male | Total |
|---|---|---|---|
| Directors | 5 | 3 | **8** |
| Other Senior Managers (band 8A+) | 71 | 41 | **112** |
| Employees | 4,815 | 1,552 | **6,367** |
| **Total** | 4,891 | 1,596 | **6,487** |

## Staff Survey

The National NHS Staff Survey is the most substantial insight into staff engagement and experience that we have, and it enables us to benchmark our progress with developing our culture at the RUH with other Trusts.

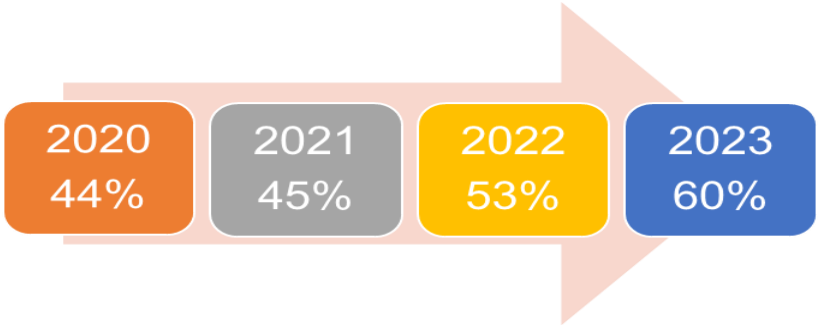
As an organisation, we have a target to be in the top 3 nationally for “recommended as a place to work” as there is a direct link between this metric and high patient safety and care quality outcomes.

## NHS Staff Survey 2023 – Summary of performance

The NHS Staff Survey aligns with the seven elements of the NHS People Promise and is a key measure of staff engagement.

All staff were invited to complete the annual NHS Staff Survey in autumn 2023 and 60% responded an improvement of 7% compared to 2022. Global Majority colleagues account for 19.2% of the total response rate (up 4% from last year).

The last four years has seen an increased trajectory of response rates:

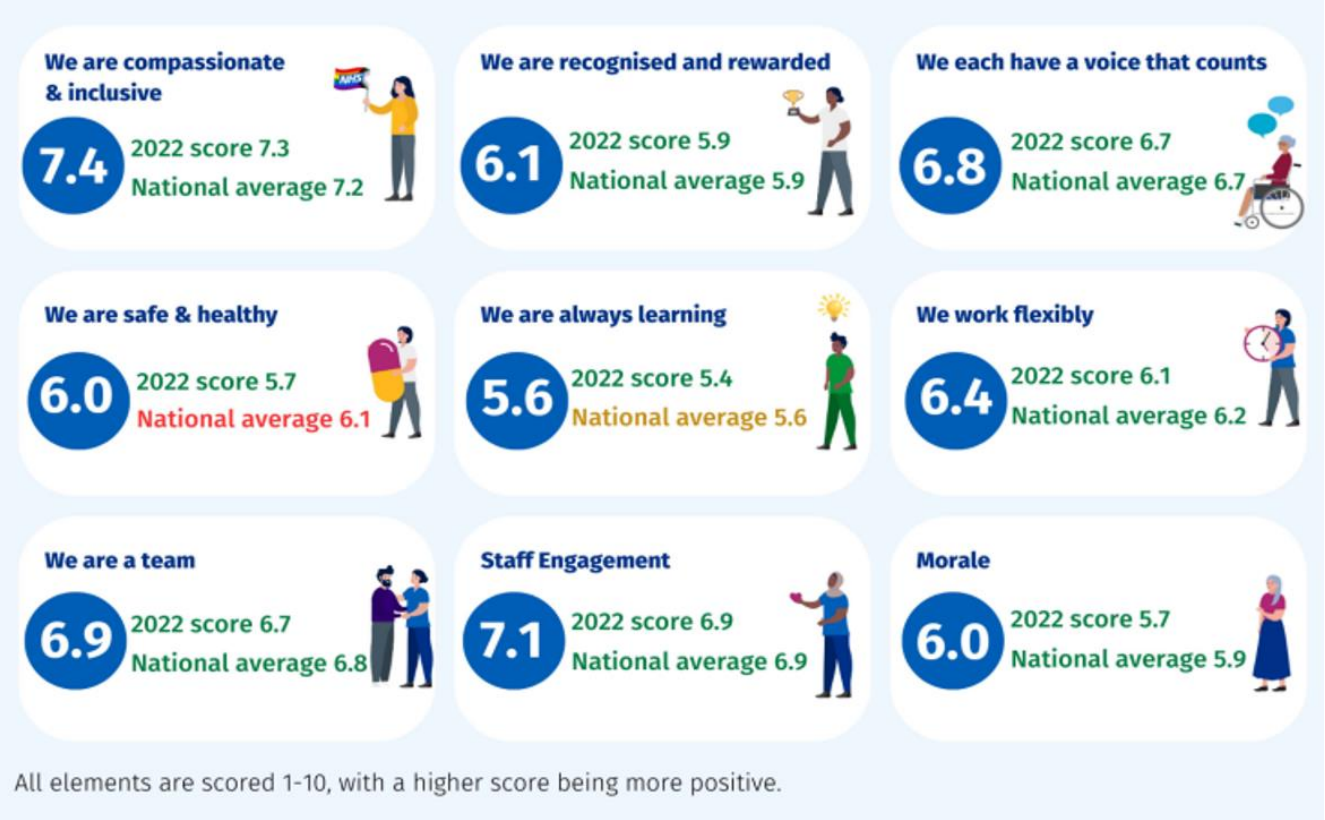



Our response rate demonstrates a picture of improving engagement, now 14% higher than the average for comparable organisations.

The following table outlines our scores against the People Promise Themes compared to 2022:

| RUH scores against People Promise themes | | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| PP1 | We are compassionate and inclusive | 7.4 | 7.3 | **7.4** |
| PP2 | We are recognised and rewarded | 6.0 | 5.9 | **6.1** |
| PP3 | We each have a voice that counts | 6.8 | 6.7 | **6.8** |
| PP4 | We are safe and healthy | 5.8 | 5.7 | **6.0** |
| PP5 | We are always learning | 5.3 | 5.4 | **5.6** |
| PP6 | We work flexibly | 6.1 | 6.1 | **6.3** |
| PP7 | We are a team | 6.7 | 6.7 | **6.9** |
| E_4 | Staff Engagement | 7.0 | 6.9 | **7.1** |
| M_4 | Morale | 5.8 | 5.7 | **6.0** |

The RUH scores higher than the national average in seven out of the nine themes:




**The story of the 2023 staff survey**

**Recommended as a place to work and receive care:**

People are telling us that, for the most part, the RUH is patient centred, and care orientated (77%) and generally acts on concerns when they are raised by patients (70%). People can also see how their work makes a positive difference to patient wellbeing (88%).

68% of us would recommend it as good place to work, and a great place to receive care and treatment (71%), yet over half of us are toying with the idea of leaving (53%), even though it is probably unlikely that we will act on that (18%/12%).

Over half of us look forward to coming to work, and a much higher percentage feel enthusiastic about our roles (71%) and trusted to carry out our duties to a high standard (91%), working within clearly defined responsibilities (89%).

**Demands, recognition, value, and time:**

It can be hard to meet conflicting demands (58%) and there continues to be a strong perception that we do not have enough staff (71%).

Scores were fairly neutral in terms of whether we offer appropriate recognition and value, and there remains widespread dissatisfaction about levels of pay (only 29% of us believe we are sufficiently remunerated).

Many feel that we impose (or have imposed upon us) unrealistic time pressures (43% aren't sure about whether the time pressures are realistic or not, or perhaps they are reflecting that this varies over time), although our efforts to promote work-life balance are becoming more visible (49%).

**Working hours, overwork, and related issues:**

41% of us work additional paid hours, whilst 53% regularly work additional unpaid hours (63% in Corporate, 62% in Family and Specialist Services Division (FASS), and 40% of respondents reported having felt unwell due to work stress.

Over half of us sometimes come to work despite not feeling very well.

However, pressure to overwork, or work when not feeling well does not seem to come from managers, with most people feeling able to speak to their managers about work stress and related health concerns.

Our people reflect that they often find the work emotionally exhausting, frustrating, and tiring.

**Teams and colleagues:**

In general people feel a sense of belonging within their teams, and we enjoy working with our colleagues (84%), we generally understand each other's roles (73%), feel respected (74%), and feel a strong personal attachment to the team (67%).

People have slightly less confidence in how this aids effectiveness, conflict resolution and inter-team collaboration.

Our colleagues are kind, encouraging, appreciative and generally promote wellbeing. People tend to like their managers and find them supportive and encouraging.

**Working hours, overwork, and related issues:**

We need to do more to ensure (and demonstrate that) we act fairly in relation to career progression, although 74% of respondents felt that individual differences were generally respected.

People reported having had an annual appraisal but reflected that the experience had not necessarily made any real positive impact how they undertake their roles, overcome obstacles, or feel valued.

Having significantly improved our digital capability around appraisals, there are clear indications that central support is needed to improve the quality and meaningfulness of the appraisal conversation.

**Incidents, violence, and aggression and raising concerns:**

37% of us witnessed near misses, and only 40% of us feel confident that we'd be treated fairly in the event of a near miss.

For the most part experiences of physical violence from anyone (managers, colleagues, patients, or members of the public) are very rare, although still far more frequent than we would want. Whilst we have seen improvements in reporting of violence, still only 65% of those who experience it report it.

Our people feel slightly more confident to raise concerns about unsafe clinical practice (70%, or general concerns 65%), than they do about the organisation's willingness or ability to address such concerns (56% clinical concerns / 51% general concerns).

**Developing potential, making suggestion and decisions:**

59% of us feel supported to develop our potential, and there are clear indications that this percentage would be much higher if we improved the frequency and quality of appraisal and supervision conversations.

Respondents reflected that the organisation does not always offer us challenging work, yet they also felt that there were ample opportunities to improve skills and knowledge.

There are opportunities to show initiative and make suggestions, but fewer opportunities to make decisions affecting work.

**Key areas of focus:**

The general pattern of increasing engagement and improvement across the majority of metrics provides evidence for the effectiveness of projects and workflows aligned to the RUH People Plan.

**Specific areas for continuation are:**

- Civility and Kindness workstream is having an impact on how colleagues are communicating with each other and managers.
- Compassionate Leaders training and development sessions are well-received, and the quality of the conversation (in general) seems to be getting better.
- Programme 4: Equality, Diversity, and Inclusion (EDI) has increased engagement from members of the global majority.
- Dignity at Work Programme is increasing the reporting of violence, aggression, harassment, and bullying, and will continue to do so as the policy becomes embedded.

**Health and Wellbeing:**

- Reviewing the Health and Wellbeing offer (in relation to financial wellbeing and our use of Reward Gateway)
- Upgrade Health and Wellbeing Strategy to include creation of wellbeing hubs, use of charitable funds for wellbeing, and a broader Wellbeing at Work Programme

**Empowered Teams and Decision Making:**

- Review of central support for team development – impact measurement and evaluation of planned interventions
- Creation of self-service resources for teams (e.g., the TED tool), aimed at empowering decision making for greater effectiveness.

**Basics Matter:**

- Continued and ongoing support is required for the Basics Matter work, as perceptions that there is 'not enough' of something are likely to be linked to fundamental needs not being fully met (i.e., rest areas, staff taking breaks, financial support, health and wellbeing resources, staff recreational activity etc.)

Progress made on addressing challenges identified in the Staff Survey is monitored by the RUH People Plan Programme Group and People Committee, and through Divisional Performance Review Meetings (PRMs).

**Relevant union officials**

The total number of employees who were relevant union officials during 2023/24 was twenty-seven. The full-time equivalent employee number was 6117.

**Percentage of time spent on facility time during 2023/24**

| Percentage of time | Number of employees (2023/24) | Number of employees (2022/23) |
|---|---|---|
| 0-1% | 25 | 4 |
| 1-50% | 0 | 10 |
| 51-99% | 1 | 1 |
| 100% | 1 | 1 |
| **Total cost of facility time** | **£78,877** | **£98,759** |
| **Total pay bill** | **£343,000,000** | **£323,281,000** |
| **% of total pay bill spent on facility time** | **0.02%** | **0.03%** |

## Paid trade union activities during 2023/24

The time spent on paid trade union activities as a percentage of total paid facility time hours was 8.28% compared to 14.55% on 2022/23.

## Off payroll engagements

In accordance with the HM Treasury annual reporting guidance the Trust is required to report the number of off-payroll engagements, of more than £245 per day, that were in place as at 31st March 2024 (table 1); all off-payroll workers engaged at any point during the year ended 31 March 2024 (table 2); and any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024 (table 3). Table 4 shows the detail of the Exit package details for the Trust for the period, with the sole area of exit packages being contractual payments made in lieu of notice.

From April 2017, the Government has reformed the legislation associated with off-payroll payments so that public sector bodies are responsible for deducting and paying all employment taxes and national insurance contributions from the individuals concerned. As a result of this all off-payroll arrangements, irrespective of value, are assessed and steps taken to ensure that tax and national insurance is deducted correctly.

**Table 1: Highly paid off-payroll worker engagements as at 31 March 2024 earning £245 per day or greater**

| | 2023/24 Number | 2022/23 Number |
|---|---|---|
| Number of existing engagements as of 31 March 2024 | 175 | 162 |
| Of which, the number that have existed for: | | |
| Less than one year at time of reporting. | 23 | 21 |
| Between one and two years at time of reporting. | 18 | 13 |
| Between two and three years at time of reporting. | 11 | 11 |
| Between three and four years at time of reporting. | 9 | 12 |
| Four or more years at time of reporting. | 116 | 105 |

**Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2024 earning £245 per day or greater**

| | 2023/24 Number | 2022/23 Number |
|---|---|---|
| Number of off-payroll workers engaged during the year ended 31 March 2024 | 181 | 162 |
| Of which: | | |
| Number not subject to off-payroll legislation * | 76 | 32 |
| Number not subject to off-payroll legislation and determined as in-scope of IR35 * | 8 | 0 |
| Number subject to off-payroll legislation and determined as out of scope of IR35 * | 97 | 130 |
| Number of engagements reassessed for compliance or assurance purposes during the year | 0 | 0 |
| Number of engagements that saw a change to IR35 status following review | 0 | 0 |

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

**Table 3: Off-payroll board member/senior official engagements**

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024.

| | 2023/24 Number | 2022/23 Number |
|---|---|---|
| Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year | 0 | 1 |
| Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements. | 40 | 37 |

There were no new off-payroll engagements of more than £245 per day for longer than 6 months entered into or in respect of Board members or senior officials with significant financial responsibility during the year ended 31 March.

**Staff Exit Packages (figures subject to audit)**

Staff exit packages include those made under nationally agreed arrangements or local arrangements for which Treasury approval is required. This does not include retirements due to ill health. Figures for 2023-24 are included in this table, the 2022-23 figure is in brackets.

| | Number of compulsory redundancies | Number of other departures agreed | Total number of exit packages |
|---|---|---|---|
| **Exit package cost band** | | | |
| <£10,000 | 1 (2) | 23 (7) | 24 (9) |
| £10,000 - £25,000 | 1 (0) | 8 (0) | 9 (0) |
| £25,001 - 50,000 | 3 (2) | 1 (0) | 4 (2) |
| £50,001 - £100,000 | 4 (0) | 0 (0) | 4 (0) |
| £100,001 - £150,000 | 1 (0) | 0 (0) | 1 (0) |
| >£150,001 | 0 (0) | 0 (0) | 0 (0) |
| **Total number of exit packages by type** | **10 (4)** | **32 (7)** | **42 (11)** |
| **Total cost (£)** | **£558,000 (£147,000)** | **£252,000 (£31,000)** | **£810,000 (£178,000)** |

The compulsory redundancies within the group were as a result of restructures. 8 of the 10 compulsory redundancies were from a hosted organisation: Health Innovation West of England.

**Exit packages: other (non-compulsory) departure payments**

| | 2023 - 2024 | | 2022 - 2023 | |
|---|---|---|---|---|
| | Payments agreed number | Total value of agreements £0 | Payments agreed number | Total value of agreements £0 |
| Voluntary redundancies including early retirement contractual costs. | 0 | 0 | 0 | 0 |
| Mutually agreed resignations (MARS) contractual costs. | 0 | 0 | 0 | 0 |
| Early retirements in the efficiency of the service contractual costs. | 0 | 0 | 0 | 0 |
| Contractual payments in lieu of notice. | 32 | 252 | 7 | 31 |
| Exit payments following Employment Tribunals or court orders. | 0 | 0 | 0 | 0 |
| Non-contractual payments requiring MHT approval. | 0 | 0 | 0 | 0 |
| **Total** | **32** | **252** | **7** | **31** |

| | |
|---|---|
| Payments for loss of office | £0 |
| Payments to past senior managers | £0 |

**Equality Report**

Our Equality, Diversity, and Inclusion Policy is to deliver equality of employment opportunity and experience consistently and effectively at work. Our inclusion agenda is one of our highest priorities.

Our policies aim to ensure that no job applicant or employee receives less favourable treatment, where it cannot be shown to be justifiable, on the grounds of:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Our performance against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) improved in 2023/24.

Equality and Health Inequality Assessments are undertaken when writing or refreshing policies. Work is ongoing to further enhance our Equality and Quality Impact Assessments for all decision making and strategic projects. Our Staff Networks review and comment on policies and decisions as part of the consultation process.

We have six staff networks:

- REACH (Race, Ethnicity and Cultural Heritage)
- Enable (staff with disabilities)
- LGBTQ+ (lesbian, gay, bisexual, and transgender)
- Women's Network (includes Menopause support group)
- Men's Network
- Armed Forces Network

The networks also help us to increase inclusivity through celebratory events such as History Months, Pride, and awareness days, providing opportunities for staff to both educate and share their lived experience with all our staff.

We have complied with the reporting requirements for equality and diversity, reports, and action plans for the Workforce Race Equality Standard, (WRES), Workforce Disability Equality Standard (WDES), and Gender Pay reports can be viewed via our Internet pages. These reports provide a focus for the Equality, Diversity, and Inclusion agenda, which forms a significant part of our people plan.

Our overall equality objectives for the next 12 months are in line with the NHS People Plan and 6 High Impact EDI Actions:

- To create safe, inclusive, diverse teams and working environments in which people feel they belong, are valued, and can thrive.
- To promote and design-in diversity at all levels, advocating the benefits of this both internally and to our wider community.
- To reduce occurrences of discrimination, prejudice, abuse, and harassment based on difference across all organisational teams, structures, and systems.

**Gender pay**

The Trust has a legal duty to publish Gender Pay Gap information yearly by 30th March each year for the previous calendar year. We collected our data on 31st March 2023. The gender pay gap looks at both the mean and median average. We believe the median average is a more representative measure of the pay gap because it is not affected by outliers (a few individuals at the top or bottom of the range). Key findings are:

- The median pay gap between our male and female medical staff remains the organisation's largest difference in pay. It has increased further, continuing to be in favour of men. Male employees from the medical staff group are earning an average of £14.55 per hour more than their female colleagues. This is an increase of £2.35 compared to the 2022 median average and £4.84 more than 2021 median average.
- The medical and dental staff group is the only pay group that has an almost 50/50 split in gender representation. All other groups are majority female.

- The median pay gap for the whole organisation achieves parity, with the overall median pay gap at -0.16%, the median male hourly rate is £17.28, and the median female hours rate is £17.31.

In 2023 we set our goal to be for the NHS staff survey results to see an increase in the percentage of female staff that recommend the RUH as a place to work and feel satisfied with the level of pay in the 2023/24 staff survey.

We have seen those improvements with female staff's responses positively increasing across all areas compared with the 2022 staff survey, indicating an improvement in experience for female employees. There is a large increase in the percentage of female employees recommending the organisations as a place to work at the same rate as male employees. There is no significant difference between satisfaction of the level of pay between male and female employees.

| Survey Question: NHS Staff Survey 2022 results | Male | Female |
|---|---|---|
| Percentage satisfied with recognition for good work | 61% ▬ | 57% ↑ |
| Percentage satisfied with extent organisation values my work | 46% ↓ | 51% ↑ |
| Percentage satisfied with level of pay | 29% ↓ | 30% ↑ |
| Percentage satisfied with opportunities for flexible working patterns | 60% ↑ | 59% ↑ |
| Percentage would recommend organisation as place to work | 68% ↑ | 68% ↑ |

**Key:** ↑ results increased compared to 2022 staff survey; ↓ results decreased compared to 2022 staff survey; ▬ results did not change compared to 2022 staff suvey.

Gender pay discrepancies impacting the Medical and Dental workforce are nationally recognised (Independent Review into Gender Pay Gaps in Medicine 2020). For the RUH, this gap decreased over the course of 2021/22, but increased again in 2022/23.

Internally, we have recognised that more work needs to be done to address the inequalities experienced by female employees, which will be assisted in 2024/25 with significantly improved data quality and frequency. We will:

- Continue ongoing work with the RUH Medical Directorate to address the three core sources of discrepancy (basic salary, on-call payments and the LCEAs).
- Analyse and act on more granular detail related to staff pay, including interventions such as self-rostering to support significant life events, childcare provisions (such as dedicated drop-off points), annualised hours and term-time working.
- Review the reporting cycle for our gender pay gap snapshot in March 2024. We have also developed a dashboard that makes the gender pay gap data accessible and live for leaders to review on a regular basis.

## Governance of the Trust

### Role of the Board of Directors

The Board of Directors takes collective responsibility for the exercise of powers and the performance of the Trust. It is legally responsible for the delivery of high quality, effective services and for making decisions relating to the strategic direction, financial control, and performance of the Trust. The Board of Directors attaches great importance to ensuring that the Trust operates to high ethical and compliance standards. In addition, it seeks to adhere to the principles of good corporate practice as set out in the *Code of Governance for NHS provider Trusts* implemented April 2023.

The Board of Directors is responsible for:

- Determining the strategic direction of the Trust in consultation with the Council of Governors.
- Setting targets, monitoring performance, and ensuring that resources are used in the most appropriate way.
- Providing leadership for the Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed.
- Making sure the Trust performs in the best interests of the public, within legal and statutory requirements.
- Ensuring the quality and safety of healthcare services delivered by the Trust and applying principles and standards of quality governance set out by the Department of Health and Social Care, the Care Quality Commission and other relevant NHS bodies.
- Being accountable for the services provided and how public funds are spent and exercising those functions effectively, efficiently, and economically.
- Maintaining effective governance measures.
- Specific duties relating to audit, remuneration, clinical governance, charitable funds, and risk assurance.
- Compliance with the Trust's provider licence; and
- Compliance with the Trust's Constitution.

The Board of Directors meets bi-monthly in public and has a formal schedule of matters specifically reserved for its decision, including approving strategy, business plans and budgets, approving high value expenditure and contracts, regulations, and control, receiving and interrogating updates on operational and financial performance, quality of care, and people-related matters, annual reporting and monitoring how strategy is being implemented at an operational level. The Board of Directors delegates other matters to its sub-committees and to the Executive Directors and senior management.

### Board of Directors' focus

Annually, the content of agendas for the following 12 months is agreed to ensure there is a good order and appropriate timing to the management of the above responsibilities and functions.

Board meetings follow a formal agenda which were ordered under the three People groups around which the Trust's new vision is structured:

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

The Board of Directors has timely access to all relevant operational, financial, regulatory, and quality information. Upon appointment to the Board of Directors, all Directors (Executive and Non-Executive) are fully briefed about their roles and responsibilities. Ongoing development is provided collectively through Board Seminars which take place bi-monthly and Away Days as required. Individual training needs are assessed through the appraisal process and all Directors are able to attend regional and national events.

The Board of Directors develops its understanding of the views of Governors and members/stakeholders through a variety of mechanisms. This includes Executive and Non-Executive Director attendance at meetings of the Council of Governors and its working groups; attendance at joint Board and Council away day events, and participation in meetings involving members, such as at the Annual Members' Meeting. The Board continues to value the work of the Governors and is looking forward to reintroducing Governor Constituency meetings throughout 2024/25.

**Role of the Chair**

The Chair leads the Board of Directors and is responsible for ensuring that the Board works effectively together to enable the Trust to achieve its aims, that it focuses on the strategic development of the Trust and for ensuring that robust governance and accountability arrangements are in place, as well as evaluating the performance of the Board of Directors, its committees, and individual Non-Executive Directors. The Chair is also responsible for ensuring that the Council of Governors are able to fulfil their core role of holding the Non-Executive Directors to account for the performance of the Board.

**Role of the Non-Executive Directors**

Non-Executive Directors share the corporate responsibility for ensuring that the Trust is run efficiently, economically, and effectively. Non-Executive Directors use their expertise and experience to scrutinise the performance of management, monitor the reporting of performance and satisfy themselves as to the integrity of financial, clinical, and other information. The Non-Executive Directors also fulfil their responsibility for determining appropriate levels of remuneration for Executive Directors.

