Royal United Hospitals Bath
NHS Foundation Trust

Annual Report and Accounts

2022/23

Royal United Hospitals Bath NHS Foundation Trust

Annual Report and Accounts

2022/23

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

Contents

Message from the Chair and Chief Executive

We will begin where we always do when we reflect on the year gone by, and that is by extending our enormous gratitude to the amazing people we work with. As ever, the way they have faced another year of challenge, with such commitment and compassion for the people we care for, is something that we remain in awe of.

We would also like to extend our thanks to our volunteers, who we were thrilled to welcome back to the RUH following the pandemic. Our volunteers are highly important to the RUH; whether it's those who come in to visit our wards with their Pets As Therapy Dogs, those who help our patients and visitors find their way around the hospital, or serving customers in our shop and café – and many other roles besides. They are all an essential part of the RUH's DNA.

It's fitting that our thanks focuses on our people, because that's what the RUH is all about. And by 'people,' we mean the people we work with, the people we care for and those in our community.

Throughout much of last year, we engaged with those people to understand what's important about what we do. We used what they told us to create a vision for the RUH and in September 2022 we launched 'The RUH; where you matter.' This sets out our commitment to the organisation we want to be in the future.

We want everyone who comes through our doors to know that they are welcome, safe, respected and can be their authentic selves. We want to throw our arms around those who are in seldom heard groups and make sure that those in diverse groups see themselves represented and understood at the RUH.

Our Trust values and significant work in the space of kindness and civility has helped us to get this right some of the time. However, we are open about the fact that there is still work to do elsewhere so that we are offering a consistent experience to all our people.

Our Trust strategy, which will set out what we will be delivering over the next three years, will be published in July and we are excited to share our ambitions for the RUH as well as tell our people what will look, feel and be different for them. And developing our organisational culture will go hand in hand with this strategy.

Onto operational matters, and we are pleased to report that our performance in reducing waiting lists for elective (planned) procedures remains strong. In fact, the RUH is one of a handful of trusts to achieve the government's 2022/23 target to deliver 104% of 2019/20 activity levels – we in fact delivered 106%.

We acquired a local private hospital, the former Circle Hospital, now renamed Sulis Hospital Bath, in 2021. One of the main drivers behind this was to help maintain a suitable mix of NHS and private capacity in Bath to meet demand. We continue to work with colleagues locally and across the wider system and region to fully realise our ambitions for this site. In 2023/24 we are forecasting an even stronger performance against the target and we have a comprehensive plan to ensure that we do this.

We are still experiencing challenges in our Emergency Department performance, which in part is due to the number of patients we have in the hospital who are well enough to leave the acute setting but need some extra support when they get home.

Whilst this number has not been where we would want it to be for much of 2022/23, we have begun to see green shoots of progress thanks to our Home is Best programme. We are grateful to our partner colleagues at BaNES council for helping to get more of our patient's home in a safe and timely way.

Our official Trust charity, RUHX, has had an exciting year, embracing a new purpose and a new name. RUHX will focus on going further to give every patient the extraordinary care they deserve, while supporting our staff to do what they do best and furthering innovation within our hospitals. The Charity also made a significant funding contribution to the construction of our soon to be completed Dyson Cancer Centre, for which we are very grateful.

A key achievement has been leading the work of the NHS Charities Together Community Partnerships grants programme to secure £400,000 of funding over two years distributed to community groups in Bath and North East Somerset, Swindon and Wiltshire. This project will help the people in our community to recover from COVID, and will prioritise the most vulnerable groups impacted, focusing on deprivation, ethnicity, and mental health. We are grateful to RUHX – as well the Friends of the RUH – for all that they do in support of our work.

Later this year, we look forward to celebrating the NHS' 75th birthday; another opportunity to thank our staff and reflect on our legacy. We will also be opening