Non-Executive Directors are appointed on a three-year term of office. A Non-Executive Director can be reappointed for a second three-year term subject to the recommendation of the Council of Governors' Nominations and Remuneration Committee and approval by the Council of Governors. In exceptional cases, a Non-Executive Director's term of office can be extended beyond a second term on an annual case-by-case basis by the Council of Governors, subject to a formal recommendation from the Chair, satisfactory performance and in accordance with the needs of the Board of Directors. In any event, no Non-Executive Director may serve more than nine years in total.

Removal of the Chair or another Non-Executive Director requires the approval of three quarters of the members of the Council of Governors.

The Chair, other Non-Executive Directors, and the Chief Executive (except in the case of the appointment of a new Chief Executive) are responsible for deciding the appointment of Executive Directors. The Chair and other Non-Executive Directors are responsible for the appointment and removal of the Chief Executive, whose appointment requires approval by the Council of Governors.

**Board of Directors Completeness**

The Directors' summary biographies describe the skills, experience, and expertise of each Director. There is a clear separation of the roles of the Chair and the Chief Executive.

All of the Non-Executive Directors are considered to be independent in accordance with the NHS Foundation Trust Code of Governance. The Board considers that the Non-Executive Directors bring a wide range of business, commercial, strategic, and financial knowledge required for the successful direction of the Trust. All directors are equally accountable for the proper management of the Trust's affairs.

The balance, completeness and appropriateness of the Board of Directors is reviewed at least annually to ensure its effectiveness.

**Non-Executive Director Appointments**

The Council of Governors' Nomination Committee is a sub-committee of the Council of Governors and is responsible for approving the Non- Executive Director appointment process, including interview panel membership. The Committee also recommends Non-Executive Director appointments to the Council of Governors.

Two new Non-Executive Directors, Hannah Morley, and Paul Fox joined the Trust on 1st April 2023, their appointments were approved by the Council of Governors in March 2023.

On 13 July 2023 the Nomination and Remuneration Committee met to review the reappointments of Ian Orpen and Antony Durbacz, Non-Executive Directors for a further three-year term. Their reappointments were formally approved by the Council of Governors in September 2023.

In December 2023, the Chair asked the Council of Governors to consider re-appointing Nigel Stevens, Non-Executive Director for an additional one-year term. The Council of Governors reviewed his performance and agreed that despite serving 6 years already, it was in the best interests of the Trust to extend his term of office for a further 12-month period (1 April 2024 to 31 March 2025).

**Board evaluation and development**

Evaluation of the Chair's performance is led by the Senior Independent Director under the auspices of the Council of Governors' Nominations and Remuneration Committee, which is also responsible for evaluating the performance of the Non-Executive Directors. The Chief Executive's performance is evaluated by the Chair. The Chief Executive is responsible for

undertaking an evaluation of the performance of individual Executive Directors, the outcome of which is reported to the Board of Directors' Nominations and Remuneration Committee. Each Committee of the Board of Directors undertakes an annual self-assessment and reports the outcome to the Board of Directors.

The Board of Directors undertakes an annual development review of its performance and its effectiveness as a unitary board. The Board of Directors attend away day sessions as required throughout the year, which provide an opportunity for the Board to debate strategic issues in an informal setting. The Board of Directors has a programme of Board Seminars that are held on months when no public meetings are scheduled. These cover a range of topical issues and are often facilitated or attended by external colleagues. Individual Directors attend a range of formal and informal training and networking events as part of their ongoing development.

### Board Committees

The Board of Directors has delegated responsibilities to its committees to undertake specified activities and provide assurance to Board members. The committees provide the Board of Directors with a written report of their proceedings. Each committee is chaired by a Non-Executive Director. A summary of each committee's role is set out below:

### Trust Management Executive

The Trust Management Executive (TME) is chaired by the Chief Executive and has delegated powers from the Board of Directors to oversee the day-to-day management of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives. Meetings consist of a combination of regular updates on key aspects of performance, monitoring of specific areas of risk, including around financial recovery, as well as space for strategic thinking and team development, with Improving Together remaining a key driver for how agendas are designed. Membership of TME consists only of the Executive Directors and members of the divisional management triumvirates (heads of divisions, divisional directors of operations and heads of nursing/midwifery). These meetings are held monthly.

### Audit and Risk Committee

The Audit and Risk Committee has been Chaired by Antony Durbacz until June 2023, Paul Fox took over from September 2023. The Committee is responsible for:

- Governance - reviewing the establishment and maintenance of an effective system of internal control and probity across the whole of the organisation's activities.
- Internal Audit - ensuring that there is an effective internal audit function established by the Trust that meets mandatory NHS Internal Audit Standards.
- External Audit - reviewing the work and findings of the External Auditor and considering the implications and management response to their work.

- Local Counter-Fraud - ensuring that there is an effective counter-fraud function established by management that meets NHS Counter-Fraud standards.
- Management - reviewing reports and positive assurances from Directors and managers on the overall arrangements for governance, probity, and internal control.
- Risk Management - assuring the Board of Directors that the Risk Management system operating within the Trust is robust and effective.

There were no significant issues relating to the financial statements, operations or compliance considered by the Audit and Risk Committee during the year.

The Audit and Risk Committee is also responsible for monitoring the external auditor's independence and objectivity, including the effectiveness of the audit process. There is an annual review undertaken by the members of the Committee, assessing the performance of the external audit providers against an agreed set of key performance indicators (KPIs). These KPIs include verifying compliance with statutory requirements and deadlines, communication with key senior management personnel, satisfactory planning processes, and confirmation that the provision of staff to carry out work for the Trust are those named and qualified to do so.

The current external auditor, Deloitte, has not provided any non-audit services for the Group in 2023/24.

**Non-Clinical Governance Committee (NCGC)**

The Non-Clinical Governance Committee is chaired by Sumita Hutchison. NCGC focuses primarily on providing assurance to the Board that the Trust has a robust framework for the management of risks arising from or associated with estates and facilities; capital development, environment, and equipment; digital developments; environmental sustainability; health and safety; information governance; business continuity; business development and other non-clinical areas as may be identified. In 2023/24, this Committee has been particularly focused on assessing how the Trust, working with partners locally, its staff and the local community, can better embed environmental sustainability in its activities. In addition, the Committee has been focused on the Trust's ability to take advantage of digital developments.

**Quality Governance Committee**

The Quality Governance Committee is chaired by Ian Orpen. The Committee focuses primarily on providing assurance to the Board that the Trust's clinical services are meeting all of the requirements for good quality (patient experience, patient safety and clinical effectiveness). The Committee ensures that the Trust has a robust framework for the management of risks arising from or associated with clinical incident management and reporting, quality improvement, compliance with the Care Quality Commission's standards, medical records, research, and development, and maintaining clinical competence.

During 2023/24, the Committee has had a keen focus on strengthening oversights and assurance and learning from events across quality. The Committee has played a pivotal role in supporting the development and introduction of the Patient Safety Incident Response Framework, which will help us to build on our existing culture of continuous improvement.

### People Committee

The People Committee is chaired by Paul Fairhurst. This Committee's work focuses on the People Plan Programmes of work helping to ensure the right culture is in place across the organisation. It supported the rolling out of a just and learning approach in leadership and management and is supporting steps to address issues around discrimination throughout the organisation. The Committee has also maintained its focus on gaining assurance as to the effectiveness of the Trust's staff health and wellbeing provision and Basics Matter programme.

### Finance and Performance Committee

The Finance and Performance Committee has been chaired by Nigel Stevens until September 2023; Antony Durbacz took over from October 2023. This Committee's key role is to provide assurance to the Board on the Trust's operational and financial performance. Specifically, it assesses the effectiveness of business planning and financial management systems, and the extent to which the organisation is operating in line with its annual business plan objectives. The Committee continues to have a key focus on the steps that the Trust is taking to address the backlogs in non-elective care, including assessing the impact that Sulis Hospital and other potential developments on that site could have both for the Trust and the wider BSW system.

### Subsidiary Oversight Committee

The Subsidiary Oversight Committee is chaired by Nigel Stevens, and its key role is to ensure that the Trust has appropriate oversight of the performance and governance of its subsidiary(ies) – it acts as the main governance link between the Trust as parent and any subsidiaries within the group.

### Commercial Transactions Steering Group

The Commercial Transactions Steering Group is chaired by the Trust Chair. It meets as required to provide detailed scrutiny and assurance of aspects of tenders and other significant transactions as delegated by the Board of Directors.

### Board of Directors' Nominations and Remuneration Committee

The Board of Directors' Nominations and Remuneration Committee is chaired by Alison Ryan, the Trust Chair. The Committee's key roles and responsibilities are to appoint the Chief Executive and the Executive Directors and to determine the appropriate terms and conditions of employment for them.

### The Charities Committee

The Charities Committee is chaired by Sumita Hutchison. The Royal United Hospital Charitable Fund (working name RUHX) was formed under a Deed dated 10 September 1996 as amended by a Supplemental Deed of 9 December 2009. It is registered with the Charity Commission in England and Wales (Registered number 1058323). The Trust is the Corporate Trustee of the

Charity, acting through its voting Board of Director members who are collectively referred to as the Trustee's Representatives and their duties are those of trustees.

The main beneficiaries of the Charity are the Trust's patients and staff through the provision of grants to the Trust for purchasing and developing facilities; training and development of staff; and research and development. The Charity's structure is diverse and reflects the breadth of variety of activities within the Trust. There are in excess of 100 separate funds.

Although the Charities Committee is a formal sub-committee of the Board of Directors, arrangements have been implemented to operate this group and the Full Corporate Trustee of the charity at arm's length from the Trust. These arrangements include: a formal service level agreement between the Trust and the charity outlining the support and associated costs to the charity, presenting the Charity Annual Report and Accounts to the Full Corporate Trustee, and implementing a separate charity strategy.

## Board and Committee attendance

| | Appointment Date | | Board of Directors' (7 Meetings) | Audit and Risk Committee (4 Meetings) | Charities Committee (4 Meetings) | Finance and Performance Committee (10 meetings) | Non-Clinical Governance Committee (5 meetings) | Nominations and Remuneration Committee (3 Meetings) | People Committee (6 Meetings) | Quality Governance Committee (12 Meetings) | Subsidiary Oversight Committee (6 Meetings) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | From | To | | | | | | | | | |
| **Non-Executive Directors** | | | | | | | | | | | |
| **Alison Ryan, Chair** | 01/04/19 | 31/03/25 | **7** | **N/A** | **4** | **N/A** | **N/A** | **3** | **N/A** | **N/A** | **N/A** |
| **Nigel Stevens** | 01/04/18 | 31/03/25 | **6** | **1** (1) | **N/A** | **9** | **N/A** | **3** | **N/A** | **N/A** | **5** |
| **Antony Durbacz** | 01/11/20 | 31/12/26 | **6** | **1** (2) | **N/A** | **9** | **2** (2) | **2** | **N/A** | **N/A** | **3** (4) |
| **Ian Orpen** | 07/09/20 | 31/08/26 | **6** | **3** (3) | **N/A** | **N/A** | **3** (3) | **3** | **2** (3) | **12** | **3** |
| **Hannah Morley** | 01/04/23 | 31/03/26 | **4** | **N/A** | **N/A** | **N/A** | **3** (3) | **3** | **5** | **9** | **N/A** |
| **Paul Fairhurst** | 01/10/22 | 30/09/25 | **7** | **N/A** | **N/A** | **9** | **N/A** | **3** | **6** | **10** | **N/A** |
| **Paul Fox** | 01/04/23 | 31/03/26 | **6** | **4** | **N/A** | **10** | **5** | **3** | **N/A** | **N/A** | **3**(3) |
| **Sumita Hutchison** | 04/09/19 | 31/08/25 | **6** | **4** | **4** | **N/A** | **5** | **3** | **6** | **N/A** | **N/A** |
| **Executive Directors (voting)** | | | | | | | | | | | |
| **Cara Charles–Barks Chief Executive** | 01/09/20 | - | **7** | **N/A** | **N/A** | **8** | **N/A** | **N/A** | **4** | **N/A** | **1** |
| **Andrew Hollowood Chief Medical Officer & Deputy CEO** | 14/11/22 | - | **6** | **0** | **N/A** | **7** | **N/A** | **N/A** | **3** | **7** | **1** |
| **Antonia Lynch Chief Nursing Officer** | 01/04/21 | - | **7** | **N/A** | **3** | **2** | **1(1)** | **N/A** | **4** | **10** | **5** |
| **Paran Govender Chief Operating Officer** | 02/10/23 | - | **3** (4) | **N/A** | **N/A** | **3** (4) | **1(1)** | **N/A** | **1** (2) | **5** (6) | **N/A** |
| **Simon Sethi Chief Operating Officer** | 15/01/21 | 16/04/23 | **1** (1) | **N/A** | **N/A** | **1** (1) | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** |
| **Niall Prosser Interim COO** | 16/04/23 | 02/10/23 | **3** (3) | **N/A** | **N/A** | **5** (5) | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** |
| **Libby Walters Chief Financial Officer** | 01/06/18 | - | **7** | **4** | **4** | **10** | **N/A** | **N/A** | **N/A** | **N/A** | **6** |
| **Joss Foster Chief Strategic Officer** | 01/07/12 | - | **7** | **N/A** | **2** | **N/A** | **4** | **N/A** | **5** | **N/A** | **1** |
| **Alfredo Thompson Chief People Officer** | 31/01/22 | - | **7** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **6** | **N/A** | **2** |
| **Executive Directors (non-voting)** | | | | | | | | | | | |
| **Brian Johnson Director of Estates and Facilities** | 01/04/19 | 28/02/24 | **3** (6) | **N/A** | **N/A** | **N/A** | **4** (4) | **N/A** | **6** | **N/A** | **1** |
| **Christopher Brooks-Daw Director of Governance & Chief of Staff** | 05/01/24 | - | **2** (2) | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** |

** The number in brackets is the total amount of meetings individuals should have attended and are different to the total number of meetings. This was due to changes in who attended committee meetings and/or new terms of office.

## The Council of Governors

As a Foundation Trust, the RUH is accountable to its members who are represented by an elected Council of Governors.

The Council of Governors is made up of 21 governors:

- 11 Public Governors, (elected by public members from six constituencies namely, City of Bath, North East Somerset, Mendip, North Wiltshire, South Wiltshire and Rest of England and Wales)
- 5 Staff Governors (elected by staff members) and
- 5 Stakeholder Governors (appointed by partner organisations)

The Council of Governors is chaired by the Trust Chair, Alison Ryan. Governors at the Royal United Hospitals Bath provide a direct link between the Foundation Trust and its members. The Council of Governors' primary role is to represent the interests and views of members, the local community, other stakeholders, and the public in general. The Council has a right to be consulted on the Trust's strategies and plans and any matter of significance affecting the Trust or the services it provides.

The Council of Governors' roles and responsibilities are set out in law and are detailed in the Trust's Constitution. The work of the Governors is divided between their statutory and non-statutory duties.

In preparing the NHS Foundation Trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors.

The work of the Council of Governors Nominations and Remunerations Committee has been referred to elsewhere in this report. In addition to this committee, the Council has four working groups whose work is broadly aligned to Board Committees, with the Non-Executive Chairs in regular attendance to respond to Governor queries. The four working Groups are:

- Membership and Outreach
- Quality
- Strategy and Business Planning
- People

The Working Groups continue to meet regularly to take forward tasks assigned by the Council and provide a full report at each of the Council of Governors meetings. All Governors are invited to participate in their working groups. Working Group meetings were attended by Executive Directors and Senior Managers to support information sharing and engagement with Governors.

Governors are encouraged to attend Board meetings and raise questions, and each Working Group nominates one of their members to attend the relevant Board Committee meetings to observe. This observer reports back to the Working Group to help inform future interactions with the Committee Chairs.

The Trust has continued to deliver an effective Governor induction and a continuing Governor development programme, supported by external agencies such as NHS Providers.

## 2023/24 Governor Elections

During 2023/24 the Trust held a constituency-wide election to elect three Staff Governors and five Public Governors across five constituencies. Governors were elected into each constituency.

Each constituency, with the exception of North East Somerset had a contested election and there was a noticeable decline in participation which ranged from 6.1% to 11%. The full election report is available from the Membership Office at ruhmembership@nhs.net.

The Trust commenced the year with two Governor vacancies, these were for Stakeholder Governors and work is in progress to appoint a BaNES representative from BSW ICS and a representative from the University of Bath as a matter of priority. A third vacancy arose in the Mendip constituency during the course of the year and a by-election will be held at the earliest opportunity.

### Governors by constituency – 1 April 2023 to 31 March 2024

The Governor's terms of appointment can be seen in the table below. There are 21 Governor Positions in total. As at 31 March 2024, there were 18 Governors in post (10 public, 5 staff and 3 appointed) and 3 vacancies.

| Public Governors | Constituency | Term of Appointment |
|---|---|---|
| Nicola James | City of Bath | 01/11/2022 – 31/10/2025 |
| Viv Harpwood<br>(Lead Governor from November 2023) | City of Bath | 01/11/2022 – 31/10/2025 |
| Suzanne Harris | North East Somerset | 02/11/2020 - 31/10/2023 |
| Anna Beria | North East Somerset | 01/11/2022 - 31/10/2025 |
| Vic Pritchard | North East Somerset | 01/11/2023 - 31/10/2026 |
| John Osman | Somerset (Mendip) | 02/11/2020 - 31/10/2023 |
| Anne Martin | Somerset (Mendip) | 01/11/2016 - 05/01/2024 |
| Kate Cozens | Somerset (Mendip) | 01/11/2023 - 31/10/2026 |
| Peter McCowen<br>(Lead Governor until November 2023) | North Wiltshire | 02/11/2020 - 31/10/2023 |
| Nick Gamble | North Wiltshire | 01/03/2023 - 31/10/2025 |
| Paul Newman | North Wiltshire | 01/11/2023 - 31/10/2026 |
| Horace Prickett | South Wiltshire | 27/10/2021 - 31/10/2023 |
| Di Benham | South Wiltshire | 01/11/2022 - 31/10/2025 |
| Ian Lafferty | South Wiltshire | 01/11/2023 - 31/10/2026 |
| Ramal Royal | Rest of England & Wales | 01/11/2022 - 31/10/2025<br>(Stood down 30/05/2023) |
| Anne-Marie Walker | Rest of England & Wales | 01/11/2023 - 31/10/2025 |

| Staff Governors | Constituency | Term of Appointment |
|---|---|---|
| Julie Stone | Staff | 02/11/2020 - 31/10/2023 |
| Sophie Legg | Staff | 01/11/2019 - 31/10/2023 |
| Narinder Tegally | Staff | 01/11/2019 - 31/10/2022<br>01/11/2022 - 31/10/2025 |
| Baz Harding-Clark | Staff | 02/11/2020 - 31/10/2023<br>01/11/2023 - 31/10/2026 |
| Beas Bhattacharya | Staff | 01/11/2022 - 31/10/2025 |
| Craig Jones | Staff | 01/11/2023 - 31/10/2026 |
| Gary Chamberlain | Staff | 01/11/2023 - 31/10/2026 |

| Stakeholder Governors | Organisation | Term of Appointment |
|---|---|---|
| Cllr Alison Born | BaNES Council | 20/05/2021 |
| Cllr Johnny Kidney | Wiltshire Council | 01/10/2017 |
| Dr Catrinel Wright | BSW ICS (Wiltshire) | 20/05/2021 – 26/04/2024 |
| Vacancy | BSW ICS (BaNES) | - |
| Vacancy | University of Bath | - |

**Council of Governor Meetings**

The Council of Governors has met formally four times during the year. Attendance is detailed in the table overleaf, but good attendance by Governors has meant that they have been kept up to date on current matters relating to the Trust and Community and have also had the opportunity to ask questions of all Board members. The Chief Executive provides an update report to Governors as a standing agenda item and other members of the Executive Team attend as required.

All of the Council of Governor meetings were held in person at various venues around Bath during 2023/24. The Trust website was updated with the details of each meeting to allow for public viewing. Among the decisions taken in 2023/24 were the following:

- Appointed Viv Harpwood, Public Governor as Lead Governor.
- Approved the Deputy Lead Governor appointment process.
- Appointed Nick Gamble, Public Governor as Deputy Lead Governor.
- Approved amendments to the Council of Governors Terms of Reference.
- Approved the content of the Chair's appraisal and the suggested objectives.
- Approved amendments to the People Working Group Terms of Reference.
- Approved the reappointment of Ian Orpen, Non-Executive Director from 1 September 2023 to 31 August 2026.

- Approved the reappointment of Antony Durbacz, Non-Executive Director from 1 November 2023 to 31 October 2026.
- Approved the reappointment of Nigel Stevens, Non-Executive Director for a further 12-month term of office.
- Approved the extension of Viv Harpwood, Public Governor's term of office from 31 October 2024 to 31 October 2025.
- Approved the RUH Anti-Racist Statement.
- Approved the appointment of Trust's External Auditors.

Governors are required to disclose details of any material interests which may conflict with their role as Governors at each Council of Governors meeting. A register of Governors interests is available to members of the public by contacting the Membership Office via the details below.

There are a number of ways for members and the public to communicate with the Governors:

- Email: RUHmembership@nhs.net
- Post: RUH Membership Office (D1), Royal United Hospitals Bath NHS Foundation Trust, Combe Park, Bath, BA1 3NG
- Telephone: 01225 82 6288 / 1262

**Membership and attendance at Council of Governors meetings 2023/24**

The following table sets out Governor Attendance at Council of Governor meetings during the period 1st April 2023 to 31st March 2024. The figure in brackets denotes the number of meetings an individual could be expected to attend by virtue of their membership of the Council. A figure of zero in brackets (0) indicates that the individual was not a member or that their attendance was not mandatory.

| Council of Governor meeting attendance | | | | |
|---|---|---|---|---|
| **Governor name** | | | **Non-Executive Directors** | |
| Anna Beria | 4/4 | | Alison Ryan (Chair) | 4/4 |
| Anne Martin | 0/0 | | Nigel Stevens | 4 (0) |
| Anne-Marie Walker | 2/2 | | Sumita Hutchison | 2 (0) |
| Baz Harding-Clark | 3/4 | | Anthony Durbacz | 3 (0) |
| Beas Bhattacharya | 1/4 | | Ian Orpen | 2 (0) |
| Cllr Alison Born | 2/4 | | Paul Fairhurst | 3 (0) |
| Cllr Johnny Kidney | 2/4 | | Hannah Morley | 2 (0) |
| Craig Jones | 2/2 | | Paul Fox | 4 (0) |
| Di Benham | 2/4 | | | |
| Dr Catrinel Wright | 0/4 | | | |
| Gary Chamberlain | 1/2 | | **Executive Directors** | |
| Horace Prickett | 0/2 | | Cara Charles-Barks | 2 (0) |
| Ian Lafferty | 2/2 | | Libby Walters | 1 (0) |
| John Osman | 1/2 | | Niall Prosser | 1 (0) |
| Julie Stone | 0/2 | | Joss Foster | 1 (0) |
| Kate Cozens | 2/2 | | Simon Sethi | 0 (0) |
| Narinder Tegally | 2/4 | | Alfredo Thompson | 0 (0) |
| Nick Gamble | 3/4 | | Brian Johnson | 0 (0) |
| Nicola James | 4/4 | | Paran Govender | 1 (0) |
| Paul Newman | 2/2 | | Toni Lynch | 0 (0) |
| Peter McCowen | 1/2 | | Andy Hollowood | 0 (0) |
| Ramal Royal | 0/0 | | Christopher Brooks-Daw | 0 (0) |
| Sophie Legg | 1/2 | | | |
| Suzanne Harris` | 1/2 | | | |
| Vic Pritchard | 2/2 | | | |
| Viv Harpwood | 4/4 | | | |

## Foundation Trust Membership

The Royal United Hospitals Bath NHS Foundation Trust membership is made up of public and staff members. Membership is free and people can become a member by completing a short application form which is available on the Trust's website (https://secure.membra.co.uk/RoyalBathApplicationForm/) or in a printed form found around the hospital. Public members receive the Trust's magazine Insight, invitations to come to events or have their say over how services are run at the hospital. They are eligible to vote during the public governor elections or stand for election themselves.

## Public members

Anyone who is aged 16 or over and lives in England and Wales can become a member of the RUH. We have six public member constituencies as follows:

- City of Bath
- North East Somerset
- Mendip
- North Wiltshire
- South Wiltshire
- Rest of England and Wales

## Staff members

Staff who are permanently employed or hold a fixed term contract of at least 12 months are automatically opted into staff membership but may opt out if they wish. Staff members are represented by five Governors.

## Developing a representative membership and engagement

The Board of Directors and the Council of Governors are committed to ensuring that the membership is representative of the local community served by the Trust. The Council of Governors' Membership and Outreach Working Group reviews membership data on an annual basis and is content that the Trust's membership is representative of the community who use our services.

The Trust has a Membership Development and Engagement Strategy which is updated annually with the help of the Governor's Membership and Outreach Working Group. The strategy sets out objectives that will be achieved to develop an engaged membership. The Trust's Membership aim is to ensure that the public is at the heart of everything we do by creating a representative membership and engaging them in the development and transformation of their health services. The Trust's strategy aims to recruit a representative membership base of the community we serve who are actively engaged in working for the good of the Trust. It also considers and monitors engagement levels through surveys, attendance at Governor Constituency meetings and member events.

As at 31st March 2024, the Trust had 17,202 members, made up of 10,600 public members (patients, carers, and the public) and 6,602 staff members. The Trust has a number of channels for engaging and communicating with its members, including:

- Members' e-communications
- Online surveys
- Caring for You events (postponed due to operational pressures)
- Staff tri-weekly newsletters, monthly virtual staff briefs and weekly Q&A sessions.
- Governor Constituency meetings
- The Annual Members' Meeting

Ongoing operational pressures have meant that the Trust has continued to be limited in the scale and scope of its engagement activities during 2023/24 but some progress has been made in terms of resuming face to face engagement. A number of Governors have attended local Patient Participation Group meetings and RUH Careers Fairs. During these events Members had the opportunity to interact with Governors and were able to find out more about the role of the Governor and how they could become involved in supporting the RUH.

The Trust held its first face to face Annual General Meeting combined with Annual Members Meeting since the Covid-19 pandemic on the 20 September 2023 at the Apex City of Bath Hotel, in excess of 150 people were in attendance.

Recruitment of members has remained constrained due to limited resources; however, a number of members have been recruited by Governors through their attendance at Patient Participation Groups and the RUH Careers Fair. A small number of members have also been recruited via our online application form.

**Membership size and movements 2023/24:**

| Public constituency | Members | | Staff constituency | Members |
|---|---|---|---|---|
| As at 1st April 2023 | 10,827 | | As at 1st April 2023 | 5,507 |
| As at 31st March 2024 | 10,600 | | As at 31st March 2024 | 6,602 |

| Analysis of current membership | | | |
|---|---|---|---|
| | **Public constituency** | **Number of members** | **Eligible Membership** |
| **Age (years):** | 0-16 | 2 | 166,986 |
| | 17-21 | 68 | 61,901 |
| | 22+ | 9,771 | 698,903 |
| **Ethnicity:** | White | 8,925 | 855,768 |
| | Mixed | 87 | 19,169 |
| | Asian or Asian British | 193 | 23,630 |
| | Black or Black British | 126 | 9,364 |
| | Other | 37 | 0 |
| **Scio-economic groupings*** | AB | 2,741 | 103,034 |
| | C1 | 3,164 | 119,037 |
| | C2 | 2,119 | 81,169 |
| | DE | 2,507 | 83,662 |
| **Gender Analysis** | Male | 3,578 | 455,441 |
| | Female | 6,878 | 472,347 |
| | | | |
| The analysis section of this report excludes: 759 public members with no dates of birth, 1232 members with no stated ethnicity and 143 members with no gender. | | | |

## NHS Foundation Trust Code of Governance disclosures

The Code of Governance for NHS provider trusts (the Code of Governance) was published in October 2022 and has been applicable since 1 April 2023. The Royal United Hospitals Bath NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis.

The Board considers that for the 2023-24 year the Trust has been fully compliant with the provisions of the Code, with the exception of provision C.4.7 that states “evaluation of the boards of NHS foundation trusts should be externally facilitated at least every three years”. Having already been commissioned in 2022-23, the external review being undertaken by Aqua was delayed during 2023-24 and was undertaken in May and June 2024.

The Board is committed to the highest standards of good corporate governance and follows an approach that complies with this code through the arrangements that it puts in place for our governance structures, policies, and processes and how it will keep them under review. These arrangements are set out in documents that include:

- The Constitution of the Trust
- Standing orders
- Standing financial instructions
- Integrated Governance Framework
- Accountability Framework
- Terms of reference for the Board of Directors, the Council of Governors, and their committees
- Annual declarations of interest
- Annual Governance Statement

The Trust considers that it complies with the specific disclosure requirements as set out in the NHS Foundation Trust Code of Governance and NHS Foundation Trust Annual Reporting Manual (FT ARM).

| **Code section** | **Code Provision** | **Annual Report and Accounts Section** |
|---|---|---|
| A 2.1 | The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency, and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy. | Performance report, Stakeholder relations and Environmental matters |
| A 2.3 | The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices, or behaviour throughout the business are aligned with the trust’s vision, values, and strategy, it should seek assurance that management has taken corrective action. The annual report should explain | Staff report |

| Code section | Code Provision | Annual Report and Accounts Section |
|---|---|---|
| | the board's activities and any action taken, and the trust's approach to investing in, rewarding, and promoting the wellbeing of its workforce. | |
| A 2.8 | The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements. | Performance report, purpose, and activities. Also, Stakeholder relations. |
| B 2.6 | The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:<br>• has been an employee of the trust within the last two years<br>• has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director, or senior employee of a body that has such a relationship with the trust<br>• has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme<br>• has close family ties with any of the trust's advisers, directors, or senior employees<br>• holds cross-directorships or has significant links with other directors through involvement with other companies or bodies<br>• has served on the trust board for more than six years from the date of their first appointment<br>• is an appointed representative of the trust's university medical or dental school.<br>Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why. | Directors' report |
| B 2.13 | The annual report should give the number of times the board and its committees met, and individual director attendance. | Governance of the Trust |

| Code section | Code Provision | Annual Report and Accounts Section |
|---|---|---|
| B 2.17 | For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors. | Directors' report and Council of Governors |
| C 2.5 | If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors. | Additional Directors' report disclosure |
| C 2.8 | The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference. | Directors' Report - Council of Governors |
| C 4.2 | The board of directors should include in the annual report a description of each director's skills, expertise, and experience. | Directors' Report |
| C 4.7 | All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors. | Additional Directors' report disclosure and Annual Governance Statement |
| C 4.13 | The annual report should describe the work of the nominations committee(s), including:<br>• the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline<br>• how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition<br>• the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives | Remuneration report |

| Code section | Code Provision | Annual Report and Accounts Section |
|---|---|---|
| | • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served<br>• the gender balance of senior management and their direct reports. | |
| C 5.15 | Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied. | Directors' Report - Council of Governors |
| D 2.4 | The annual report should include:<br>• the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed<br>• an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans<br>• where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit<br>• an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services. | Financial Performance |
| D 2.6 | The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced, and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy. | Annual Governance Statement |
| D 2.7 | The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report. | Annual Governance Statement |

| Code section | Code Provision | Annual Report and Accounts Section |
|---|---|---|
| D 2.8 | The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report. | Annual Governance Statement<br><br>(complied) |
| D 2.9 | In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare. | In annual accounts and Financial Performance section of Annual Report. |
| E 2.3 | Where a trust releases an executive director, e.g., to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings. | Not applicable |
| Appendix B, para 2.3 | The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. | Directors' Report - Council of Governors |
| Appendix B, para 2.14 | The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report. | Directors' Report - Council of Governors |
| Appendix B, para 2.15 | The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, e.g., through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations. | Directors' Report - Council of Governors |

| Code section | Code Provision | Annual Report and Accounts Section |
|---|---|---|
| Additional requirement of FT ARM resulting from legislation | If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report.<br><br>This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012.<br><br>* Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance).<br><br>** As inserted by section 151 (6) of the Health and Social Care Act 2012) | This power has not been exercised |

## NHS System Oversight Framework

NHS England and NHS Improvement's NHS System Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated 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). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access, and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS Foundation Trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence.

### Segmentation

During quarter 3 of 2023/24, the Trust moved into segment 3 as a result of:

- Cancer - 62-day backlog
- Finance – Efficiency, Stability and Agency Spend
- Elective - Diagnostics
- UEC - Proportion of patients seen within four hours

This segmentation information is the Trust's current position as at 1 April 2024. Current segmentation information for NHS trusts and foundation trusts id published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

## Statement of Accounting Officer's responsibilities

**Statement of the Chief Executive's responsibilities as the accounting officer of the Royal United Hospitals Bath NHS Foundation Trust (RUH)**

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require Royal United Hospitals Bath NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Royal United Hospitals Bath NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed:

**Cara Charles-Barks, Chief Executive** **Date: 27 June 2024**

# Annual Governance Statement 2023/24

## Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

## The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Royal United Hospitals Bath NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The system of internal control has been in place in Royal United Hospitals Bath NHS Foundation Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

## Capacity to handle risk

I have overall and final responsibility for all risk, health, and safety issues and for providing the Trust with the necessary organisation and resources to produce, implement and manage effective policy and action to realistically minimise risk to the lowest possible level within available resources.

The Board of Directors holds ultimate responsibility and accountability for the quality and safety of services provided by the Royal United Hospitals Bath NHS Foundation Trust. The Board has approved the Strategic Framework for Risk Management which provides a clear and systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial, and financial processes across the Trust. The Strategic Framework sets out the role of the Board of Directors, the Trust Management Executive, the Divisional Boards, and the Board of Director Committees, together with the individual responsibilities of the Chief Executive, Executive Directors, and all staff in managing risks.

Operationally, the Royal United Hospitals Bath NHS Foundation Trust uses a web-enabled electronic risk management system (Datix) to record, manage and monitor risks on the Trust-wide Risk Register. Significant risks (significance is based on the risk score allocated to each risk) are reviewed monthly by the Trust Management Executive, which comprises executive directors, divisional senior management, and other senior corporate leaders. The Trust Management Executive provides oversight of the significant risks until they have been managed to an acceptable level of risk.

The Board of Directors reviews the top operational risks scoring 16 and above on a quarterly basis, alongside the Board Assurance Framework (BAF). The BAF is made up of a relatively small number of high-level risks (12 on the current Framework) which could, if not properly

managed or mitigated, prevent the Trust from achieving its key objectives. In addition, the monthly operational performance and finance reports that are presented at Board meetings highlight any key areas of risk and the Board of Directors' report template includes a section on risk. The BAF risks and mitigating actions can be seen on page 130 of this statement.

### Board Committees

The Audit and Risk Committee has overall responsibility for ensuring there is effective risk management process employed across the Trust. The Audit and Risk Committee receive information annually from the Trust's internal auditors through their work which supports the Board Assurance Framework and through this work the Committee supports the Board to be assured over the robustness of the Trust's application of sound internal control processes.

The Board of Directors has established five other Assurance Committees, each chaired by a Non-Executive Director together with other Non-Executive Director members that ensure that there are effective monitoring and assurance arrangements in place to support the system of internal control. The Board is also able to delegate specific topics to the Committees for detailed consideration. The key responsibilities of each Committee in relation to risk management are set out below:

Audit and Risk Committee

- Provides assurance to the Board of Directors about the robustness and effectiveness of the overall systems of governance and internal control.
- Oversight of the Trust's risk management systems and processes.
- Oversight of the work of the internal and external auditors.
- Provides assurance of financial risk management processes.
- Tests the effectiveness of processes for keeping the BAF relevant and up to date.

Quality Governance Committee

- Provides assurance as to the quality and safety of the Trust's services.
- Provides assurance that the Trust's key clinical systems and processes are effective and robust.
- Reviews arrangements for investigating and learning from complaints and incidents.
- Provides oversight of divisional approaches to risk management.
- Reviews allocated risks on the BAF.

Non-Clinical Governance Committee

- Provides assurance that key non-clinical systems and processes are effective and robust.
- Provides specific oversight for the management of non-clinical health and safety risk, business continuity and information technology.
- Oversees the Trust's approach to environmental sustainability and the move towards carbon neutrality.
- Provides assurance as to the development and maintenance of the Trust's estate and facilities.

- Oversees the preparation, adoption and implementation of the Trust's digital strategy, and its approach to enabling the development of digital developments in care provision.
- Reviews allocated risks on the BAF.

People Committee

- Provides assurance that systems for managing people-related risk are sound and robust, including in relation to recruitment and retention.
- Oversees the development of appropriate cultural norms across the organisation.
- Provides specific oversight of human resource systems and processes.
- Oversees the achievement of the Trust's commitments under the People Plan.
- Oversees the approach to workforce planning.
- Reviews allocated risks on the BAF.

Finance and Performance Committee

- Provides assurance that the Trust's financial and operational performance is in line with the Trust's operational targets and business plan objectives.
- Scrutinises the effectiveness of the Trust's financial management systems.
- Specifically ensures that the Trust is taking the right approach to meeting its NHS Constitutional targets.
- Reviews allocated risks on the BAF.

Subsidiary Oversight Committee

- Provide the RUH Board with "line of sight" of Sulis' activities without overriding the independence of the Sulis Board. Specifically, its roles are to:
- Ensure that the aims and objectives of acquiring or setting up a subsidiary unit or organisation are being met.
- Ensure that key business plan milestones are being achieved, and that there are robust plans in place to address any divergence from agreed performance levels.
- Gain assurance that any quality, financial regulatory or legal risks incurred by the subsidiary are being properly managed.

After each meeting, the Committee Chair presents a report to the next available meeting of the Board of Directors highlighting the key issues discussed, any risks identified, key decisions and recommendations using an 'ALERT, ASSURE ADVISE' template. One Committee may also recommend that another Committee considers a matter that has been brought to its attention that would be of relevance to that other committee.

Charities Committee

The Board of Directors has also established a Charities Committee, which is responsible for reviewing and approving the use of the Trust's charitable funds.

## Non-Executive Directors

All Committees are chaired by a nominated Non-Executive Director. The Audit and Risk Committee which plays a pivotal role in providing assurance on the risk management processes of the Trust has a membership of only Non-Executive Directors. Through the Non-Executive Directors, together with the Non-Executive Audit and Risk Committee chair, they all have a responsibility to challenge robustly the effective management of risk and to seek reasonable assurance of adequate control.

The Audit Committee provides a key forum through which the Trust's Non-Executive Directors bring independent judgement to bear on issues of risk management and performance. The constructive interface between the Audit and Risk Committee and Board supports the effectiveness of the Trust's systems of internal control.

## Executive Directors

As Accounting Officer, I have overall responsibility for risk management across all organisational, financial, and clinical activities. Other members of the Executive Team exercise lead responsibility for the specific types of risk dependent on both where the risk exists and what type of risk it is.

The day-to-day oversight has been delegated to the Chief Nursing Officer who is responsible for the strategic development and implementation of organisational risk management systems and processes and for ensuring there is a robust system in place for monitoring compliance with standards and the Care Quality Commission (CQC) registration and legal requirements. The Chief Nursing Officer is also responsible for patient safety, patient experience and medical legal matters (jointly with the Chief Medical Officer (CMO).

The Trust's Chief Medical Officer oversees medical risk for the Trust, also acting as Chief Clinical Information Officer and Caldicott Guardian.

The Chief Finance Officer has responsibility and accountability for financial risks, as well as being designated as Senior Information Risk Officer (SIRO) responsible for maintaining and assuring the framework for managing information governance-related risks. The Chief Finance Officer attends the Trust's Audit and Risk Committee and liaises with internal audit, external audit, and counter fraud services, who undertake programmes of audit with a risk-based approach.

There has been an in-year change in Estates and Facilities, with this becoming a joint responsibility across the Chief Nursing Officer and Chief Operating Officer as guided by their respective portfolios.

The Trust's 'Trust Management Executive', chaired by the Chief Executive, has the remit to ensure oversight of the adequacy of the management of key risks facing the organisation.

The day-to-day management of risks is undertaken by Divisions and corporate managers, who are charged with ensuring that risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where issues are identified. There is a process of escalation to Executive Directors through Divisional Performance Reviews, relevant committees and governance groups as required where there are challenges in implementing mitigations.

Divisional Governance committees introduced to further strengthen the governance arrangements are now embedded in the risk management structure and have responsibility for the oversight of divisional governance and risk processes.

Responsibilities and system of internal control for risk management are managed and supported operationally through the Head of Risk and Assurance who has responsibility for ensuring that staff are trained and equipped to manage risk effectively and in accordance with the Strategic Framework for Risk Management.

### The Risk and Control Framework

The Strategic Framework for Risk Management defines risk, the Trust's risk appetite, and identifies individual and collective responsibility for risk management within the organisation. It also sets out the Trust's approach to the identification, assessment, scoring, treatment and monitoring of risk. The strategic framework:

- Defines the objectives of risk management and the process and structure by which it is undertaken
- Defines the Trust's risk appetite which articulates the content and range of risk(s) that the Trust might take in different areas
- Sets out the lead responsibilities and the organisational arrangements as to how these are discharged
- Sets out the key policies, procedures and protocols governing risk management.

The Trust uses a risk assessment matrix to score individual risks. The risk assessment matrix enables the Trust to assess the level of risk in a standardised way, using a 5x5 (impact x likelihood) risk matrix methodology. This prioritisation tool is based on national guidance. Each risk is given a score for both the consequence/severity of the potential risk and its likelihood of occurring. The two scores are then multiplied together to give an overall risk impact score. The higher the final score the greater the risk. All risks are recorded and held on the Datix risk management system, which is used to produce reports across all levels of management.

The Board of Directors undertakes a quarterly review and discussion of the significant risks, that is those rated as ≥16, on the Trust risk register, to ensure that the right issues are being captured, that high scoring risks are being effectively managed or mitigated and that scoring is consistent and reasonable.

The Trust Management Executive must approve all risks added to the risk register with a score of 16 or above and undertakes a monthly review of all current risks on the risk register with a score of 10-15 in order to ensure that lower scoring risks with the potential to have significant impact on the organisation are not overlooked. The Trust Management Executive are also responsible for reviewing and approving any current risks that have been downgraded from a major risk.

The Trust seeks to ensure that lessons learned from incidents, complaints and other investigations are used to update and improve practice. These issues are regularly communicated to the Trust Quality and Safety Group (TQSG) where Trust-wide representatives have the opportunity to discuss themes which may emerge from these investigations and make recommendations for, and implement, policy or procedural change. The Upward Report from TQSG shares and communicates key messages to the Quality Governance Committee to

ensure Board visibility of emerging themes, learning and improvement and how they are being disseminated across the organisation.

The way we respond to patient safety incident reporting has changed in 2023-2024 as we transitioned to using the Patient Safety Incident Response Framework (PSIRF) as part of national improvements linked the NHS Patient Safety Strategy. This is described in our associated incident policies, supported by our governance structures and teams from Board to point of care. Our Integrated Quality and Performance Report, reflecting activity and learning through our incident processes is presented at each Board of Directors' meeting and is published on the Trust's website. Additionally, our Quality Governance Committee receives routine reports across incidents, risks, learning from deaths and improvements, sharing this through its upward report to Board.

### Board Assurance Framework

The Trust has a Board Assurance Framework (BAF). The BAF process enables the Trust to gain assurance that it has a well-balanced set of objectives for the year and that there are controls and assurances in place to manage the key risks associated with achieving these objectives.

The BAF is reviewed on a quarterly basis at private meetings of the Board of Directors, and an update summary is subsequently presented at the next available public meeting. Each BAF risk is assigned to a lead Executive Director and to the relevant Board committee for oversight. The Board Committees oversee and review their respective risks, with the responsible Executive Director updating the controls and mitigations regularly. The Committees may also increase or decrease the ratings for their risks to reflect the effectiveness of the mitigations and controls, and /or developments in the external environment. The Framework is refreshed at the start of each financial year, with the Board holding a workshop to agree on the key areas of focus.

### Quality Governance

The Trust is committed to providing excellent healthcare services that meet the needs of our patients and their families and provides the highest quality standards. The Board and Senior Management Team have a critical role in leading a culture which promotes the delivery of high-quality services. All efforts are focussed on creating an environment for change and continuous improvement.

The Trust has a robust Quality Governance reporting structure in place through an established Quality Governance Committee. The Quality Governance arrangements are described in the Integrated Governance Framework which is reviewed on an annual basis. The framework was presented for approval at the Board of Directors in July 2023. This framework is a means by which the Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the strategic objectives. The Integrated Governance and Accountability Framework makes it clear that quality governance is the responsibility of the Board supported by the Quality Governance Committee for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. The Quality Governance Committee reviews on-going compliance in meeting the Care Quality Commission's (CQC) essential standards informed by any CQC Inspection and reviews the monthly quality

performance report. The Quality Account published alongside this Annual Report and Accounts describes quality improvements and quality governance in more detail.

The Chief Executive is ultimately accountable for quality governance. Each Executive Director is a lead for a number of Board objectives. The responsible officers for quality are the Chief Medical Officer who leads on clinical effectiveness and the Chief Nursing Officer who leads on patient safety and patient experience.

Improving Together is the operational management system we share across the Acute Hospital Alliance in BSW. It aligns with the five components of NHS Impact and links improvement tools and routines with the behaviours needed for a culture of continuous improvement. It is founded on the development of a coaching approach, which enables every member of staff to improve the services they work in and contribute to achieving our strategy. Evidence shows that Trusts that have a continuous improvement approach like this provide better patient care, and colleagues working in these Trusts have greater job satisfaction.

Ultimately Improving Together is about improving the quality-of-care provision. By focusing our efforts where they will have the most positive impact on our services, we will improve the way we work and our quality of care. It covers the following main areas:

- Alignment of priorities – using the strategic planning framework from board to ward we focus on linked priorities, helping us achieve our goals more effectively.
- Empowerment – colleagues will know they are empowered to make changes in their team. Every member of RUH will be supported to develop and improve their skills to be able to identify and adopt improved ways of working.
- Developing our culture – by empowering each and every member of staff to have a voice and supporting our leaders to adopt compassionate and enabling leadership approaches.
- Improving quality – by adopting an evidenced based continuous improvement approach to better understand and continually improve the services we offer.
- Stopping doing things that do not add value to the people we care for, people we work with and people in our community.

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes on the quality of services. The equality/quality impact assessment (EQIA) process involves a structured risk assessment using a standard template which requires Divisional Management Team sign off. The Chief Medical Officer and Chief Nursing Officer are responsible for assuring themselves and the Board that Cost Improvement Programmes will not have an adverse impact on quality and equality. This process is currently under review to further strengthen the process.

Delivery of the Trust's strategic objectives is underpinned by the publication of the annual quality account which sets out the progress made against our quality priorities in 2023-24 and the quality priorities selected for 2024-25. Progress of the priorities is monitored via the Trust Quality and Safety Group and Quality Governance Committee; reviewing a suite of quality metrics that track performance against key quality indicators.

The Integrated Performance Report (IPR) is aligned to our key areas of focus within the strategic planning framework. It comprises of detailed reports on quality, operational

performance, finance, and workforce, has been received by the Board monthly and is considered in detail. Our divisions follow the same approach via the Executive Performance Review Meetings.

The Trust reviews the implementation status of all National Institute for Clinical Excellence guidance and Central Alerting System guidance to risk-assess any development areas for the Trust and to take action to implement recommendations. Data quality issues that have been highlighted are picked up by the Data Quality Action Group which is chaired by the Associate Director for Data Insights. It has representation from operational teams, Clinical Coding, Business Intelligence, Finance and the EPR team. In addition to this, the Board of Directors receives an annual mortality review report which compares the Trust's hospital standardised mortality rate (HSMR) with other comparable Trusts. The Trust uses clinical outcome data to assess and improve services with participation in national audits as well as undertaking local audits.

The Trust has a Freedom to Speak Up Guardian (FTSUG) to act in an independent and impartial capacity to support staff who raise concerns and whom has access to the Chief Executive and the Trust's nominated Non-Executive Director for 'Freedom to Speak Up'.

Risk management is embedded in the activity of the organisation in a variety of ways. A suite of risk management policies and guidelines underpins the Risk Management Strategy and are available to staff on the intranet. Training sessions are available to staff across the Trust. Divisions and Corporate Functions proactively identify risks which are recorded on risk registers. The specialties and divisions also retrospectively identify risk through adverse incident reporting, receipt and response to complaints and claims, patient and staff surveys and feedback, and concerns raised by the coroner.

Due to the devolved nature of risk management and compliance of incident reporting and investigation at a local level, quality and quantity of incident reporting continues to improve and develop. The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning takes place and improvement actions are taken. The ICS quality leads are an integral part of the Trust quality governance arrangements and attend key quality committees. The Trust works in partnership with our commissioners to share learning and improvement actions.

The Trust launched the new National Patient Safety Incident Response Framework (PSIRF) on the 1st April 2024. The framework sets out a new approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This is a significant change to how staff work and respond to patient safety events and the Trust is developing documentation and training to support effective implementation. The National Reporting Learning System has also been replaced with the Learning From Patient Safety Events (LFPSE) system. The Trust has actively engaged with this transition.

The Trust has taken the following actions to improve the quality of its services and reduce the rate of patient safety incidents that have resulted in severe harm or death by:

- Regular oversight by the Board of the Board Assurance Framework and application of the Board approved risk appetite and risk tolerances which has enabled a focus on risks outside of tolerance.

- Monitoring ward to board reporting on key patient safety and experience indicators and reporting these monthly to Board via the Integrated Performance Report.
- Reviewing a significant proportion of deaths in hospital through the Trust's Medical Examiners, Learning from Deaths Process and Mortality Review Group. Specific consideration has been given to how we monitor and capture patient safety risks (ensuring close alignment to our PSIRF processes) and our policies for both audit/effectiveness and mortality were updated accordingly.
- Preparations for the community Medical Examiner roll-out have been continued to progress, and our medical examiners are now operating within the majority of our local GP surgeries. We are still awaiting formal notification of when the community Medical Examiner roll-out will become statutory (anticipated for September 2024).
- Approval and initiation of the Patient Safety Incident Response plan to transition to the Patient Safety Incident Response Framework.
- Weekly review of all reported patient safety events of concern to agree the appropriate level of review and identify any immediate actions to mitigate identified risk.
- Establishing a Patient Safety Event Oversight group to ensure that themes and learning from patient safety events reports are maximised and inform safety improvement work.
- Establishing a Quality and Safety Improvement group to ensure improvement work reflects the insights from patient safety event reports and to oversee the delivery of improvement aligned to our patient safety priorities.
- Our Risk Management System, Datix, provides a range of quantitative data to support analysis across services and wards to provide assurance that we have effective systems for the monitoring of patient safety events.
- Improving the voice of patients, families, and carers in the management of patient safety events by; recruiting patient safety partners and incorporating patient engagement into the process for managing patient safety events as part of our PSIRP.
- Refreshing our Patient Experience strategy and ensuring that patient feedback provides insight to the quality and safety of our services and informs improvement.

The Trust continues to demonstrate a clear commitment to person centred care and acknowledges that this correlates with good patient engagement. Patients' experience of using the Trust's services is reviewed by the Board of Directors in a number of different ways:

- The monthly Quality Report (part of the Integrated Performance Report) provided to the Board of Directors includes results of the Friends and Family Test which are triangulated with other performance data for each ward, feedback through complaints, patient surveys and Patient Advice Liaison Service contacts.
- A patient story is presented at each Public Board meeting.
- Quarterly Patient Feedback and Incident, Claims and Inquest reports are presented to the Board of Directors.
- Executive and Non-Executive Directors' Go and See and patient safety visits.
- Member and patient feedback at the Annual Members' Meeting and Governor Constituency meetings.

- Board of Directors' annual mortality review.
- National Patient Safety reports to Board.

The Trust's Council of Governors engage with the quality agenda through its relevant working groups and a nominated Governor attends the Quality Governance Committee to observe. There is nominated Governor observer at Board Sub-Committees.

**The principles risk as per our Board Assurance Framework relate to the following areas:**

**The BAF risks are:**

- Without ensuring that we achieve the high standards of quality and safe care, we may not deliver outstanding services.
- Increasing demand for both emergency and planned care exceeding our capacity to treat patients promptly, may lead to longer wait times for planned procedures.
- Without fostering a culture of inclusion and actively addressing managerial discrimination, we may hinder staff recruitment and retention, expose the Trust to financial and reputational damage, and undermine our ability to deliver the best possible patient care.
- The limited supply of healthcare professionals in the national NHS workforce market could pose challenges for the Trust in attracting and retaining the necessary workforce to meet patient care demands.
- Without strong management and leadership development, including succession planning, we risk limiting our ability to cultivate a positive culture and sustain improvements. This could negatively impact patient care, staff satisfaction, and workforce stability.
- Without fostering a culture of financial accountability and implementing a viable financial plan, the Trust may not achieve financial recovery and sustainability, ultimately effecting our ability to provide safe, appropriate, and effective care to our patients.
- If Sulis Hospital does not maintain effective financial management strategies and achieve agreed financial and operational targets, it may not support the Trust in providing crucial additional elective and diagnostic capacity.
- By not strategically allocating resources to address the health and care needs of our most vulnerable communities, we may not improve health outcomes, reduce existing inequalities, or ensure equitable access to quality care.
- Our aging estate with increasing backlog maintenance needs could lead to service disruptions, compromised patient safety, and a degraded experience for both patients and staff.
- Climate change and its accelerating consequences threaten the health of patients, staff, and the wider community. Failure to achieve net zero goals and adapt to climate-related risks (e.g., overheating, flooding) may jeopardise the Trust's sustainability, its ability to provide care, and its commitment to future generations.
- Insufficient investment in digital capabilities may hinder the Trust's potential to enhance patient and staff experiences, optimise efficiency, and improve overall effectiveness and care delivery.

- Cyber-security breaches, caused by deliberate malicious acts or inadvertent actions by staff, could result in an inability to use digital platforms, resulting in loss of services and data across the Trust, and in turn causing risk to patients.

**Controls and mitigations include:**

We have an established and robust framework that oversees the management of our key risks.

Each risk on the BAF has identified controls, mitigation measures and assurance measures. These provide an overview of the measures in place, as well as actions being taken to manage each risk to its lowest level of exposure.

Each risk reports into its respective Board sub-committee. For example, the Quality Governance Committee receives updates on risks relating to quality, providing assurance to the Trust Board. The Trust Board also receives regular reports on the BAF. Additionally, our internal audit process tests the strength of our risk management framework, providing significant assurance with minor improvements for the past two years.

We have established Quality Governance Structures, including the Quality Governance Committee that provides assurance to the Trust Board, with oversight through the Trust Quality and Safety Group. Each clinical division has an established governance committee, reporting into the Trust Quality and Safety Group. A comprehensive reporting mechanism provides insights into present performance against quality measures, allowing risk forecasting and intervention if needed.

Each risk has an identified Executive Director leading, with the Chief Nursing Officer and Chief Medical Officer leading on quality related risks. For example, the Chief Medical Officer leads on the work associated with the risk relating to health inequalities. The Quality Governance Committee provides assurance to the Trust Board that this risk is understood and mitigated. Our strategic approach is overseen by our Health Inequalities Lead, linking to our Trust Strategy and being an anchor in our community. Our Clinical Strategy Steering Group, a sub-group of the Trust Management Executive, links into the BSW Inequalities Strategy Group as part of the BSW ICB fie commitment to ring-fence funds to support health inequalities.

The Chief People Officer leads on the People related risks, with the People Committee overseeing the risks, providing assurance to the Board. It uses a range of data sources, including WRES, WDES, NHS Staff Survey, information from employee networks and vacancy/attendance data.

The Chief Operating Officer leads on performance and service capacity risks, with these risks mainly reporting through the Finance and Performance Committee. The COO is also a member of the Quality Governance Committee, which brings synergy to discussions across performance and quality. The Performance Review Meetings, Chaired by the COO, bring robust connections with the Divisions. The Integrated Performance Report, received by the Board at each meeting, provides detailed insights into the overarching position across performance, allowing response and intervention as needed.

The Chief Finance Officer leads on finance risks, as well as digital/information technology risks. Financial risks report through the Finance and Performance Committee, with Digital/IT risks reporting to the Non-Clinical Governance Committee.

Our Chief Nursing Officer and Chief Operating Officer lead on risks across our physical estate, health and safety and sustainability. These risks all report through the Non-Clinical Governance Committee, providing assurance to the Trust Board. To manage these risks, the respective teams across estates and facilities, health and safety and sustainability report into the respective executive leads.

Controls, mitigations and associated actions link to multiple other workstreams, including improvement, transformation and business planning.

### Risks on the risk register

The following provides an overview of the risks rated as ≥16 on our organisational risk register. The organisational risk register, alongside our BAF form core components of our risk framework.


Risks are controlled and mitigated through a combination of increasing capacity, regular management meetings, the introduction of new procedures, routine updates and sitreps, investment, prioritisation mechanisms and the introduction of new software. Management, oversight, and assurance takes place through identified risk owners, reporting mechanisms to the Trust Board through Board sub-committees.

The Trust has assessed compliance with the NHS provider licence section 4 (governance). The Trust believes that effective systems and processes are in place to maintain and monitor the following conditions:

- The effectiveness of governance structures
- The responsibilities of Directors and subcommittees
- Reporting lines and accountabilities between the Board, its subcommittees, and the Executive Team.
- The submission of timely and accurate information to assess risks to compliance with the Trust's licence *and*
- The degree and rigour of oversight the Board has over the Trust's performance.

## Communication with stakeholders

Communication with stakeholders is central to ensuring risks identified by stakeholders that affect the Trust can be captured, assessed, discussed and, where appropriate, action plans can be developed to resolve any issues. A number of forums exist that allow communication with stakeholders including:

- **The Council of Governors** has a formal role as a stakeholder body for the wider community, and as part of the Trust's governance structure. The Council holds formal Council of Governor meetings quarterly, and these are open to the public, as well as constituency meetings (for publicly elected governors), member newsletters, and the Annual Members' Meeting.
- **Meetings with partner organisations**, regular review meetings take place with partner organisations including Council representatives, voluntary sector, and local universities.
- **BSW ICS partners**, including monthly meetings that bring together Chairs, Chief Executives, Chief Financial Officers, and other key staff.
- **Staff** – weekly staff newsletters, monthly staff engagement meetings, staff survey and team briefings.
- **Public and service users** – patient surveys, Patient and Carer Experience Group and Patient Advice and Liaison Service.

## Developing workforce safeguards

The following approaches and mechanisms are used to ensure that Short-, Medium- and Long-Term workforce strategies support staffing systems to ensure that staff processes are safe sustainable and effective:

- The People Plan was agreed by the RUH Board in July 2022 and outlines the people strategy and agenda for the next three to five years, with refreshes as required.
- As a portfolio of work, the People Plan has been captured in eleven programmes, spanning a three-to-five-year period, with associated projects.
- Programme governance is managed through the People Programme Board and People Committee.
- The RUH's strategic workforce plan identifies the workforce requirement for the next 5 years by staff group and specialist area for medical, clinical, and non-clinical staff.
- The workforce plan is reviewed annually against the Trust operational plan/NHS long term workforce plan to ensure the 5-year outlook is maintained and aligned with the Divisional operational plans, ensuring a bottom-up approach to planning. The workforce plan is developed ensuring clinical outcomes and safe staffing levels are achieved within the appropriate financial envelope.
- Programme for Nurse Associates and Advanced Clinical Practitioners.
- Policy drafted on responding to unplanned workforce challenges.
- Planning cycle where each Division has submitted business plans for 2024/25 including a QUIP and improvement plan.

- Areas with higher levels of turnover, remain as active recruitment campaigns with a regular timeframe to ensure that these pipelines are maintained with trained staff.
- Any proposed changes to clinical staffing profiles undergo scrutiny and assurance in accordance with national guidance by the Chief Medical and Nursing Officers.
- The nursing establishment and skill mix on wards is assessed bi-annually using the SNCT assessment and reported to the Trust Board through the Clinical Governance Committee, in accordance with National Quality Board guidance.
- Safe care used on a daily basis to support safe acuity dependency and activity levels.
- Benchmarking via Model Hospital, specifically Care Hours Per Patient Day across various patient settings, helps identify and benchmark typical nursing and care staff utilisation.
- GIRFT used across a number of specialties.
- All workforce plans and improvement plans go through an EQIA.
- Single Oversight Framework (level 3) – enhanced levels of approval for bank and agency.
- Improvement programme has focussed on effective use of bank and agency including value for money.
- Workforce risks are identified and monitored in the Board Assurance Framework and divisional risk registers and assurance is provided via the People Committee and Integrated Performance reviews.

Our Board is provided with assurance of these mechanisms and processes in the following ways.

- E-Roster is used to capture and collate staffing numbers and skills mix for nursing staff. As part of the People Plan, a project is in place to improve E-Rostering practice and coverage across the RUH. A programme of work is also implementing E-Job Planning and rostering across medical colleagues.
- Alignment of ESR, SNCT, Rostering, Job Planning undertaken.
- The Guardian of Safe Working ensures issues of compliance with Doctor in Training rotas are addressed and provides assurance to the board on a quarterly and annual basis.
- Power BI dashboards have now increased access to workforce data, enabling management teams to review and seek assurance on their workforce metrics.
- Integrated performance reports articulate safe staffing levels and bank/agency usage on a monthly basis. This includes a bi-monthly People Dashboard that is presented to the People Committee for necessary assurance.
- Divisional Performance Review meetings consider staffing issues with escalation of any concerns to Executive colleagues monthly.
- The RUH Board Assurance Framework (BAF) brings together, in one place, relevant information on the risks to the Board's strategic objectives; it is a tool for the Board to give assurance against delivery of key organisational objectives. The RUH People Plan enables us to mitigate and manage workforce risk.

- The BAF workforce risks will be a primary focus for reporting to the People Committee during 2024/25, with regular assurance and 'exception' reporting at each Committee meeting.

## Compliance with the Care Quality Commission

The Trust is compliant with the registration requirements of the Care Quality Commission (CQC) and is registered with no conditions applied.

During 2023-24 the Trust received inspections of the Medicine and Maternity core services and Radiotherapy.

### Medical care (including older people's care) inspection

The CQC undertook a focused unannounced inspection of the Medicine core service in July 2023. The inspection covered the Safe and Well Led Key Lines of Enquiry. The CQC published the inspection report on 18 October 2023 giving a rating of 'Requires Improvement' for Medicine. This represented a change from the previous rating of "Good".

The CQC inspection report praised the outstanding programme provided by the Trust for its international nurses in terms of education and pastoral care. The Trust was promoted as a great place to work and to advance careers which led to a successful retention rate of international nurses. The CQC found the service had enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The CQC recognised the skills and abilities of our leaders to run services and they were seen as visible and approachable for patients and staff. The Trust had a vision for what it wanted to achieve, and a strategy created in partnership with relevant stakeholders. The CQC also noted the positive culture for reporting and managing patient safety incidents and the work being carried out to further improve safeguarding.

However, the CQC identified a number of improvements that the Trust needs to make in order to comply with the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). These include improving monitoring of risks to patients, such as through the completion of fluid charts, improving governance and risk systems to monitor the quality and safety of services, ensuring the appropriate recording of controlled medicines, and ensuring the premises and equipment are properly maintained. An improvement plan was put in place following the inspection, and progress in implementing the actions from this plan is being reviewed through the Trust Quality and Safety Group on a quarterly basis.

### Maternity inspection

The CQC carried out a short notice announced inspection of Maternity in November 2023, looking at the Safe and Well led key lines of enquiry, as part of the CQC national maternity inspection programme. The inspection report was published on 27 March 2024 and the service retained its 'outstanding' rating. Inspectors found examples of outstanding practice relating to the Trust's commitment to continuously improving services, patient experience and the supportive environment provided for staff. The development of a maternity and neonatal communication plan to improve engagement with staff was noted as 'outstanding practice', as was the Maternity Development Panel, which supports staff to develop their own projects and ideas to further improve the care we provide for our community. The CQC also noted that the service ran a forum with doulas, antenatal workers, hypnobirthing teachers and other

professionals working with women and birthing people in the community to open channels of communication and to work collaboratively on providing personalised care and support.

Community Birth Centres in Frome and Chippenham were also included in the inspection, with both centres receiving an overall 'good' rating. Inspectors recognised the community teams' commitment to continually learning and improving services, including several initiatives to tackle health inequalities and the ongoing quality improvement projects facilitating women and birthing people's choice of birth place.

Radiotherapy

The CQC carried out an announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of the radiotherapy service on 21 February 2024. The Trust is awaiting a copy of the final inspection report from the CQC. The Trust is not rated for this inspection and the CQC does not publish IR(ME)R reports on their website although they may include some details from the inspection anonymously in an overall annual report.

## Mandatory Statements

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

## Review of Economy, Efficiency and Effectiveness of the use of Resources

The Board of Directors has received regular reports about the economy, efficiency, and effectiveness of the use of resources. Regular meetings between Divisions and the Executive Directors take place to assess performance against plans. Reports provide detail on the financial, clinical, and operational performance of the Trust, and they highlight any risks and areas of concerns. Investments are determined against detailed business plans and outcomes are reviewed against those plans.

The Audit and Risk Committee considers matters of probity, the propriety, regularity of public finances and value for money, which arise from the work of the external auditors and the Trust's local counter fraud specialist and internal audit service.

Internal audit has reviewed various systems and processes in place during the year and has published reports setting out required actions to ensure economy, efficiency, effectiveness, and use of resources. The outcomes of these reports are graded as to the level of assurance and are reviewed by the respective Board committees. The committees maintain oversight of the actions being taken to address any recommendations arising from the internal audit reviews.

The Trust continues to actively pursue the opportunities as identified through the model hospital, GIRFT and the population health data, increasingly the Trust is working with system partners to identify how working collaboratively can reduce the cost base. This is reviewed at the Acute Hospital Alliance and BSW Directors of Finance meetings.

Arrangements to operate efficiently, economically, and effectively are formally reviewed by external audit.

Departmental cost improvement programmes and their delivery is tracked through the Directorate Performance Reviews and facilitated by the 'Improving Together' operating management system.

The Trust's finances are reviewed by the Finance and Performance Committee at its monthly meetings. Monthly performance, workforce and quality information is scrutinised each month by the Board and Trust Management Executive through the Integrated Performance Report.

### Information governance

The Trust recognises the importance, value and risk that comes with processing large volumes of personal, sensitive, and corporate data. The Trust is committed to proactively managing the confidentiality, integrity, availability, and resilience of this data through clear leadership and accountability, which is underpinned by the Trust's values and behaviours through awareness and education. This assurance is provided by a strong leadership team managing the Information Security and Governance to include one of the few NHS Trusts to have a dedicated cyber security team.

The Chief Medical Officer (Caldicott Guardian) and Chief Finance Officer (Senior Information Risk Owner (SIRO), oversee compliance and adherence to the Trusts Confidentiality, Information Risk and Security policies and procedures which define how the Trust proactively balances a data protection by design and default approach while ensuring that the right data is available at the right time to ensure excellent care can be provided.

Information Governance arrangements within the organisation are constantly reviewed by the Trust. The Data Security and Protection Toolkit (DSPT) is an annual assessment which demonstrates that organisations can meet the required standards in relation to confidentiality, security, and resilience of personal information.

In June 2023, the Trust's internal auditors published their review of the overall design and operation of key mandatory Data Security and Protection Toolkit (DSPT) controls. They rated the review as providing '*significant assurance*'. The submission that was subsequently made in June 2023 was that the Trust was assessed as 'Standards Met'.

Between 1 July 2023 and 31 March 2024, the Trust has had occasion to report one information governance incident to the Information Commissioner's Office (ICO). This related to the Trust web pages that were externally facing to the public did not have the correct Cookies policy deployed. An intensive investigation was undertaken, and details provided to the Board and to

the ICO which resulted in no further action being taken. This highlighted the quick responsive work of the information governance group and information security team and thus able to satisfy the enquiry raised by the ICO.

During the year, work has continued to align processes with ICS partners, with a joined-up approach to digital leadership across the three Acute Trusts within the BSW ICS. This has included sharing knowledge and resources, aligned best practice, and collaborated on programmes of work to improve consistency for patients and service users. Work continues in this digital space with patient safety and the services at the forefront of decision making.

### Data quality and governance

There is corporate leadership for data quality with the Chief Financial Officer (SIRO) holding responsibility for the quality of performance data which is reported monthly at the Trust Board and assurance committees.

The Trust has an up-to-date Data Quality Policy that was last refreshed in March 2024.

Effective decision-making by the Board of Directors is reliant upon the quality of the data received to inform those decisions. It is therefore imperative that the Board receives regular assurances over the sources of key data underpinning its performance and the integrity of its reporting against national targets. The Trust has an established system for data quality management which includes a team of Senior Business Analysts who provide support to the clinical teams / service lines in reviewing quality, activity and the patient activity data that contributes to finance information. Analysts support investigation and correction of data errors. The development of user-friendly reporting formats (such as Business Objects, Scorecards and Dashboards and SPC charts) is aimed at displaying information in a format that drives greater engagement from teams. In turn, greater engagement creates more feedback on quality and drives accuracy.

There is a regular internal audit programme which picks up key reporting including Referral to Treatment waiting times. The most recent audit by KPMG in March-24 found 'significant assurance with minor improvement'

The Trust has established a Data Quality Steering Group which reports into the Clinical Informatics Board (as a sub-group of the Management Board). The role of this Group is to ensure there is a central repository of data quality issues and risks and that remedial actions are being undertaken. The Group also ensures that the response to internal and external data quality audits are progressed, and the requisite governance improvements are undertaken in line with Information Governance Toolkit standards.

### Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit and Risk Committee and

Quality Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors and its committees have met regularly and kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring of outcomes agreed as indicators of effective controls. The Board and its committees review the Integrated Performance Report monthly which covers the key national priority and regulatory indicators, and locally derived key performance indicators. The report provides more detailed briefings on any areas of adverse performance. This report is supported by a number of more granular reports reviewed by Board committees and regular Divisional Performance Review meetings with the Executive Directors.

Internal Audit provides me with an opinion about the effectiveness of the assurance framework and the internal controls reviewed as part of the Internal Audit plan. Work undertaken by Internal Audit is reviewed by the Assurance Committees. The Board Assurance Framework and the top risks on the Risk Register are reviewed by the Board of Directors four times a year. The Board of Directors reviews the full Risk Register annually. This provides me and the Board of Directors with evidence of the effectiveness of controls in place to manage risks to achieving the Trust's principal priorities.

The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection and these are underpinned by the Improving Together methodology.

The Audit and Risk Committee has provided the Board of Directors with an independent and objective review of financial and corporate governance, and internal financial control within the Trust. The Audit and Risk Committee has received reports from external and internal audit, including reports relating to the Trust's counter fraud arrangements. The Committee agrees an annual risk based internal audit plan and receives reports on the outcomes of the reviews of the system of internal control during the course of the financial year.

Clinical Audit is one of a number of methods used by the Trust for assessing the quality and safety of care provided to patients. Clinical audit is an essential part of the Quality Improvement process and all audits undertaken within the Trust must demonstrate the potential to improve the standard of care delivered. The Trust has a Clinical Audit Policy which sets out how Clinical Audit should be conducted in the Trust.

The Trust's Clinical Audit Annual Programme of priority topics is approved by the Trust Quality and Safety Group and includes topics identified from the National Clinical Audit and Patient Outcomes Programme, National Institute for Health and Clinical Excellence guidance, Central Alerting System Alerts and Serious Incidents. The Trust Quality and Safety Group receives a quarterly progress report on the outcome of the clinical audit programme.

During 2023-24, Internal Audit conducted nine internal audits. The finalised reports have resulted in the identification of 5 high, 24 medium and 19 low risk findings to improve weaknesses in the design of controls and/or operating effectiveness. The areas the reports covered included:

- Discharge
- Infection control
- CNST Maternity Incentive Scheme
- Patient Experience

- Waiting List Management (data quality)
- Budget management (financial)
- eRostering (Governance)
- Data Security and Protection Toolkit (DSPT)
- Risk Management (Risk)

The Head of Internal Audit's opinion for the period-based 1 April 2023 to 31 March 2024 is one of significant assurance with minor improvements required.

A summary of the five high risk findings were considered in forming the opinion as to the adequacy and effectiveness of the Trust's framework of governance, risk management and control is set out below:

- Infection Prevention and Control - The initial risk assessments (IRA1s) were not regularly completed in a timely manner and were often incomplete.
- eRostering - The eRostering policy is not made available on the Intranet. The Trust does not have a Standard Operating Procedure (SOP) available to relevant staff.
- eRostering - No formal reporting processes due to a lack of overarching committee within the Trust.
- eRostering - No escalation framework available for non-compliance with eRostering, including unapproved rosters and not finalising rosters before payroll cut-off date. Action deadline: 31st March 2024.
- Patient Experience - Actions identified from complaints are not always followed up in divisions. Action deadline: 1st October 2024.

Four of the five high risk actions above have been completed and closed. In relation to the Patient Experience action, the team will be creating a central record to ensure actions can be documented, and any actions agreed from each complaint will be appropriately monitored and tracked by 1st October 2024.

A report is produced at the conclusion of each audit assignment and, where scope for improvement is found, recommendations are made, and appropriate action plans agreed with management. Reports are issued to and followed up with the responsible Executive Directors, with the results of audit work reported to the Audit and Risk Committee. An audit tracker of outstanding recommendations is updated and shared with Internal Auditors. In addition to the planned programme of work, internal audit provides advice and assistance to senior management on control issues and other matters of concern. Where Internal Audit issued a report rated high risk, the relevant audit Executive Lead will attend the relevant sub-committee of the Board to provide assurance and to enable them to oversee improvements.

The Trust is focused on action plans to address the identified risks reported in 2023-24 which have been approved by the Trust Audit and Risk Committee. The Trust will utilise an electronic solution to track all audit recommendations and actions to enhance monitoring and oversight throughout 2024/25.

My review is also informed by External Audit opinion, inspections carried out by the Care Quality Commission and other external inspections and reviews.

## Conclusion

No significant internal control issues have been identified. My review confirms that the Trust has a sound system of internal control that supports the achievement of its policies, aims and objectives.

Signed

**Cara Charles-Barks**
**Chief Executive (Accounting Officer)**
**27 June 2024**

# Independent Auditors' Report

## Independent auditor's report to the board of governors and board of directors of Royal United hospitals Bath NHS Foundation Trust

### Report on the audit of the financial statements

#### Opinion

In our opinion the financial statements of Royal United hospitals Bath NHS Foundation Trust (the 'foundation trust') and its subsidiaries (the 'group'):

- give a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2024 and of the group's and foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the group statement of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of changes in taxpayers' equity;
- the group and foundation trust statements of cash flows; and
- the related notes 1 to 43.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England.

#### Basis for opinion

We conducted 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. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

#### Conclusions relating to going concern

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the group and the foundation trust is adopted in consideration of the requirements set out in the Department of Health and Social Care Group Accounting Manual which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

## Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

## Responsibilities of accounting officer

As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the foundation trust without the transfer of the foundation trust's services to another public sector entity.

## Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

## Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

We considered the nature of the group and its control environment, and reviewed the group's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit, local counter fraud about their own identification and assessment of the risks of non-compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the group operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the group's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018, Health and Safety Act and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists such as valuations, pensions and IT specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud or non-compliance with laws and regulations in the following areas, and our specific procedures performed to address them are described below:

- determination of whether an expenditure is capital in nature and was recognised in the correct financial period: we tested the expenditure on a sample basis to assess whether they meet the relevant accounting requirements to be recognised as capital in nature; we agreed a sample of year-end capital accruals to supporting documentation and assessed whether the capitalised expenditure is recognised in the correcting accounting period.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management, internal audit and in-house legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and

- reading minutes of meetings of those charged with governance, and reviewing internal audit reports, and reviewing correspondence with CQC.

## Report on other legal and regulatory requirements

### Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

### Matters on which we are required to report by exception

*Use of resources*

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of this matter.

### Respective responsibilities of the accounting officer and auditor relating to the foundation trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the Auditor Guidance Notes issued by the Comptroller & Auditor General, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2024 by the time of the issue of our audit report. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

*Annual Governance Statement and compilation of financial statements*

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

*Reports in the public interest or to the regulator*

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of this matter.

Certificate of completion of the audit

We certify that we have completed the audit of Royal United Hospitals Bath NHS Foundation Trust in accordance with requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Michelle Hopton (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Bristol, United Kingdom
27 June 2024

# Royal United Hospitals Bath NHS Foundation Trust

# Annual accounts for the year ended 31 March 2024

**Foreword to the accounts**

**Royal United Hospitals Bath NHS Foundation Trust**

These accounts, for the year ended 31 March 2024, have been prepared by Royal United Hospitals Bath NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

**Signed** 

**Name** **Cara Charles-Barks**
**Job title** **Chief Executive**
**Date** **27 June 2024**

# Consolidated Statement of Comprehensive Income

| | | Group | |
|---|---|---|---|
| | | 2023/24 | 2022/23 |
| | Note | £000 | £000 |
| Operating income from patient care activities | 3 | 507,561 | 485,743 |
| Other operating income | 4 | 48,205 | 39,478 |
| Operating expenses | 6, 8 | (555,115) | (515,975) |
| **Operating (deficit)/ surplus from continuing operations** | | **651** | **9,246** |
| Finance income | 10 | 2,871 | 1,135 |
| Finance expenses | 11 | (1,925) | (784) |
| PDC dividends payable | | (6,551) | (7,339) |
| **Net finance costs** | | **(5,605)** | **(6,988)** |
| Other gains | 12 | 92 | 69 |
| Share of losses of joint arrangements | 25 | (56) | - |
| **(Deficit)/ surplus for the year from continuing operations** | | **(4,918)** | **2,327** |
| **(Deficit)/ surplus for the year** | | **(4,918)** | **2,327** |
| **Other comprehensive income** | | | |
| **Will not be reclassified to income and expenditure:** | | | |
| Impairments | 7 | (4,684) | (1,810) |
| Revaluations | 20 | 1,086 | 9,815 |
| Other reserve movements | | (1) | (1) |
| **Total other comprehensive income** | | **(3,599)** | **8,004** |
| **May be reclassified to income and expenditure when certain conditions are met:** | | | |
| Fair value gains/(losses) on financial assets mandated at fair value through OCI | 26 | 226 | (350) |
| **Total comprehensive (expense)/ income for the period** | | **(8,291)** | **9,981** |

## Statements of Financial Position

| | | Group | | Trust | |
|---|---|---|---|---|---|
| | Note | 31 March 2024 £000 | 31 March 2023 £000 | 31 March 2024 £000 | 31 March 2023 £000 |
| **Non-current assets** | | | | | |
| Intangible assets | 14,15 | 7,105 | 7,600 | 6,132 | 6,626 |
| Property, plant and equipment | 17,18 | 301,392 | 288,156 | 297,029 | 287,367 |
| Right of use assets | 23,24 | 51,035 | 51,167 | 50,237 | 50,332 |
| Investments in associates and joint ventures | 25 | - | 56 | - | - |
| Other investments / financial assets | 26 | 4,833 | 6,483 | 3,941 | 3,941 |
| Receivables | 29 | 1,862 | 1,996 | 5,455 | 2,327 |
| **Total non-current assets** | | **366,227** | **355,458** | **362,794** | **350,593** |
| **Current assets** | | | | | |
| Inventories | 28 | 8,284 | 7,003 | 6,258 | 5,823 |
| Receivables | 29 | 30,482 | 28,784 | 26,622 | 25,724 |
| Cash and cash equivalents | 31 | 38,526 | 47,106 | 33,865 | 41,102 |
| **Total current assets** | | **77,292** | **82,893** | **66,745** | **72,649** |
| **Current liabilities** | | | | | |
| Trade and other payables | 32 | (55,298) | (70,664) | (50,152) | (66,160) |
| Borrowings | 34 | (3,070) | (2,155) | (2,796) | (1,953) |
| Provisions | 35 | (475) | (263) | (454) | (190) |
| Other liabilities | 33 | (13,298) | (2,407) | (11,388) | (810) |
| **Total current liabilities** | | **(72,141)** | **(75,489)** | **(64,790)** | **(69,113)** |
| **Total assets less current liabilities** | | **371,377** | **362,862** | **364,749** | **354,129** |
| **Non-current liabilities** | | | | | |
| Borrowings | 34 | (54,128) | (54,502) | (53,997) | (54,315) |
| Provisions | 35 | (1,370) | (1,525) | (1,370) | (1,525) |
| **Total non-current liabilities** | | **(55,498)** | **(56,027)** | **(55,367)** | **(55,840)** |
| **Total assets employed** | | **315,879** | **306,835** | **309,382** | **298,289** |
| | | | | | |
| **Financed by** | | | | | |
| Public dividend capital | | 253,535 | 236,187 | 253,535 | 236,187 |
| Revaluation reserve | | 41,562 | 46,645 | 41,562 | 46,645 |
| Income and expenditure reserve | | 12,303 | 13,388 | 14,286 | 15,457 |
| Charitable fund reserves | 27 | 8,479 | 10,615 | - | - |
| **Total taxpayers' equity** | | **315,879** | **306,835** | **309,383** | **298,289** |

The notes on pages 153 to 217 form part of these accounts.

Name Cara Charles-Barks
Position Chief Executive
Date **27 June 2024**

# Consolidated Statement of Changes in Equity for the year ended 31 March 2024

| Group | Note | Public dividend capital | Revaluation reserve | Income and expenditure reserve | Charitable fund reserves | Total |
|---|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 | £000 |
| **Taxpayers' and others' equity at 1 April 2023 - brought forward** | | **236,187** | **46,645** | **13,388** | **10,615** | **306,835** |
| Deficit for the year | | - | - | (6,073) | 1,155 | **(4,918)** |
| **Total comprehensive (expense) /income** | | **-** | **-** | **(6,073)** | **1,155** | **(4,918)** |
| Other transfers between reserves | | - | (1,485) | 1,485 | - | **-** |
| Impairments | 7 | - | (4,684) | - | - | **(4,684)** |
| Revaluations | 20 | - | 1,086 | - | - | **1,086** |
| Fair value gains on financial assets mandated at fair value through OCI | 26 | - | - | - | 226 | **226** |
| Public dividend capital received | cashflow | 17,348 | - | - | - | **17,348** |
| Other reserve movements | | - | - | 3,503 | (3,517) | **(14)** |
| **Taxpayers' and others' equity at 31 March 2024** | | **253,535** | **41,562** | **12,303** | **8,479** | **315,879** |

# Consolidated Statement of Changes in Equity for the year ended 31 March 2023

| Group | Note | Public dividend capital | Revaluation reserve | Income and expenditure reserve | Charitable fund reserves | Total |
|---|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 | £000 |
| **Taxpayers' and others' equity at 1 April 2022 - brought forward** | | **207,344** | **39,906** | **7,125** | **13,636** | **268,011** |
| Surplus for the year | | - | - | 1,544 | 783 | **2,327** |
| **Total comprehensive (expense) /income** | | **-** | **-** | **1,544** | **783** | **2,327** |
| Other transfers between reserves | | - | (1,266) | 1,266 | - | **-** |
| Impairments | 7 | - | (1,810) | - | - | **(1,810)** |
| Revaluations | 20 | - | 9,815 | - | - | **9,815** |
| Fair value gains/(losses) on financial assets mandated at fair value through OCI | 26 | - | - | - | (350) | **(350)** |
| Public dividend capital received | cashflow | 29,666 | - | - | - | **29,666** |
| Public dividend capital repaid | | (823) | - | - | - | **(823)** |
| Other reserve movements | | - | - | 3,453 | (3,454) | **(1)** |
| **Taxpayers' and others' equity at 31 March 2023** | | **236,187** | **46,645** | **13,388** | **10,615** | **306,835** |

# Statement of Changes in Equity for the year ended 31 March 2024

| Trust | Note | Public dividend capital | Revaluation reserve | Income and expenditure reserve | Total |
|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 |
| **Taxpayers' and others' equity at 1 April 2023 - brought forward** | | **236,187** | **46,645** | **15,457** | **298,289** |
| Surplus for the year | | - | - | (2,659) | **(2,659)** |
| **Total comprehensive (expense) /income** | | **-** | **-** | **(2,659)** | **(2,659)** |
| Other transfers between reserves | | - | (1,485) | 1,485 | **-** |
| Impairments | 7 | - | (4,684) | - | **(4,684)** |
| Revaluations | 20 | - | 1,086 | - | **1,086** |
| Share of comprehensive income from associates and joint ventures | 25 | - | - | | **-** |
| Public dividend capital received | cashflow | 17,348 | - | - | **17,348** |
| Other reserve movements | | - | - | 3 | **3** |
| **Taxpayers' and others' equity at 31 March 2024** | | **253,535** | **41,562** | **14,286** | **309,383** |

# Statement of Changes in Equity for the year ended 31 March 2023

| Trust | Note | Public dividend capital | Revaluation reserve | Income and expenditure reserve | Total |
|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 |
| **Taxpayers' and others' equity at 1 April 2022 - brought forward** | | **207,344** | **39,906** | **7,381** | **254,631** |
| Surplus for the year | | - | - | 7,043 | **7,043** |
| **Total comprehensive (expense) /income** | | **-** | **-** | **7,043** | **7,043** |
| Other transfers between reserves | | - | (1,266) | 1,266 | **-** |
| Impairments | 7 | - | (1,810) | - | **(1,810)** |
| Revaluations | 20 | - | 9,815 | - | **9,815** |
| Public dividend capital received | cashflow | 29,666 | - | - | **29,666** |
| Public dividend capital repaid | cashflow | (823) | - | - | **(823)** |
| Other reserve movements | | - | - | (233) | **(233)** |
| **Taxpayers' and others' equity at 31 March 2023** | | **236,187** | **46,645** | **15,457** | **298,289** |

**Information on reserves**

**Public dividend capital**
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

**Revaluation reserve**
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

**Income and expenditure reserve**
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

**Charitable funds reserve**
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 27.

# Statements of Cash Flows

| | Note | Group 2023/24 £000 | Group 2022/23 £000 | Trust 2023/24 £000 | Trust 2022/23 £000 |
|---|---|---|---|---|---|
| **Cash flows from operating activities** | | | | | |
| Operating (deficit)/ surplus | | 651 | 9,228 | 2,972 | 14,016 |
| **Non-cash income and expense:** | | | | | |
| Depreciation and amortisation | 6 | 19,374 | 19,267 | 18,572 | 16,117 |
| Net impairments | 7 | 2,497 | (1,297) | 2,498 | (1,297) |
| Income recognised in respect of capital donations | 4 | (683) | (1,229) | (683) | (4,509) |
| Decrease/(increase) in receivables and other assets | | (120) | (16,101) | (3,117) | (16,261) |
| (Increase) in inventories | | (1,281) | (1,212) | (435) | (1,337) |
| (Decrease) / increase in payables and other liabilities | | (4,801) | 11,293 | (5,214) | 10,337 |
| (Decrease) / increase in provisions | | (293) | (253) | (241) | (332) |
| Movements in charitable fund working capital | | 60 | 432 | - | - |
| Other movements in operating cash flows | | (3,309) | (121) | - | - |
| **Net cash flows from operating activities** | | **12,096** | **20,007** | **14,352** | **16,734** |
| **Cash flows from investing activities** | | | | | |
| Interest received | | 2,571 | 979 | 2,704 | 979 |
| Purchase and sale of financial assets / investments | | - | - | - | (290) |
| Purchase of intangible assets | | (1,975) | (1,527) | (1,975) | (1,527) |
| Sales of intangible assets | | - | - | - | 16 |
| Purchase of PPE and investment property | | (29,071) | (46,786) | (28,558) | (47,068) |
| Sales of PPE and investment property | | 149 | 104 | 124 | - |
| Receipt of cash donations to purchase assets | | 682 | 1,078 | 683 | 4,509 |
| Net cash flows from charitable fund investing activities | | 2,180 | 3,384 | - | - |
| **Net cash flows used in investing activities** | | **(25,464)** | **(42,768)** | **(27,022)** | **(43,381)** |
| **Cash flows from financing activities** | | | | | |
| Public dividend capital received | | 17,348 | 29,666 | 17,348 | 29,667 |
| Public dividend capital repaid | | - | (823) | - | (823) |
| Movement on loans from DHSC | | (313) | (313) | (313) | (313) |
| Capital element of lease liability repayments | | (2,808) | (3,857) | (2,830) | (1,560) |
| Interest on loans | | (128) | (133) | (128) | (133) |
| Interest paid on lease liability repayments | | (1,780) | (636) | (1,726) | (462) |
| PDC dividend paid | | (7,531) | (7,170) | (7,531) | (7,170) |
| Cash flows from (used in) other financing activities | | - | (18) | 437 | (3) |
| **Net cash flows from financing activities** | | **4,788** | **16,716** | **5,257** | **19,203** |
| **Decrease in cash and cash equivalents** | | **(8,580)** | **(6,045)** | **(7,413)** | **(7,444)** |
| **Cash and cash equivalents at 1 April - brought forward** | | **47,106** | **53,151** | **41,098** | **48,542** |
| **Cash and cash equivalents at 31 March** | 31 | **38,526** | **47,106** | **33,685** | **41,098** |

## Notes to the Accounts

### Note 1 Accounting policies and other information

### Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2023/24 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

**Accounting convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, and certain financial assets and financial liabilities.

### Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The Directors have a reasonable expectation that this will continue to be the case.

### Note 1.3 Consolidation

**NHS Charitable Funds**

The Trust is the corporate trustee to the RUH Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the Charitable Fund and has the ability to affect those returns and other benefits through its power over the fund.

The Charitable Fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the Charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

**Other subsidiaries**

The Trust has a subsidiary Sulis Hospital, as the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

Where subsidiaries' accounting policies are not aligned with those of the Trust, then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

**Joint ventures**

The Trust has a one third controlling interest in Wiltshire Health and Care LLP, in partnership with Salisbury NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust.

The LLP has a separate Board but strategic control of the organisation remains with the partners as detailed in the Members Agreement signed by the three NHS Foundation Trusts.

**Note 1.4 Revenue from contracts with customers**

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The timing of satisfaction of performance obligations relates to the typical timing of payment (i.e. credit terms).

**Revenue from NHS contracts**

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. In 2023/24 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage in addition to the price of the related service.

In 2022/23 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at a rate of 75% of the tariff price.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular Integrated Care Board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2023/24, Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners. In 2022/23 elective recovery funding for providers was separately identified within the aligned payment and incentive contracts.

**Revenue from research contracts**

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

**Note 1.4 Revenue from contracts with customers continued**

**NHS injury cost recovery scheme**
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Each year, the Compensation Recovery Unit (CRU) advises a percentage of receiving the income, this should be included within the provision for impairment of receivables. For 2023-24 is 23.07%, Therefore, 23.07% of accrued ICR revenue within the provision for impairment of receivables.

**Note 1.5 Other forms of income**

**Grants and donations**
Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

**Apprenticeship service income**
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

**Note 1.6 Expenditure on employee benefits**

**Short-term employee benefits**
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

**Pension costs**

*NHS Pension Scheme*
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

**Note 1.7 Expenditure on other goods and services**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

**Note 1.8 Discontinued operations**

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

**Note 1.9 Property, plant and equipment**

**Recognition**
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

*Subsequent expenditure*
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

**Measurement**

*Valuation*
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

**Note 1.9 Property, plant and equipment continued**

*Depreciation*
Items of property, plant and equipment are depreciated using the straight line method, over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

*Revaluation gains and losses*
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

*Impairments*
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

**De-recognition**

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

**Donated and grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

**Note 1.9 Property, plant and equipment continued**

**Useful lives of property, plant and equipment**

Useful lives reflect the total life of an asset and not the remaining life of an asset. Asset lives have been extended in 23/24 to reflect the usage of assets over their lifetime. The range of useful lives are shown in the table below:

| | Min life Years | Max life Years |
|---|---|---|
| Land | - | - |
| Buildings, excluding dwellings | 10 | 62 |
| Dwellings | 30 | 46 |
| Plant & machinery | 2 | 25 |
| Information technology | 2 | 7 |
| Furniture & fittings | 2 | 17 |

**Note 1.10 Intangible assets**

**Recognition**

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

*Internally generated intangible assets*

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

*Software*

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

**Measurement**

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

*Amortisation*

Intangible assets are amortised over their expected useful lives using the straight line method, in a manner consistent with the consumption of economic or service delivery benefits.

**Useful lives of intangible assets**

Useful lives reflect the total life of an asset and not the remaining life of an asset. Asset lives have been extended in 23/24 to reflect the usage of assets over their lifetime. The range of useful lives is shown in the table below:

| | Min life Years | Max life Years |
|---|---|---|
| Software licences | 2 | 10 |
| Licences & trademarks | 2 | 9 |

**Note 1.11 Business Combinations and Goodwill**

When the Trust acquires the power to exercise control over an entity, that entity is accounted for as a subsidiary using the acquisition method from the acquisition date, which is the date on which control is transferred to the Group. The Trust has control when it has the ability to affect the variable returns from the other entity through its power to direct its relevant activities. From the acquisition date the income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests (if any) are included as a separate item in the Statement of Financial Position.

When the Trust first acquires control of an entity, the Group is required to measure goodwill at the acquisition date which is the extent to which the fair value of the consideration transferred exceeds the net recognised amount (typically at fair value) of all the identifiable assets acquired and liabilities assumed.

Goodwill is recognised as an intangible asset in the Consolidated Balance Sheet. It includes non-identified intangible assets including business processes and workforce-related industry-specific knowledge and technical skills. Goodwill has an indefinite expected useful life and is not amortised, but is tested annually for impairment.

Costs related to the acquisition, are expensed as incurred.

On closure or disposal of an acquired business, goodwill would be taken into account in determining the profit or loss on closure or disposal.

**Note 1.12 Inventories**

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

**Note 1.13 Cash and cash equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

**Note 1.14 Financial assets and financial liabilities**

**Recognition**
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

**Classification and measurement**
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income depending upon type.

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure.

**Note 1.14 Financial assets and financial liabilities continued**

**Financial assets and financial liabilities at amortised cost**

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

**Financial assets measured at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition

The Trust has irrevocably elected to measure the following equity instruments at fair value through other comprehensive income. All gains and losses arising from investment funds held by The Royal United Charitable Fund will be measured at fair value through Other Comprehensive Income. The investment fund does not meet the criteria set out in the accounting standards to be recognised as a gain or loss through income and expenditure.

**Financial assets and financial liabilities at fair value through income and expenditure**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

**Impairment of financial assets**

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

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NHS debt. Judgement is also applied, where the expectation of future credit losses is anticipated to impact upon the recoverable amount of the asset. The age of a receivable is taken into account and the more overdue a receivable becomes, the higher the value of expected credit loss.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

**Derecognition**

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

**Note 1.15 Leases**

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

**The Trust as a lessee**

*Recognition and initial measurement*
At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

*Subsequent measurement*
As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

**The Trust as a lessor**

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

*Finance leases*

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

*Operating leases*
Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

**Note 1.15 Leases continued**

**Initial application of IFRS 16 in 2022/23**

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments were not revisited.

*The Trust as lessee*
For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the Statement of Financial Position immediately prior to initial application. Hindsight was used in determining the lease term where lease arrangements contained options for extension or earlier termination.

No adjustments were made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets had a value below £5,000. No adjustments were made in respect of leases previously classified as finance leases.

*The Trust as lessor*
Leases of owned assets where the Trust was lessor were unaffected by initial application of IFRS 16.

**Note 1.16 Provisions**

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted

| | | Nominal rate | Prior year rate |
|---|---|---|---|
| Short-term | Up to 5 years | 4.26% | 0.47% |
| Medium-term | After 5 years up to 10 years | 4.03% | 0.70% |
| Long-term | After 10 years up to 40 years | 4.72% | 0.95% |
| | Exceeding 40 years | 4.40% | 0.66% |

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2024:

| | Inflation rate | Prior year rate |
|---|---|---|
| Year 1 | 3.60% | 7.40% |
| Year 2 | 1.80% | 0.60% |
| Into perpetuity | 2.00% | 2.00% |

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.45% in real terms (prior year: 1.30%).

**Clinical negligence costs**

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 36 but is not recognised in the Trust's accounts.

**Non-clinical risk pooling**
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

**Note 1.17 Contingencies**

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 37 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 37, unless the probability of a transfer of economic benefits is remote.
Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

**Note 1.18 Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

**Note 1.19 Value added tax**

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

**Note 1.20 Corporation tax**

Under current legislation, Foundation Trusts are not liable for corporation tax.

The Trust's subsidiary company files a separate tax return to the Trust.  The subsidiary is not expected to pay any corporation tax in this financial period due to accumulated tax losses.

Deferred taxes are provided for on temporary differences and carry forwards. This is in line with the expected corporation tax rate increase, and the deferred tax assets not expected to be realised before this time. The rate change may affect future tax charges. In addition the utilisation of any tax losses and temporary differences for which no deferred tax asset has been recognised may also affect future tax charges. Deferred taxes at the balance sheet date have been measured using these enacted tax rates and reflected in these financial statements.

**Note 1.21 Climate change levy**

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

**Note 1.22 Foreign exchange**

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

**Note 1.23 Third party assets**

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

**Note 1.24 Losses and special payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

**Note 1.25 Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

**Note 1.26 Early Adoption of Standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been adopted early in 2023/24.

**Note 1.27 Early Adoption of Standards, amendments and interpretations**

IFRS 17 Insurance Contracts - Applies to accounting periods beginning on or after January 2021. The standard is not yet adopted by the FReM which is expected from April 2025.

IFRS 14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016 and is not applicable to DHSC group bodies.

Neither standard is expected to have a material impact on the accounts.
IFRS 18 Presentation and Disclosure in Financial Statements. The Standard is not yet UK endorsed or adopted by the FReM. Until such time as it is adopted by the FReM it is not practical for entities to assess whether or not it has a material impact.

**Note 1.28 Critical judgements in applying accounting policies**

In the application of the Trust's accounting policies, management is required to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised.

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

**Note 1.28 Critical judgements in applying accounting policies continued**

Valuation basis

Department of Health and Social Care guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets. The current site in determining the MEA, the Trust has to make assumptions that are practically achievable, however the Trust is not required to have any plans to make such changes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Trust, and would not impact on service delivery or the level and volume of service provided. This is because the catchment area for patients using the services, and transport infrastructure has been taken into account when deciding on an appropriate alternative site.

For the purpose of the MEA valuation, the Trust has assumed that the modern equivalent asset for Royal United Hospital would be a multi storey building, which would occupy less land. For the purpose of the MEA valuation, the Trust has not included unused space, unused land, underutilised space and any space not used for healthcare purposes or required to directly support the delivery of healthcare, in the calculation of modern equivalent asset.

Classification of the Sulis Hospital Lease

The Trust has performed a review of IAS40 "Investment Property" and considered the classification of the Trust's external lease of the Sulis hospital site which is sub leased to the wholly owned subsidiary. As a result of this review it has been concluded that this does not meet the definition of an investment property within the Trust only balance sheet. The Hospital lease has been classified as right to use asset under IFRS16.

**Note 1.29 Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year. Given the nature of the estimation uncertainity it is difficult to complete a meaningful sensitivity analysis:

Property Valuations

Land and buildings are included in the Trust's statement of financial position at current value in existing use. The assessment of current value represents a key source of uncertainty. The Trust uses an external professional valuer to determine current value in existing use, using modern equivalent asset value methodology.

Property, plant and equipment were valued using an index from Gerald Eve as at 31 March 2024. These valuations are based on the Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health. Property valuation techniques include an inherent element of estimation; in particular specialised assets that have no active market require valuation based on assessing the likely replacement cost of an asset. Future property values will be influenced by factors such as construction costs and developments in healthcare technology and any recognised impairments. Future asset values will inevitably fluctuate but the Trust mitigates against material correcting adjustments by commissioning regular professional asset valuation reviews.

Depreciation and Amortisation

Depreciation of property, plant and equipment and amortisation of computer software the Trust exercises judgement to determine the useful lives and residual values of property, plant and equipment and computer software. Depreciation and amortisation is provided so as to write down the value of these assets to their residual value over their estimated useful lives.

Useful economic life

The useful economic life of each category of fixed asset is assessed when acquired by the Foundation Trust. A degree of estimation is occasionally used in assessing the useful economic lives of assets.

**Note 2 Operating Segments**

The Trust Board is the Chief Operating Decision Maker and considers the Trust's healthcare services, along with all the operating segments due to them having similar economic characteristics.

On 1st June 2021 the Royal United Hospitals Bath NHS FT acquired Sulis Hospital Bath Ltd. Sulis Hospital is a Private Limited Company. The financial performance of Sulis is consolidated and reported to the Board monthly. The financial position of Sulis has been shown in the segmental analysis below.

***Income and Expenditure analysis by Segment***

2023/24

| | **Trust** | **Sulis** | **Charity** | **Adjustments for intracompany eliminations** | **Total** |
|---|---|---|---|---|---|
| | **£000s** | **£000s** | **£000s** | **£000s** | **£000s** |
| Operating income | 522,234 | 39,757 | 2,762 | (8,988) | 555,766 |
| Operating expenditure | (519,262) | (38,844) | (5,410) | 8,402 | (555,115) |
| **Operating surplus /(deficit)** | **2,972** | **913** | **(2,648)** | **(586)** | **651** |
| Net finance costs | (5,630) | (619) | - | 736 | (5,513) |
| Share of loss of joint venture | - | - | - | (56) | (56) |
| **Surplus/(deficit) for the period** | **(2,659)** | **294** | **(2,648)** | **94** | **(4,918)** |
| Impairments | (4,684) | - | - | - | (4,684) |
| Revaluations | 1,086 | - | - | - | 1,086 |
| Fair value gains on financial assets mandated at fair value through OCI | - | - | 226 | - | 226 |
| Other reserve movements | - | - | (1) | - | (1) |
| **Total comphrensive expense for the period** | **(6,257)** | **294** | **(2,423)** | **94** | **(8,291)** |

***Income and Expenditure analysis by Segment***

2022/23

| | **Trust** | **Sulis** | **Charity** | **Adjustments for intracompany eliminations** | **Total** |
|---|---|---|---|---|---|
| | **£000s** | **£000s** | **£000s** | **£000s** | **£000s** |
| Operating income | 494,890 | 33,575 | 1,970 | (5,214) | 525,221 |
| Operating expenditure | (480,874) | (34,826) | (4,796) | 4,521 | (515,975) |
| **Operating surplus /(deficit)** | **14,016** | **(1,251)** | **(2,826)** | **(693)** | **9,246** |
| Net finance costs | (7,042) | (685) | 156 | 583 | (6,988) |
| Other | 69 | | | | 69 |
| **Surplus/(deficit) for the period** | **7,043** | **(1,936)** | **(2,670)** | **(110)** | **2,327** |
| Impairments | (1,810) | - | - | | (1,810) |
| Revaluations | 9,815 | - | - | - | 9,815 |
| Fair value gains on financial assets mandated at fair value through OCI | - | - | (350) | - | (350) |
| Other reserve movements | - | - | (1) | - | (1) |
| **Total comphrensive Income for the period** | **15,048** | **(1,936)** | **(3,021)** | **(110)** | **9,981** |

**Note 2 Operating Segments continued**

***Balance Sheet analysis by Segment***

2023/24

| | Trust | Sulis | Charity | Adjustments for intracompany eliminations | Total |
|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s |
| Non-Current Assets | 362,794 | 14,297 | 4,833 | (15,697) | **366,227** |
| Current Assets | 66,745 | 7,712 | 4,814 | (1,979) | **77,292** |
| Current Liabilities | (64,790) | (9,988) | (1,168) | 3,805 | **(72,141)** |
| **Total assets less liabilities** | **364,749** | **12,021** | **8,479** | **(13,872)** | **371,377** |
| Non-current liabilities | (55,367) | (13,778) | - | 13,647 | **(55,498)** |
| **Total net assets employed** | **309,382** | **(1,757)** | **8,479** | **(225)** | **315,879** |

**Note 2 Operating Segments continued**

***Balance Sheet analysis by Segment***

2022/23

| | Trust | Sulis | Charity | Adjustments for intracompany eliminations | Total |
|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s |
| Non-Current Assets | **350,593** | **1,626** | **6,483** | **(3,244)** | **355,458** |
| Current Assets | 72,649 | 6,772 | 5,308 | (1,836) | **82,893** |
| Current Liabilities | (69,113) | (6,926) | (1,176) | 1,726 | **(75,489)** |
| **Total assets less liabilities** | **354,129** | **1,472** | **10,615** | **(3,354)** | **362,862** |
| Non-current liabilities | (55,840) | (629) | - | 442 | **(56,027)** |
| **Total net assets employed** | **298,289** | **843** | **10,615** | **(2,912)** | **306,835** |

## Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

| Note 3.1 Income from patient care activities (by nature) | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Income from commissioners under API contracts | 420,034 | 392,959 |
| High cost drugs income from commissioners | 28,494 | 25,160 |
| Other NHS clinical income | 3,783 | 10,177 |
| Income from other sources (e.g. local authorities) | 1,694 | 1,653 |
| Private patient income | 16,768 | 16,107 |
| Elective recovery fund | 19,248 | 13,186 |
| National pay award central funding*** | 252 | 10,069 |
| Additional pension contribution central funding** | 13,409 | 12,032 |
| Other clinical income | 3,879 | 4,400 |
| **Total income from activities** | **507,561** | **485,743** |

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation. https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

***Additional funding was made available by NHS England in 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024. 2022/23: In March 2023, the government made a pay offer for staff on agenda for change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment at 31 March 2023.

## Note 3.2 Income from patient care activities (by source)

| | 2023/24 | 2022/23 |
|---|---|---|
| **Income from patient care activities received from:** | **£000** | **£000** |
| NHS England | 82,309 | 104,465 |
| Clinical commissioning groups | - | 75,067 |
| Integrated care boards | 400,004 | 281,527 |
| Other NHS providers | 2,249 | 2,570 |
| NHS other | 1,316 | 1,062 |
| Local authorities | 1,388 | 1,435 |
| Non-NHS: private patients | 16,768 | 16,107 |
| Non-NHS: overseas patients (chargeable to patient) | 211 | 142 |
| Injury cost recovery scheme | 554 | 316 |
| Non NHS: other | 2,762 | 3,052 |
| **Total income from activities** | **507,561** | **485,743** |
| **Of which:** | | |
| Related to continuing operations | 507,561 | 485,743 |
| Related to discontinued operations | - | - |

**Note 3.3 Overseas visitors (relating to patients charged directly by the provider)**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Income recognised this year | 211 | 142 |
| Cash payments received in-year | 154 | 94 |
| Amounts written off in-year | 3 | 1 |

**Note 4 Other operating income (Group)**

| | 2023/24 | | | 2022/23 | | |
|---|---|---|---|---|---|---|
| | Contract income | Non-contract income | Total | Contract income | Non-contract income | Total |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| Research and development | 4,519 | - | **4,519** | 3,618 | - | **3,618** |
| Education and training | 16,417 | 1,031 | **17,448** | 14,913 | 688 | **15,601** |
| Non-patient care services to other bodies | 12,258 | - | **12,258** | 6,901 | - | **6,901** |
| Reimbursement and top up funding | - | - | **-** | 2,008 | - | **2,008** |
| Income in respect of employee benefits accounted on a gross basis | 3,763 | - | **3,763** | 3,180 | - | **3,180** |
| Receipt of capital grants and donations and peppercorn leases | - | 683 | **683** | - | 1,229 | **1,229** |
| Charitable and other contributions to expenditure | - | 111 | **111** | - | 954 | **954** |
| Revenue from operating leases | - | 515 | **515** | - | 492 | **492** |
| Charitable fund incoming resources | - | 2,758 | **2,758** | - | 1,970 | **1,970** |
| Other income | 6,269 | (119) | **6,150** | 3,698 | (173) | **3,525** |
| **Total other operating income** | **43,226** | **4,979** | **48,205** | **34,318** | **5,160** | **39,478** |
| **Of which:** | | | | | | |
| Related to continuing operations | | | 48,205 | | | 39,478 |
| Related to discontinued operations | | | - | | | - |

**Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the period**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods | 997 | 47 |

**Note 4.2 Income from activities arising from commissioner requested services**

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Income from services designated as commissioner requested services | 507,561 | 485,743 |
| Income from services not designated as commissioner requested services | 48,205 | 44,528 |
| **Total** | **555,766** | **530,271** |

**Note 4.3 Fees and charges (Group)**

The following disclosure is of income from charges to service users where the full cost of providing that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Income | 3,601 | 2,817 |
| Full cost | (2,706) | (2,317) |
| **Surplus / (deficit)** | **895** | **500** |

Fees and charges relate to car parking and retail catering.

## Note 5 Operating leases - Royal United Hospitals Bath NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where Royal United Hospitals Bath Foundation Trust is the lessor.

The expected lease payments relate to leases between the Trust and Sulis Hospital, for the Hospital building and medical equipment.

### Note 5.1 Operating leases income (Group)

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| **Lease receipts recognised as income in year:** | | |
| Minimum lease receipts | 515 | 708 |
| **Total in-year operating lease income** | **515** | **708** |

### Note 5.2 Future lease receipts (Trust)

| | 31 March 2024 | 31 March 2023 |
|---|---|---|
| | £000 | £000 |
| **Future minimum lease receipts due in:** | | |
| - not later than one year | 2,505 | 2,348 |
| - later than one year and not later than two years | 2,422 | 2,310 |
| - later than two years and not later than three years | 2,470 | 2,272 |
| - later than three years and not later than four years | 2,520 | 2,204 |
| - later than four years and not later than five years | 2,570 | 2,075 |
| - later than five years | 652 | 2,551 |
| **Total** | **13,139** | **13,760** |

During 2022/23 the Trust leased a IFRS16 leases and operating leases to Sulis Hospital. The most significant of the leases was the Hospital lease. Total income that the Trust received for all leases from Sulis in 2023/24 was £3.0 million. The income received covered the cost of the leases and the Trust did not make any profit from the leasing arrangements in place.

The Hospital lease is classified as an operating lease within the Trust accounts, and as such retains the rights over the asset. The remaining leases are not material to the accounts.

**Note 6 Operating expenses (Group)**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Purchase of healthcare from non-NHS and non-DHSC bodies | 3,447 | 4,514 |
| Staff and executive directors costs | 356,505 | 333,893 |
| Remuneration of non-executive directors | 187 | 144 |
| Supplies and services - clinical (excluding drugs costs) | 51,705 | 47,098 |
| Supplies and services - general | 9,397 | 8,729 |
| Drug costs (drugs inventory consumed and purchase of non-inventory drugs) | 56,102 | 53,031 |
| Consultancy costs | 24 | - |
| Establishment | 6,953 | 7,462 |
| Premises | 19,258 | 19,768 |
| Transport (including patient travel) | 1,369 | 1,611 |
| Depreciation on property, plant and equipment and IFRS 16 assets | 16,849 | 16,858 |
| Amortisation on intangible assets | 2,525 | 2,409 |
| Net impairments | 2,497 | (1,297) |
| Movement in credit loss allowance: contract receivables / contract assets | (24) | 44 |
| Increase/(decrease) in other provisions | 48 | (31) |
| Change in provisions discount rate(s) | (251) | - |
| audit services- statutory audit | 110 | 95 |
| other auditor remuneration (external auditor only) | 49 | 76 |
| Clinical negligence | 15,506 | 13,638 |
| Legal fees | 153 | 105 |
| Insurance | 549 | 771 |
| Research and development | 4,229 | 3,680 |
| Education and training | 4,525 | 2,078 |
| Expenditure on low value leases | 140 | 105 |
| Hospitality | 79 | 115 |
| Losses, ex gratia & special payments | 27 | 55 |
| Other NHS charitable fund resources expended | 1,001 | 569 |
| Other | 2,156 | 455 |
| **Total** | **555,115** | **515,975** |
| **Of which:** | | |
| Related to continuing operations | 555,115 | 515,975 |
| Related to discontinued operations | - | - |

**Note 6.1 Other auditor remuneration (Group)**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| **Other auditor remuneration paid to the external auditor:** | | |
| 1. Audit of accounts of any associate of the trust | 49 | 76 |
| **Total** | **49** | **76** |

**Note 6.2 Limitation on auditor's liability (Group)**

The limitation on auditor's liability for external audit work is £1 million (2022/23: £1 million).

**Note 7 Impairment of assets (Group)**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| **Net impairments charged to operating surplus / deficit resulting from:** | | |
| Abandonment of assets in course of construction | 336 | - |
| Changes in market price | 2,161 | (1,297) |
| **Total net impairments charged to operating surplus / deficit** | **2,497** | **(1,297)** |
| Impairments charged to the revaluation reserve | 4,684 | 1,810 |
| **Total net impairments** | **7,181** | **513** |

**Note 8 Employee benefits (Group)**

| | 2023/24 Total £000 | 2022/23 Total £000 |
|---|---|---|
| Salaries and wages | 277,417 | 257,548 |
| Social security costs | 28,950 | 26,092 |
| Apprenticeship levy | 1,363 | 1,166 |
| Employer's contributions to NHS pensions | 44,408 | 39,640 |
| Pension cost - other | 71 | 99 |
| Temporary staff (including agency) | 10,113 | 14,192 |
| NHS charitable funds staff | 892 | 767 |
| **Total gross staff costs** | **363,214** | **339,504** |
| Recoveries in respect of seconded staff | - | - |
| **Total staff costs** | **363,214** | **339,504** |
| **Of which** | | |
| Costs capitalised as part of assets | 1,772 | 1,153 |

**Note 8.1 Retirements due to ill-health (Group)**

During 2023/24 there were no early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is 0k (£35k in 2022/23).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

## Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

### a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

### b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

**Note 10 Finance income (Group)**

Finance income represents interest received on assets and investments in the period.

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Interest on bank accounts | 2,571 | 979 |
| NHS charitable fund investment income | 300 | 156 |
| **Total finance income** | **2,871** | **1,135** |

**Note 11 Finance expenditure (Group)**

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| **Interest expense:** | | |
| Interest on loans from the Department of Health and Social Care | 127 | 131 |
| Interest on lease obligations | 1,780 | 636 |
| **Total interest expense** | **1,907** | **767** |
| Unwinding of discount on provisions | 18 | 15 |
| Other finance costs | - | 2 |
| **Total finance costs** | **1,925** | **784** |

**Note 12 Other gains / (losses) (Group)**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Gains on disposal of assets | 97 | 88 |
| Losses on disposal of assets | (5) | (19) |
| **Total gains on disposal of assets** | **92** | **69** |
| **Total other gains** | **92** | **69** |

**Note 13 Trust income statement and statement of comprehensive income**

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Trust’s deficit for the period was £2.6 million (2022/23: £7.0 million). The Trust's total comprehensive income/(expense) for the period was £6.3million (2022/23: £15.0 million).

**Note 14 Intangible assets - 2023/24**

| Group | Software licences | Licences & trademarks | Goodwill | Intangible assets under construction | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2023 - brought forward** | **989** | **17,054** | **974** | **-** | **19,017** |
| Additions | 737 | 206 | - | 1,032 | **1,975** |
| Reclassifications | 55 | - | - | - | **55** |
| Disposals / derecognition | (261) | (1,476) | - | - | **(1,737)** |
| **Valuation / gross cost at 31 March 2024** | **1,520** | **15,784** | **974** | **1,032** | **19,310** |
| | | | | | |
| **Amortisation at 1 April 2023 - brought forward** | **987** | **10,430** | **-** | **-** | **11,417** |
| Provided during the year | 20 | 2,505 | - | - | **2,525** |
| Disposals / derecognition | (261) | (1,476) | - | - | **(1,737)** |
| **Amortisation at 31 March 2024** | **746** | **11,459** | **-** | **-** | **12,205** |
| | | | | | |
| **Net book value at 31 March 2024** | **774** | **4,325** | **974** | **1,032** | **7,105** |
| **Net book value at 1 April 2023** | **2** | **6,624** | **974** | **-** | **7,600** |

**Note 14.1 Intangible assets - 2022/23**

| Group | Software licences | Licences & trademarks | Goodwill | Intangible assets under construction | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2022 - as previously stated** | **1,675** | **17,059** | **974** | **-** | **19,708** |
| Additions | - | 1,423 | - | - | **1,423** |
| Disposals / derecognition | (686) | (1,428) | - | - | **(2,114)** |
| **Valuation / gross cost at 31 March 2023** | **989** | **17,054** | **974** | **-** | **19,017** |
| | | | | | |
| **Amortisation at 1 April 2022 - as previously stated** | **1,634** | **9,488** | **-** | **-** | **11,122** |
| Provided during the year | 39 | 2,370 | - | - | **2,409** |
| Disposals / derecognition | (686) | (1,428) | - | - | **(2,114)** |
| **Amortisation at 31 March 2023** | **987** | **10,430** | **-** | **-** | **11,417** |
| | | | | | |
| **Net book value at 31 March 2023** | **2** | **6,624** | **974** | **-** | **7,600** |
| **Net book value at 1 April 2022** | **41** | **7,571** | **974** | **-** | **8,586** |

**Note 15 Intangible assets - 2023/24**

| Trust | Software licences | Licences & trademarks | Intangible assets under construction | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2023 - brought forward** | **989** | **17,054** | **-** | **18,043** |
| Additions | 737 | 206 | 1,032 | **1,975** |
| Reclassifications | 55 | - | - | **55** |
| Disposals / derecognition | (261) | (1,476) | - | **(1,737)** |
| **Valuation / gross cost at 31 March 2024** | **1,520** | **15,784** | **1,032** | **18,336** |
| | | | | |
| **Amortisation at 1 April 2023 - brought forward** | **987** | **10,430** | **-** | **11,417** |
| Provided during the year | 20 | 2,504 | - | **2,524** |
| Disposals / derecognition | (261) | (1,476) | - | **(1,737)** |
| **Amortisation at 31 March 2024** | **746** | **11,458** | **-** | **12,204** |
| | | | | |
| **Net book value at 31 March 2024** | **774** | **4,326** | **1,032** | **6,132** |
| **Net book value at 1 April 2023** | **2** | **6,624** | **-** | **6,626** |

**Note 15.1 Intangible assets - 2022/23**

| Trust | Software licences | Licences & trademarks | Intangible assets under construction | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2022 - as previously stated** | **1,675** | **17,059** | **-** | **18,734** |
| Additions | - | 1,423 | - | **1,423** |
| Disposals / derecognition | (686) | (1,428) | - | **(2,114)** |
| **Valuation / gross cost at 31 March 2023** | **989** | **17,054** | **-** | **18,043** |
| | | | | |
| **Amortisation at 1 April 2022 - as previously stated** | **1,634** | **9,488** | **-** | **11,122** |
| Prior period adjustments | | | | **-** |
| **Amortisation at 1 April 2022 - restated** | **1,634** | **9,488** | **-** | **11,122** |
| Provided during the year | 39 | 2,370 | - | **2,409** |
| Disposals / derecognition | (686) | (1,428) | - | **(2,114)** |
| **Amortisation at 31 March 2023** | **987** | **10,430** | **-** | **11,417** |
| | | | | |
| **Net book value at 31 March 2023** | **2** | **6,624** | **-** | **6,626** |
| **Net book value at 1 April 2022** | **41** | **7,571** | **-** | **7,612** |

**Useful lives of intangible assets**

Useful lives reflect the total life of an asset and not the remaining life of an asset. Asset lives have been extended in 23/24 to reflect the usage of assets over their lifetime. The range of useful lives is shown in the table below:

| | Min life | Max life |
|---|---|---|
| | Years | Years |
| Software licences | 2 | 10 |
| Licences & trademarks | 2 | 9 |

**Note 16 Impairment of Goodwill**

Under IAS 36 the Trust is required to annually assess its goodwill intangible asset for impairment. The core principle in IAS 36 is that an asset must not be carried in the financial statements at more than the highest amount to be recovered through its use or sale.

The recoverable amount is the higher of;

- fair value less costs to sell. This is the arm's length sale price between knowledgeable willing parties less costs of disposal (FVLCD); and

- value in use (VIU). This is the expected future cash flows that the asset in its current condition will produce, discounted to present value using an appropriate discount.

The Trust considers that the FVLCD will always be lower than both the carrying value of the goodwill and the value in use for the Trust. The value in use to the Trust is broader than simply the cashflows of the business as it will also reflect the extent to which the Trust can deploy the service potential of the business.

The Trust believes that there is are clear indicators that the goodwill has been impaired, following post-acquisition analysis of the business in the financial year 2021/22, as set out below.

| | 2023/24 | 2022/23 |
|---|---|---|
| | £'000 | £'000 |
| Goodwill at purchase date | 1,384 | 1,384 |
| Less impairment of goodwill at reporting date | - 410 | - 410 |
| Goodwill at reporting date | **974** | **974** |

The impairment was charged to the accounts in 2021/22. No impairment charge has been made in 2023/24 accounts.

**Note 17 Property, plant and equipment - 2023/24**

| Group | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation/gross cost at 1 April 2023 - brought forward** | **11,334** | **179,132** | **4,411** | **58,984** | **68,423** | **10** | **16,308** | **2,060** | **340,662** |
| Additions | - | 7,190 | 108 | 13,548 | 8,132 | - | 3,136 | 51 | **32,165** |
| Impairments | (560) | (6,283) | (3) | (336) | - | - | - | - | **(7,182)** |
| Revaluations | - | (4,336) | (255) | - | - | - | - | - | **(4,591)** |
| Reclassifications | - | 6,146 | - | (9,255) | 2,680 | - | 374 | - | **(55)** |
| Disposals / derecognition | - | (196) | - | - | (6,857) | (10) | (5,198) | (317) | **(12,578)** |
| **Valuation/gross cost at 31 March 2024** | **10,774** | **181,653** | **4,261** | **62,941** | **72,378** | **-** | **14,620** | **1,794** | **348,421** |
| **Accumulated depreciation at 1 April 2023 - brought forward** | **-** | **568** | **-** | **-** | **39,667** | **10** | **11,030** | **1,231** | **52,506** |
| Provided during the year | - | 6,036 | 144 | - | 4,785 | - | 1,612 | 150 | **12,727** |
| Impairments | - | 192 | - | - | - | - | - | - | **192** |
| Reversals of impairments | - | (193) | - | - | - | - | - | - | **(193)** |
| Revaluations | - | (5,533) | (144) | - | - | - | - | - | **(5,677)** |
| Disposals / derecognition | - | (196) | - | - | (6,805) | (10) | (5,198) | (317) | **(12,526)** |
| **Accumulated depreciation at 31 March 2024** | **-** | **874** | **-** | **-** | **37,647** | **-** | **7,444** | **1,064** | **47,029** |
| **Net book value at 31 March 2024** | **10,774** | **180,779** | **4,261** | **62,941** | **34,731** | **-** | **7,176** | **730** | **301,392** |
| **Net book value at 1 April 2023** | **11,334** | **178,564** | **4,411** | **58,984** | **28,756** | **-** | **5,278** | **829** | **288,156** |

**Note 17.1 Property, plant and equipment - 2022/23**

| Group | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2022 - as previously stated** | **12,499** | **167,521** | **4,167** | **28,387** | **66,943** | **10** | **17,180** | **2,079** | **298,786** |
| IFRS 16 implementation - reclassification to right of use assets | - | - | - | - | (4,494) | - | - | - | **(4,494)** |
| Additions | - | 2,246 | 130 | 35,640 | 6,000 | - | 1,318 | 7 | **45,341** |
| Impairments | (1,165) | - | - | - | - | - | - | - | **(1,165)** |
| Revaluations | - | 5,400 | (66) | - | - | - | - | - | **5,334** |
| Reclassifications | - | 3,965 | 180 | (5,043) | 1,678 | - | 125 | 8 | **913** |
| Disposals / derecognition | - | - | - | - | (1,704) | - | (2,315) | (34) | **(4,053)** |
| **Valuation/gross cost at 31 March 2023** | **11,334** | **179,132** | **4,411** | **58,984** | **68,423** | **10** | **16,308** | **2,060** | **340,662** |
| **Accumulated depreciation at 1 April 2022 - as previously stated** | **-** | **549** | **-** | **-** | **38,155** | **10** | **11,346** | **998** | **51,058** |
| IFRS 16 implementation - reclassification to right of use assets | - | - | - | - | (1,841) | - | - | - | **(1,841)** |
| Provided during the year | - | 5,009 | 143 | - | 5,048 | - | 1,999 | 267 | **12,466** |
| Impairments | - | 3,478 | - | - | - | - | - | - | **3,478** |
| Reversals of impairments | - | (4,130) | - | - | - | - | - | - | **(4,130)** |
| Revaluations | - | (4,338) | (143) | - | - | - | - | - | **(4,481)** |
| Disposals / derecognition | - | - | - | - | (1,695) | - | (2,315) | (34) | **(4,044)** |
| **Accumulated depreciation at 31 March 2023** | **-** | **568** | **-** | **-** | **39,667** | **10** | **11,030** | **1,231** | **52,506** |
| **Net book value at 31 March 2023** | **11,334** | **178,564** | **4,411** | **58,984** | **28,756** | **-** | **5,278** | **829** | **288,156** |
| **Net book value at 1 April 2022** | **12,499** | **166,972** | **4,167** | **28,387** | **28,788** | **-** | **5,834** | **1,081** | **247,728** |

**Note 17.2 Property, plant and equipment financing - 31 March 2024**

| Group | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Owned - purchased | 10,774 | 174,115 | 4,261 | 56,671 | 29,780 | 7,174 | 701 | **283,476** |
| Owned - donated/granted | - | 6,664 | - | 6,270 | 4,951 | 2 | 29 | **17,916** |
| **NBV total at 31 March 2024** | **10,774** | **180,779** | **4,261** | **62,941** | **34,731** | **7,176** | **730** | **301,392** |

**Note 17.3 Property, plant and equipment financing - 31 March 2023**

| Group | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Owned - purchased | 11,334 | 171,750 | 4,411 | 53,238 | 26,551 | 5,276 | 795 | **273,355** |
| Owned - donated/granted | - | 6,814 | - | 5,746 | 2,205 | 2 | 34 | **14,801** |
| **NBV total at 31 March 2023** | **11,334** | **178,564** | **4,411** | **58,984** | **28,756** | **5,278** | **829** | **288,156** |

**Note 17.4 Property plant and equipment assets subject to an operating lease - 31 March 2024**

| Group | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Subject to an operating lease | 106 | - | - | - | - | - | - | **106** |
| Not subject to an operating lease | 10,668 | 180,779 | 4,261 | 62,941 | 34,731 | 7,176 | 730 | **301,286** |
| **NBV total at 31 March 2024** | **10,774** | **180,779** | **4,261** | **62,941** | **34,731** | **7,176** | **730** | **301,392** |

**Note 17.5 Property plant and equipment assets subject to an operating lease - 31 March 2023**

| Group | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Subject to an operating lease | 104 | 252 | - | - | - | - | - | **356** |
| Not subject to an operating lease | 11,230 | 178,312 | 4,411 | 58,984 | 28,756 | 5,278 | 829 | **287,800** |
| **NBV total at 31 March 2023** | **11,334** | **178,564** | **4,411** | **58,984** | **28,756** | **5,278** | **829** | **288,156** |

**Note 18 Property, plant and equipment - 2023/24**

| Trust | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation/gross cost at 1 April 2023 - brought forward** | **11,334** | **179,110** | **4,411** | **58,984** | **67,932** | **10** | **16,080** | **1,948** | **339,809** |
| Additions | - | 5,181 | 108 | 17,050 | 6,232 | - | 3,072 | 9 | **31,652** |
| Impairments | (560) | (1,599) | (3) | (336) | - | - | - | - | **(2,498)** |
| Revaluations | - | (9,020) | (255) | - | - | - | - | - | **(9,275)** |
| Reclassifications | - | 6,146 | - | (9,255) | 2,680 | - | 374 | - | **(55)** |
| Disposals / derecognition | - | (196) | - | (3,502) | (7,250) | (10) | (5,198) | (317) | **(16,473)** |
| **Valuation/gross cost at 31 March 2024** | **10,774** | **179,622** | **4,261** | **62,941** | **69,594** | **-** | **14,328** | **1,640** | **343,160** |
| **Accumulated depreciation at 1 April 2023 - brought forward** | **-** | **564** | **-** | **-** | **39,770** | **10** | **10,942** | **1,156** | **52,442** |
| Provided during the year | - | 5,721 | 144 | - | 4,438 | - | 1,532 | 122 | **11,957** |
| Revaluations | - | (5,533) | (144) | - | - | - | - | - | **(5,677)** |
| Disposals / derecognition | - | (196) | - | - | (6,870) | (10) | (5,198) | (317) | **(12,591)** |
| **Accumulated depreciation at 31 March 2024** | **-** | **556** | **-** | **-** | **37,338** | **-** | **7,276** | **961** | **46,131** |
| **Net book value at 31 March 2024** | **10,774** | **179,066** | **4,261** | **62,941** | **32,256** | **-** | **7,052** | **679** | **297,029** |
| **Net book value at 1 April 2023** | **11,334** | **178,546** | **4,411** | **58,984** | **28,162** | **-** | **5,138** | **792** | **287,367** |

**Note 18.1 Property, plant and equipment - 2022/23**

| Trust | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2022 - as previously stated** | **12,499** | **167,499** | **4,167** | **28,387** | **65,320** | **10** | **17,025** | **1,973** | **296,880** |
| IFRS 16 implementation - reclassification of existing leased assets to right of use assets | - | - | - | - | (3,450) | - | - | - | **(3,450)** |
| Additions | - | 2,246 | 130 | 35,640 | 4,900 | - | 1,245 | 1 | **44,162** |
| Revaluations | (1,165) | 5,400 | (66) | - | - | - | - | - | **4,169** |
| Reclassifications | - | 3,965 | 180 | (5,043) | 2,357 | - | 125 | 8 | **1,592** |
| Disposals / derecognition | - | - | - | - | (1,195) | - | (2,315) | (34) | **(3,544)** |
| **Valuation/gross cost at 31 March 2023** | **11,334** | **179,110** | **4,411** | **58,984** | **67,932** | **10** | **16,080** | **1,948** | **339,809** |
| | | | | | | | | | |
| **Accumulated depreciation at 1 April 2022 - as previously stated** | **-** | **547** | **-** | **-** | **37,909** | **10** | **11,322** | **963** | **50,751** |
| IFRS 16 implementation - reclassification of existing leased assets to right of use assets | - | - | - | - | (1,745) | - | - | - | **(1,745)** |
| Provided during the year | - | 5,007 | 143 | - | 4,792 | - | 1,935 | 227 | **12,104** |
| Impairments | - | 1,668 | - | - | - | - | - | - | **1,668** |
| Reversals of impairments | - | (5,940) | - | - | - | - | - | - | **(5,940)** |
| Revaluations | - | (718) | (143) | - | - | - | - | - | **(861)** |
| Disposals / derecognition | - | - | - | - | (1,186) | - | (2,315) | (34) | **(3,535)** |
| **Accumulated depreciation at 31 March 2023** | **-** | **564** | **-** | **-** | **39,770** | **10** | **10,942** | **1,156** | **52,442** |
| | | | | | | | | | |
| **Net book value at 31 March 2023** | **11,334** | **178,546** | **4,411** | **58,984** | **28,162** | **-** | **5,138** | **792** | **287,367** |
| **Net book value at 1 April 2022** | **12,499** | **166,952** | **4,167** | **28,387** | **27,411** | **-** | **5,703** | **1,010** | **246,129** |

**Note 18.2 Property, plant and equipment financing - 31 March 2024**

| Trust | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Owned - purchased | 10,774 | 172,402 | 4,261 | 56,671 | 27,305 | 7,050 | 650 | **279,113** |
| Owned - donated / granted | - | 6,664 | - | 6,270 | 4,951 | 2 | 29 | **17,916** |
| **Total net book value at 31 March 2024** | **10,774** | **179,066** | **4,261** | **62,941** | **32,256** | **7,052** | **679** | **297,029** |

**Note 18.3 Property, plant and equipment financing - 31 March 2023**

| Trust | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Owned - purchased | 11,334 | 171,732 | 4,411 | 53,238 | 25,956 | 5,135 | 758 | **272,564** |
| Owned - donated / granted | - | 6,814 | - | 5,746 | 2,206 | 3 | 34 | **14,803** |
| **Total net book value at 31 March 2023** | **11,334** | **178,546** | **4,411** | **58,984** | **28,162** | **5,138** | **792** | **287,367** |

**Note 18.4 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024**

| Trust | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Subject to an operating lease | 106 | - | - | - | - | - | - | **106** |
| Not subject to an operating lease | 10,668 | 179,066 | 4,261 | 62,941 | 32,256 | 7,052 | 679 | **296,923** |
| **Total net book value at 31 March 2024** | **10,774** | **179,066** | **4,261** | **62,941** | **32,256** | **7,052** | **679** | **297,029** |

**Note 18.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023**

| Trust | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Subject to an operating lease | 11,334 | 171,732 | 4,411 | 53,238 | 25,956 | 5,135 | 758 | **272,564** |
| Not subject to an operating lease | - | 6,814 | - | 5,746 | 2,206 | 3 | 34 | **14,803** |
| **Total net book value at 31 March 2023** | **11,334** | **178,546** | **4,411** | **58,984** | **28,162** | **5,138** | **792** | **287,367** |

**Useful lives of property, plant and equipment**

Useful lives reflect the total life of an asset and not the remaining life of an asset. Asset lives have been extended in 23/24 to reflect the usage of assets over their lifetime. The range of useful lives are shown in the table below:

| | Min life | Max life |
|---|---|---|
| | Years | Years |
| Buildings, excluding dwellings | 10 | 62 |
| Dwellings | 30 | 46 |
| Plant & machinery | 2 | 25 |
| Information technology | 2 | 7 |
| Furniture & fittings | 2 | 17 |

**Note 19 Donations of property, plant and equipment**

The Trust received donations from which assets were purchased to the value of £4.0m (£4.5m 2022/23).

The donations were made up as follows:
- £3.3m from RUH X for various medical equipment including surgical robot, gamma camera, ITU pendants and incubators
- £0.6m from Bath Cancer Support Group for equipment for Radiotherapy and £0.1m frrom Paulton Hospital League of Friends for X-Ray equipment

**Note 20 Revaluations of property, plant and equipment**

The Trust's policy is to complete a full revaluation at least every five years realting to Land and Buildings, with a desktop review every three years. Gerald Eve, who are members of the Royal Institute of Chartered Surveyors and are independent of the Trust, undertook a desktop valuation using indices of the Trust's land and buildings as at 31 March 2024. The last full revaluation was undertaken as at 31 March 2020. The valuations were carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1).

The total net impairment charged to the accounts is £2.2m, this is a result of the desktop valuation of land, buildings and dwellings as at 31 March 2024 following a valuation carried out by Gerald Eve in line with Trust’s policy.

**Note 21 Leases - Royal United Hospitals Bath NHS Foundation Trust as a lessee**

The Trust holds a number of finance leases under IFRS16 relating to medical equipment and buildings.  The most signifcant of these relate to the lease of the Hospital site for Sulis Hospital.

**Note 22 Heritage Assets**

The Trust hold a number of art works.  The art is across a variety of mediums and have either been donated or transferred from the acquisition of The Royal National Hospital for Rheumatic Diseases in 2015.

These assets are not operational and are not held to deliver front line services or back office functions. Therefore the assets will not be recognised in the statement of financial position.

The assets were last valued in 2015 for insurance purposes.  The Trust has not obtained up to date valuations, as the cost will not be commensurate with the benefits to users of the financial statements.

The art works are held at various locations across the Trust site and a small number have been loaned to the Bath Medical Museum.  The art collection is managed by the Art & Design Manager.

**Note 23 Right of use assets - 2023/24**

| Group | Property (land and buildings) | Plant & machinery | Transport equipment | Total | Of which: leased from DHSC group bodies |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2023 - brought forward** | **51,863** | **3,551** | **85** | **55,499** | **1,675** |
| Additions | 2,426 | 27 | - | **2,453** | - |
| Remeasurements of the lease liability | 1,345 | - | - | **1,345** | - |
| Movements in provisions for restoration / removal costs | 332 | - | - | **332** | - |
| Disposals / derecognition | (179) | (15) | - | **(194)** | (179) |
| **Valuation/gross cost at 31 March 2024** | **55,787** | **3,563** | **85** | **59,435** | **1,496** |
| **Accumulated depreciation at 1 April 2023 - brought forward** | **3,330** | **975** | **27** | **4,332** | **17** |
| Provided during the year | 3,309 | 785 | 28 | **4,122** | 218 |
| Disposals / derecognition | (39) | (15) | - | **(54)** | 177 |
| **Accumulated depreciation at 31 March 2024** | **6,600** | **1,745** | **55** | **8,400** | **412** |
| **Net book value at 31 March 2024** | **49,187** | **1,818** | **30** | **51,035** | **1,084** |
| **Net book value at 1 April 2023** | **48,533** | **2,576** | **58** | **51,167** | **1,658** |

| | |
|---|---|
| Net book value of right of use assets leased from other NHS providers | - |
| Net book value of right of use assets leased from other DHSC group bodies | 1,084 |

**Note 23.1 Right of use assets - 2022/23**

| Group | Property (land and buildings) | Plant & machinery | Transport equipment | Total | Of which: leased from DHSC group bodies |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2022 - brought forward** | **-** | **-** | **-** | **-** | **-** |
| IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets | - | 4,494 | - | **4,494** | - |
| IFRS 16 implementation - adjustments for existing operating leases / subleases | 24,345 | 495 | 63 | **24,903** | 1,419 |
| Transfers by absorption | - | - | - | **-** | - |
| Additions | 27,518 | 1,376 | 22 | **28,916** | 256 |
| Reclassifications | - | (2,814) | - | **(2,814)** | - |
| **Valuation/gross cost at 31 March 2023** | **51,863** | **3,551** | **85** | **55,499** | **1,675** |
| **Accumulated depreciation at 1 April 2022 - brought forward** | **-** | **-** | **-** | **-** | **-** |
| IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets | - | 1,841 | - | **1,841** | - |
| Transfers by absorption | - | - | - | **-** | - |
| Provided during the year | 3,330 | 1,035 | 27 | **4,392** | 17 |
| Reclassifications | - | (1,901) | - | **(1,901)** | - |
| **Accumulated depreciation at 31 March 2023** | **3,330** | **975** | **27** | **4,332** | **17** |
| **Net book value at 31 March 2023** | **48,533** | **2,576** | **58** | **51,167** | **1,658** |
| **Net book value at 1 April 2022** | **-** | **-** | **-** | **-** | **-** |

| | |
|---|---|
| Net book value of right of use assets leased from other NHS providers | 49,509 |
| Net book value of right of use assets leased from other DHSC group bodies | 1,658 |

**Note 24 Right of use assets - 2023/24**

| Trust | Property (land and buildings) £000 | Plant & machinery £000 | Transport equipment £000 | Total £000 | Of which: leased from DHSC group bodies £000 |
|---|---|---|---|---|---|
| **Valuation / gross cost at 1 April 2023 - brought forward** | **49,491** | **2,435** | **85** | **52,011** | **1,676** |
| Additions | 2,591 | 201 | - | **2,792** | - |
| Remeasurements of the lease liability | 1,345 | - | - | **1,345** | - |
| Disposals / derecognition | (179) | (15) | - | **(194)** | (179) |
| **Valuation/gross cost at 31 March 2024** | **53,248** | **2,621** | **85** | **55,954** | **1,497** |
| | | | | | |
| **Accumulated depreciation at 1 April 2023 - brought forward** | 958 | 695 | 26 | **1,679** | 220 |
| Provided during the year | 3,521 | 542 | 28 | **4,091** | 218 |
| Reclassifications | - | - | - | **-** | 177 |
| Disposals / derecognition | (38) | (15) | - | **(53)** | - |
| **Accumulated depreciation at 31 March 2024** | **4,441** | **1,222** | **54** | **5,717** | **615** |
| | | | | | |
| **Net book value at 31 March 2024** | **48,807** | **1,399** | **31** | **50,237** | **882** |
| **Net book value at 1 April 2023** | **48,533** | **1,740** | **59** | **50,332** | **1,456** |

| | |
|---|---|
| Net book value of right of use assets leased from other NHS providers | - |
| Net book value of right of use assets leased from other DHSC group bodies | 882 |

**Note 24.1 Right of use assets - 2022/23**

| Trust | Property (land and buildings) £000 | Plant & machinery £000 | Transport equipment £000 | Total £000 | Of which: leased from DHSC group bodies £000 |
|---|---|---|---|---|---|
| **Valuation / gross cost at 1 April 2022 - brought forward** | **-** | **-** | **-** | **-** | **-** |
| IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets | - | 3,450 | - | **3,450** | - |
| IFRS 16 implementation - adjustments for existing operating leases / subleases | 1,419 | 423 | 63 | **1,905** | 1,419 |
| Additions | 48,072 | 1,376 | 22 | **49,470** | 257 |
| Reclassifications | - | (2,814) | - | **(2,814)** | - |
| **Valuation/gross cost at 31 March 2023** | **49,491** | **2,435** | **85** | **52,011** | **1,676** |
| **Accumulated depreciation at 1 April 2022 - brought forward** | **-** | **-** | **-** | **-** | **-** |
| IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets | - | 1,745 | - | **1,745** | 220 |
| Provided during the year | 958 | 851 | 26 | **1,835** | - |
| Reclassifications | - | (1,901) | - | **(1,901)** | - |
| **Accumulated depreciation at 31 March 2023** | **958** | **695** | **26** | **1,679** | **220** |
| **Net book value at 31 March 2023** | **48,533** | **1,740** | **59** | **50,332** | **1,456** |
| **Net book value at 1 April 2022** | **-** | **-** | **-** | **-** | **-** |

| | |
|---|---|
| Net book value of right of use assets leased from other NHS providers | 48,876 |
| Net book value of right of use assets leased from other DHSC group bodies | 1,456 |

**Note 24.2 Reconciliation of the carrying value of lease liabilities**

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 34.

| | Group | | Trust | |
|---|---|---|---|---|
| | 2023/24 | 2022/23 | 2023/24 | 2022/23 |
| | £000 | £000 | £000 | £000 |
| **Carrying value at 1 April** | **51,145** | **2,086** | **50,756** | **1,680** |
| IFRS 16 implementation - adjustments for existing operating leases | - | 24,903 | - | 1,836 |
| Lease additions | 2,453 | 28,916 | 2,460 | 49,703 |
| Lease liability remeasurements | 1,345 | - | 1,345 | - |
| Interest charge arising in year | 1,780 | 636 | 1,726 | 462 |
| Early terminations | (135) | (903) | (135) | (903) |
| Lease payments (cash outflows) | (4,588) | (4,493) | (4,557) | (2,022) |
| **Carrying value at 31 March** | **52,000** | **51,145** | **51,595** | **50,756** |

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

**Note 24.3 Maturity analysis of future lease payments at 31 March 2024**

| | Group | | Trust | |
|---|---|---|---|---|
| | Total | Of which leased from DHSC group bodies: | Total | Of which leased from DHSC group bodies: |
| | 31 March 2024 | 31 March 2024 | 31 March 2024 | 31 March 2024 |
| | £000 | £000 | £000 | £000 |
| **Undiscounted future lease payments payable in:** | | | | |
| - not later than one year; | 4,260 | 225 | 4,141 | 225 |
| - later than one year and not later than five years; | 13,395 | 891 | 13,071 | 891 |
| - later than five years. | 58,907 | - | 58,908 | - |
| **Total gross future lease payments** | **76,562** | **1,116** | **76,120** | **1,116** |
| Finance charges allocated to future periods | (24,562) | (25) | (24,524) | (25) |
| **Net lease liabilities at 31 March 2024** | **52,000** | **1,091** | **51,596** | **1,091** |
| **Of which:** | | | | |
| Leased from other NHS providers | | - | | - |
| Leased from other DHSC group bodies | | 1,091 | | 1,091 |

**Note 24.4 Maturity analysis of future lease payments at 31 March 2023**

| | Group | | Trust | |
|---|---|---|---|---|
| | Total | Of which leased from DHSC group bodies: | Total | Of which leased from DHSC group bodies: |
| | 31 March 2023 | 31 March 2023 | 31 March 2023 | 31 March 2023 |
| | £000 | £000 | £000 | £000 |
| **Undiscounted future lease payments payable in:** | | | | |
| - not later than one year; | 3,389 | 255 | 3,260 | 255 |
| - later than one year and not later than five years; | 13,019 | 1,021 | 12,761 | 1,020 |
| - later than five years. | 60,165 | 218 | 60,163 | 218 |
| **Total gross future lease payments** | **76,573** | **1,494** | **76,184** | **1,493** |
| Finance charges allocated to future periods | (25,428) | (39) | (25,428) | (39) |
| **Net finance lease liabilities at 31 March 2023** | **51,145** | **1,455** | **50,756** | **1,454** |
| **Of which:** | | | | |
| Leased from other NHS providers | | - | | - |
| Leased from other DHSC group bodies | | | | |

**Note 25 Investments in associates and joint ventures**

| | Group | | Trust | |
|---|---|---|---|---|
| | 2023/24 | 2022/23 | 2023/24 | 2022/23 |
| | £000 | £000 | £000 | £000 |
| **Carrying value at 1 April - brought forward** | **56** | **56** | **-** | **56** |
| Share of profit / (loss) | (56) | - | (56) | (56) |
| **Carrying value at 31 March** | **-** | **56** | **-** | **-** |

**Note 26 Other investments / financial assets (non-current)**

| | Group | | Trust | |
|---|---|---|---|---|
| | 2023/24 | 2022/23 | 2023/24 | 2022/23 |
| | £000 | £000 | £000 | £000 |
| **Carrying value at 1 April - brought forward** | **6,483** | **10,157** | **3,941** | **3,241** |
| Acquisitions in year | 41 | 60 | - | 700 |
| Movement in fair value through OCI | 226 | (350) | - | - |
| Disposals | (1,917) | (3,384) | - | - |
| **Carrying value at 31 March** | **4,833** | **6,483** | **3,941** | **3,941** |

**Note 26 Disclosure of interests in other entities**

The Trust has a one third controlling interest in Wiltshire Health and Care LLP, in partnership with Salisbury NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust.

Wiltshire Health and Care LLP formed in July 2016, and became responsible for the delivery of adult community healthcare across Wiltshire for at least the next five years. The LLP has a separate Board but strategic control of the organisation remains with the partners as detailed in the Members' Agreement signed by the three NHS Foundation Trusts.

The clinical services provided to Wiltshire are procured mainly from Great Western Hospitals NHS Foundation Trust, with other small service provision, both clinical and corporate, received from Salisbury NHS Foundation Trust and the Royal United Hospitals Bath NHS Foundation Trust on a contract basis.

**Note 27 Analysis of charitable fund reserves**

| | 31 March 2024 £000 | 31 March 2023 £000 |
|---|---|---|
| **Unrestricted funds:** | | |
| Unrestricted income funds | 2,664 | 2,627 |
| **Restricted funds:** | | |
| Other restricted income funds | 5,815 | 7,988 |
| | **8,479** | **10,615** |

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

**Note 28 Inventories**

| | Group | | Trust | |
|---|---|---|---|---|
| | 31 March 2024 £000 | 31 March 2023 £000 | 31 March 2024 £000 | 31 March 2023 £000 |
| Drugs | 2,041 | 2,070 | 1,963 | 1,992 |
| Consumables | 6,130 | 4,842 | 4,182 | 3,740 |
| Energy | 113 | 91 | 113 | 91 |
| **Total inventories** | **8,284** | **7,003** | **6,258** | **5,823** |

Inventories recognised in expenses for the year were £78,152k (2022/23: £79,314k). Write-down of inventories recognised as expenses for the year were £0k (2022/23: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £111k of items purchased by DHSC (2022/23: £954k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

**Note 29 Receivables**

| | Group | | Trust | |
|---|---|---|---|---|
| | 31 March 2024 | 31 March 2023 | 31 March 2024 | 31 March 2023 |
| | £000 | £000 | £000 | £000 |
| **Current** | | | | |
| Contract receivables | 23,191 | 22,157 | 19,938 | 19,638 |
| Capital receivables | - | - | - | 849 |
| Allowance for impaired contract receivables / assets | (1,187) | (1,208) | (894) | (1,074) |
| Deposits and advances | 54 | 25 | 47 | 28 |
| Prepayments (non-PFI) | 5,590 | 6,909 | 5,174 | 5,547 |
| Finance lease receivables | - | - | 349 | 113 |
| PDC dividend receivable | 906 | - | 906 | - |
| VAT receivable | 656 | 371 | 656 | 371 |
| Other receivables | 453 | 249 | 446 | 252 |
| NHS charitable funds receivables | 819 | 281 | - | - |
| **Total current receivables** | **30,482** | **28,784** | **26,622** | **25,724** |
| **Non-current** | | | | |
| Contract assets | 1,396 | 1,391 | 1,396 | 1,392 |
| Allowance for impaired contract receivables / assets | (266) | (285) | (266) | (285) |
| Finance lease receivables | - | - | 3,593 | 330 |
| Other receivables | 732 | 890 | 732 | 890 |
| **Total non-current receivables** | **1,862** | **1,996** | **5,455** | **2,327** |
| **Of which receivable from NHS and DHSC group bodies:** | | | | |
| Current | 15,443 | 15,954 | 11,739 | 5,327 |
| Non-current | 732 | 890 | 1,130 | 1,107 |

**Note 29.1 Allowances for credit losses - 2023/24**

| | Group | Trust |
|---|---|---|
| | Contract receivables and contract assets | Contract receivables and contract assets |
| | £000 | £000 |
| **Allowances as at 1 Apr 2023 - brought forward** | **1,493** | **1,359** |
| New allowances arising | 159 | - |
| Changes in existing allowances | (183) | (183) |
| Utilisation of allowances (write offs) | (16) | (16) |
| **Allowances as at 31 Mar 2024** | **1,453** | **1,160** |

**Note 29.2 Allowances for credit losses - 2022/23**

| | Group | Trust |
|---|---|---|
| | Contract receivables and contract assets | Contract receivables and contract assets |
| | £000 | £000 |
| **Allowances as at 1 Apr 2022 - as previously stated** | **1,552** | **1,393** |
| New allowances arising | 317 | 306 |
| Changes in existing allowances | - | (273) |
| Reversals of allowances | (273) | (30) |
| Utilisation of allowances (write offs) | (103) | - |
| Changes arising following modification of contractual cash flows | - | (37) |
| **Allowances as at 31 Mar 2023** | **1,493** | **1,359** |

**Note 30 Finance leases (Royal United Hospitals Bath NHS Foundation Trust as a lessor)**

This note discloses future lease payments receivable from lease arrangements classified as finance leases where the Royal United Hospitals Bath NHS Foundation Trust is the lessor.

There are a number of finance and operating leases between Sulis Hospital and the Trust. These relate to the lease of the Sulis Hospital Site and various medical equipment.

**Note 30.1 Reconciliation of the carrying value of finance lease receivables (net investment in the lease)**

| | Trust | |
|---|---|---|
| | **2023/24** | **2022/23** |
| | **£000** | **£000** |
| **Finance lease receivables at 1 April** | **443** | **552** |
| Additions | 3,836 | - |
| Interest arising (unwinding of discount) | 133 | 17 |
| Lease receipts (cash payments received) | (471) | (126) |
| **Finance lease receivables at 31 March** | **3,941** | **443** |

**Note 30.2 Finance lease receivables maturity analysis as at 31 March 2024**

| | Trust | |
|---|---|---|
| | Total | Of which leased to DHSC group bodies: |
| | 31 March 2024 | 31 March 2024 |
| | £000 | £000 |
| **Undiscounted future lease receipts receivable in:** | | |
| not later than one year; | 348 | - |
| later than one year and not later than two years; | 482 | - |
| later than two years and not later than three years; | 451 | - |
| later than three years and not later than four years; | 354 | - |
| later than four years and not later than five years; | 353 | - |
| later than five years. | 3,036 | - |
| **Total future finance lease payments to be received** | **5,024** | **-** |
| Unearned interest income | (1,083) | - |
| **Net investment in lease (net lease receivable)** | **3,941** | **-** |
| **of which:** | | |
| Leased to other NHS providers | | - |
| Leased to other DHSC group bodies | | - |

**Note 30.3 Finance lease receivables maturity analysis as at 31 March 2023**

| | Trust | |
|---|---|---|
| | Total | Of which leased to DHSC group bodies: |
| | 31 March 2023 | 31 March 2023 |
| | £000 | £000 |
| **Undiscounted future lease receipts receivable in:** | | |
| not later than one year; | 113 | - |
| later than one year and not later than two years; | 130 | - |
| later than two years and not later than three years; | 130 | - |
| later than three years and not later than four years; | 100 | - |
| later than four years and not later than five years; | - | - |
| later than five years. | - | - |
| **Total future finance lease payments to be received** | **472** | **-** |
| Unearned interest income | (29) | - |
| **Net investment in lease (net lease receivable)** | **443** | **-** |
| **of which:** | | |
| Leased to other NHS providers | | - |
| Leased to other DHSC group bodies | | - |

### Note 31 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

| | Group | | Trust | |
|---|---|---|---|---|
| | 2023/24 | 2022/23 | 2023/24 | 2022/23 |
| | £000 | £000 | £000 | £000 |
| **At 1 April** | **47,106** | **53,151** | **41,102** | **48,542** |
| Net change in year | (8,580) | (6,045) | (7,237) | (7,440) |
| **At 31 March** | **38,526** | **47,106** | **33,865** | **41,102** |
| **Broken down into:** | | | | |
| Cash at commercial banks and in hand | 4,349 | 4,480 | 3 | 4 |
| Cash with the Government Banking Service | 34,177 | 42,626 | 33,862 | 41,098 |
| **Total cash and cash equivalents as in SoFP** | **38,526** | **47,106** | **33,865** | **41,102** |
| **Total cash and cash equivalents as in SoCF** | **38,526** | **47,106** | **33,865** | **41,102** |

### Note 31.1 Third party assets held by the trust

Royal United Hospitals Bath NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

| | Group and Trust | |
|---|---|---|
| | 31 March 2024 | 31 March 2023 |
| | £000 | £000 |
| Bank balances | 11 | 8 |
| **Total third party assets** | **11** | **8** |

**Note 32 Trade and other payables**

| | Group | | Trust | |
|---|---|---|---|---|
| | 31 March 2024 £000 | 31 March 2023 £000 | 31 March 2024 £000 | 31 March 2023 £000 |
| **Current** | | | | |
| Trade payables | 9,952 | 1,203 | 15,586 | 610 |
| Capital payables | 2,691 | 2,908 | 2,691 | 2,908 |
| Accruals | 22,792 | 47,206 | 14,268 | 45,156 |
| Social security costs | 8,053 | 7,196 | 7,717 | 6,987 |
| PDC dividend payable | - | 74 | - | 74 |
| Pension contributions payable | - | 4,002 | - | - |
| Other payables | 10,866 | 7,748 | 9,890 | 10,425 |
| NHS charitable funds: trade and other payables | 944 | 327 | - | - |
| **Total current trade and other payables** | **55,298** | **70,664** | **50,152** | **66,160** |
| **Of which payables from NHS and DHSC group bodies:** | | | | |
| Current | 5,024 | 3,349 | 17,544 | 15,032 |

**Note 32.1 Early retirements in NHS payables above**

There were no early retirements in the NHS payables stated above.

**Note 33 Other liabilities**

| | Group | | Trust | |
|---|---|---|---|---|
| | 31 March 2024 | 31 March 2023 | 31 March 2024 | 31 March 2023 |
| | £000 | £000 | £000 | £000 |
| **Current** | | | | |
| Deferred income: contract liabilities | 13,298 | 2,407 | 11,388 | 810 |
| **Total other current liabilities** | **13,298** | **2,407** | **11,388** | **810** |

**Note 34 Borrowings**

| | Group | | Trust | |
|---|---|---|---|---|
| | 31 March 2024 | 31 March 2023 | 31 March 2024 | 31 March 2023 |
| | £000 | £000 | £000 | £000 |
| **Current** | | | | |
| Loans from DHSC | 348 | 349 | 348 | 349 |
| Lease liabilities | 2,722 | 1,806 | 2,448 | 1,604 |
| **Total current borrowings** | **3,070** | **2,155** | **2,796** | **1,953** |
| **Non-current** | | | | |
| Loans from DHSC | 4,850 | 5,163 | 4,850 | 5,163 |
| Lease liabilities | 49,278 | 49,339 | 49,147 | 49,152 |
| **Total non-current borrowings** | **54,128** | **54,502** | **53,997** | **54,315** |

**Note 34.1 Reconciliation of liabilities arising from financing activities (Group)**

| Group - 2023/24 | Loans from DHSC | Lease liabilities | Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Carrying value at 1 April 2023** | **5,512** | **51,145** | **56,657** |
| **Cash movements:** | | | |
| Financing cash flows - payments and receipts of principal | (313) | (2,808) | **(3,121)** |
| Financing cash flows - payments of interest | (128) | (1,780) | **(1,908)** |
| **Non-cash movements:** | | | |
| Additions | - | 2,453 | **2,453** |
| Lease liability remeasurements | - | 1,345 | **1,345** |
| Application of effective interest rate | 127 | 1,780 | **1,907** |
| Early terminations | - | (135) | **(135)** |
| **Carrying value at 31 March 2024** | **5,198** | **52,000** | **57,198** |

| Group - 2022/23 | Loans from DHSC | Lease liabilities | Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Carrying value at 1 April 2022** | **5,827** | **2,086** | **7,913** |
| **Cash movements:** | | | |
| Financing cash flows - payments and receipts of principal | (313) | (3,857) | **(4,170)** |
| Financing cash flows - payments of interest | (133) | (636) | **(769)** |
| **Non-cash movements:** | | | |
| IFRS 16 implementation - adjustments for existing operating leases / subleases | | 24,903 | **24,903** |
| Additions | - | 28,916 | **28,916** |
| Application of effective interest rate | 131 | 636 | **767** |
| Early terminations | - | (903) | **(903)** |
| **Carrying value at 31 March 2023** | **5,512** | **51,145** | **56,657** |

**Note 34.2 Reconciliation of liabilities arising from financing activities**

| Trust - 2023/24 | Loans from DHSC | Lease liabilities | Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Carrying value at 1 April 2023** | **5,511** | **50,756** | **56,267** |
| **Cash movements:** | | | |
| Financing cash flows - payments and receipts of principal | (313) | (2,830) | **(3,143)** |
| Financing cash flows - payments of interest | (128) | (1,726) | **(1,854)** |
| **Non-cash movements:** | | | |
| Additions | - | 2,460 | **2,460** |
| Lease liability remeasurements | | 1,345 | **1,345** |
| Application of effective interest rate | 128 | 1,725 | **1,853** |
| Change in effective interest rate | | | **-** |
| Changes in fair value | | | **-** |
| Early terminations | - | (135) | **(135)** |
| **Carrying value at 31 March 2024** | **5,198** | **51,595** | **56,793** |

| Trust - 2022/23 | Loans from DHSC | Lease liabilities | Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Carrying value at 1 April 2022** | **5,826** | **1,680** | **7,506** |
| **Cash movements:** | | | |
| Financing cash flows - payments and receipts of principal | (313) | (1,560) | **(1,873)** |
| Financing cash flows - payments of interest | (133) | (462) | **(595)** |
| **Non-cash movements:** | | | |
| IFRS 16 implementation - adjustments for existing operating leases / subleases | - | 1,836 | **1,836** |
| Additions | - | 49,702 | **49,702** |
| Application of effective interest rate | 131 | 463 | **594** |
| Early terminations | - | (903) | **(903)** |
| **Carrying value at 31 March 2023** | **5,511** | **50,756** | **56,267** |

**Note 35.1 Provisions for liabilities and charges analysis (Group)**

| Group | Pensions: early departure costs | Legal claims | Other | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **At 1 April 2023** | **717** | **47** | **1,024** | **1,788** |
| Change in the discount rate | - | - | (251) | **(251)** |
| Arising during the year | 89 | - | 298 | **387** |
| Utilised during the year | (89) | - | (14) | **(103)** |
| Reversed unused | (10) | (32) | - | **(42)** |
| Unwinding of discount | 18 | - | 48 | **66** |
| **At 31 March 2024** | **725** | **15** | **1,105** | **1,845** |
| **Expected timing of cash flows:** | | | | |
| - not later than one year; | 128 | 15 | 332 | **475** |
| - later than one year and not later than five years; | 325 | - | 332 | **657** |
| - later than five years. | 272 | 0 | 441 | **713** |
| **Total** | **725** | **15** | **1,105** | **1,845** |

**Note 35.2 Provisions for liabilities and charges analysis (Trust)**

| Trust | Pensions: early departure costs | Legal claims | Other | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **At 1 April 2023** | **717** | **47** | **951** | **1,715** |
| Change in the discount rate | - | - | (251) | **(251)** |
| Arising during the year | 89 | - | 350 | **439** |
| Utilised during the year | (43) | - | (14) | **(57)** |
| Reclassified to liabilities held in disposal groups | (67) | - | - | **(67)** |
| Reversed unused | (10) | (32) | - | **(42)** |
| Unwinding of discount | 18 | - | 48 | **66** |
| **At 31 March 2024** | **704** | **15** | **1,084** | **1,803** |
| **Expected timing of cash flows:** | | | | |
| - not later than one year; | 128 | 15 | 311 | **454** |
| - later than one year and not later than five years; | 325 | - | - | **325** |
| - later than five years. | 272 | - | 773 | **1,045** |
| **Total** | **725** | **15** | **1,084** | **1,824** |

Pensions - early departure costs
Early retirement costs and injury benefit payments for staff, based on the information provided by NHS Pensions. The amounts and timings of the cash flows are accurate for the life of the claimant. Timings of payment are due over the life of the claimants.

Other legal claims
Litigation claims against the Trust that are being handled by NHS Litigation Authority. The provision is based on the information provided by NHS Litigation Authority. The timing of future and actual amounts remain uncertain until the claims are settled.

Other
Other provisions have been made in relation to employment issues. The amounts are estimates based on known risks and saleries and are therefore inherently uncertain. Other provisions includes a capitalised provision in relation to IFRS16 of £332,000.

## Note 36 Clinical negligence liabilities

At 31 March 2024, £188,517k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal United Hospitals Bath NHS Foundation Trust (31 March 2023: £222,132k).

## Note 37 Contingent assets and liabilities

| | Group | | Trust | |
|---|---|---|---|---|
| | 31 March 2024 | 31 March 2023 | 31 March 2024 | 31 March 2023 |
| | £000 | £000 | £000 | £000 |
| **Value of contingent liabilities** | | | | |
| NHS Resolution legal claims | 2 | 11 | 2 | 11 |
| **Gross value of contingent liabilities** | **2** | **11** | **2** | **11** |
| **Net value of contingent liabilities** | **2** | **11** | **2** | **11** |
| **Net value of contingent assets** | **-** | **-** | **-** | **-** |

**NHS Resolution claims**
Contingent liabilities are the legal claims under the liability to third parties and property expenses administered by the NHS Resolution (formerly NHS Litigation Authority). The Trust has not identified any contingent assets in 2023/24 (nil in 2022/23).

## Note 38 Contractual capital commitments

| | Group | | Trust | |
|---|---|---|---|---|
| | 31 March 2024 | 31 March 2023 | 31 March 2024 | 31 March 2023 |
| | £000 | £000 | £000 | £000 |
| Property, plant and equipment | 8,400 | 7,849 | 8,400 | 7,849 |
| Intangible assets | 394 | 23 | 394 | 23 |
| **Total** | **8,794** | **7,872** | **8,794** | **7,872** |

## Note 39 Financial instruments

### Note 39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with NHS England and Clinical Commissioning Groups and the way those bodies are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

**Currency risk**
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no establishment in other territories. The Foundation Trust therefore has low exposure to currency rate fluctuations.

**Interest rate risk**
The Trust borrows from government for capital expenditure, subject to affordability. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. Additionally the Trust's cash balances are held with the Government Banking Service. The Trust, therefore, has low exposure to interest rate fluctuations.

**Credit risk**
Because the majority of the Trust's income comes from other public sector bodies, it has low exposure to credit risk. The maximum exposures as at 31 March 2023 are in receivables from customers, as disclosed in the trade and other receivables note. These funding arrangements ensure that the Trust is not exposed to any material credit risk.

**Liquidity risk**
The Trust's operating costs are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated funds. The Trust is not, therefore, exposed to significant liquidity risks.

**Note 39.2 Carrying values of financial assets (Group)**

| Carrying values of financial assets as at 31 March 2024 | Held at amortised cost | Held at fair value through OCI | Total book value |
|---|---|---|---|
| | £000 | £000 | £000 |
| Trade and other receivables excluding non financial assets | 24,319 | - | **24,319** |
| Cash and cash equivalents | 34,531 | - | **34,531** |
| Consolidated NHS Charitable fund financial assets | 4,814 | 4,833 | **9,647** |
| **Total at 31 March 2024** | **63,664** | **4,833** | **68,497** |

| Carrying values of financial assets as at 31 March 2023 | Held at amortised cost | Held at fair value through OCI | Total book value |
|---|---|---|---|
| | £000 | £000 | £000 |
| Trade and other receivables excluding non financial assets | 23,194 | - | **23,194** |
| Cash and cash equivalents | 42,079 | - | **42,079** |
| Consolidated NHS Charitable fund financial assets | 5,308 | 6,483 | **11,791** |
| **Total at 31 March 2023** | **70,581** | **6,483** | **77,064** |

**Note 39.3 Carrying values of financial assets (Trust)**

| Carrying values of financial assets as at 31 March 2024 | Held at amortised cost | Held at fair value through OCI | Total book value |
|---|---|---|---|
| | £000 | £000 | £000 |
| Trade and other receivables excluding non financial assets | 25,294 | - | **25,294** |
| Cash and cash equivalents | 33,865 | - | **33,865** |
| **Total at 31 March 2024** | **59,159** | **-** | **59,159** |

| Carrying values of financial assets as at 31 March 2023 | Held at amortised cost | Held at fair value through OCI | Total book value |
|---|---|---|---|
| | £000 | £000 | £000 |
| Trade and other receivables excluding non financial assets | 6,914 | - | **6,914** |
| Cash and cash equivalents | 41,102 | - | **41,102** |
| **Total at 31 March 2023** | **48,016** | **-** | **48,016** |

**Note 39.4 Carrying values of financial liabilities (Group)**

| Carrying values of financial liabilities as at 31 March 2024 | Held at amortised cost | Total book value |
|---|---|---|
| | £000 | £000 |
| Loans from the Department of Health and Social Care | 5,198 | **5,198** |
| Obligations under leases | 52,000 | **52,000** |
| Trade and other payables excluding non financial liabilities | 43,696 | **43,696** |
| Provisions under contract | 1,845 | **1,845** |
| Consolidated NHS charitable fund financial liabilities | 944 | **944** |
| **Total at 31 March 2024** | **103,684** | **103,684** |

| Carrying values of financial liabilities as at 31 March 2023 | Held at amortised cost | Total book value |
|---|---|---|
| | £000 | £000 |
| Loans from the Department of Health and Social Care | 5,512 | **5,512** |
| Obligations under leases | 51,145 | **51,145** |
| Trade and other payables excluding non financial liabilities | 63,067 | **63,067** |
| Provisions under contract | 1,788 | **1,788** |
| Consolidated NHS charitable fund financial liabilities | 327 | **327** |
| **Total at 31 March 2023** | **121,839** | **121,839** |

**Note 39.5 Carrying values of financial liabilities (Trust)**

| Carrying values of financial liabilities as at 31 March 2024 | Held at amortised cost | Total book value |
|---|---|---|
| | £000 | £000 |
| Loans from the Department of Health and Social Care | 5,198 | **5,198** |
| Obligations under leases | 51,595 | **51,595** |
| Trade and other payables excluding non financial liabilities | 39,494 | **39,494** |
| Provisions under contract | 1,803 | **1,803** |
| **Total at 31 March 2024** | **98,090** | **98,090** |

| Carrying values of financial liabilities as at 31 March 2023 | Held at amortised cost | Total book value |
|---|---|---|
| | £000 | £000 |
| Loans from the Department of Health and Social Care | 5,512 | **5,512** |
| Obligations under leases | 50,756 | **50,756** |
| Trade and other payables excluding non financial liabilities | 58,013 | **58,013** |
| Provisions under contract | 1,715 | **1,715** |
| **Total at 31 March 2023** | **115,996** | **115,996** |

### Note 39.6 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

| | Group | | Trust | |
|---|---|---|---|---|
| | 31 March 2024 £000 | 31 March 2023 £000 | 31 March 2024 £000 | 31 March 2023 £000 |
| In one year or less | 49,809 | 69,012 | 55,181 | 56,670 |
| In more than one year but not more than five years | 16,424 | 14,708 | 15,055 | 1,689 |
| In more than five years | 63,019 | 64,680 | 64,065 | 4,515 |
| **Total** | **129,253** | **148,400** | **134,301** | **62,874** |

### Note 40 Losses and special payments

| | 2023/24 | | 2022/23 | |
|---|---|---|---|---|
| **Group and Trust** | **Total number of cases Number** | **Total value of cases £000** | **Total number of cases Number** | **Total value of cases £000** |
| **Losses** | | | | |
| Bad debts and claims abandoned | 11 | 6 | 138 | 30 |
| **Total losses** | **11** | **6** | **138** | **30** |
| **Special payments** | | | | |
| Compensation under court order or legally binding arbitration award | 3 | 7 | 1 | - |
| Ex-gratia payments | 33 | 14 | 43 | 25 |
| **Total special payments** | **36** | **21** | **44** | **25** |
| **Total losses and special payments** | **47** | **27** | **182** | **55** |

## Note 41 Related parties

During the year none of the Department of Health Ministers, Royal United Hospitals Bath NHS Foundation Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Royal United Hospitals Bath NHS Foundation Trust.

The Department of Health is regarded as a related party. During the 12 month period to 31 March 2024, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

**ICBs**
NHS Bath and North East Somerset, Swindon and Wiltshire ICB
NHS Bristol, North Somerset and South Gloucestershire ICB
NHS Somerset ICB

**NHS England Organisations**
NHS England - Central Specialised Commissioning Hub
NHS England - South West Regional Office
NHS England - South West Specialised Commissioning Hub
NHS England - South East Regional Office
NHS England - Wessex Specialised Commissioning Hub
NHS England - Midlands Regional Office
NHS Confederation

**NHS Trusts and Foundation Trusts**
University Hospitals Bristol and Weston NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
North Bristol NHS Trust
Salisbury NHS Foundation Trust
Avon and Wiltshire Mental Health Partnership NHS Trust
Somerset Partnership NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust

**Other Agencies**
Health Education England
Department Of Health
Bath and North East Somerset Council
Wiltshire Unitary Authority
Welsh Assembly Government (including all other Welsh Health Bodies)
Public Health England
NHS Litigation Authority
NHS Blood and Transplant (excluding Bio products Laboratory).
Alzheimer's Society
System C Healthcare Ltd

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Her Majesty's Revenue and Customs in relation to Value Added Tax, National Insurance Contributions and Income Taxes.

The Trust has also received revenue and capital payments from the Royal United Hospital Bath NHS Trust Charitable Funds, for which the Trust Board acts as Corporate Trustee. In 2023/24 the Trust received £3.3m from RUH X for various medical equipment including surgical robot, gamma camera, ITU pendants and incubators. The audited accounts of the Charitable Funds are available at www.ruh.nhs.uk.

## Note 42 Events after the reporting date

No events after the reporting date have been identified.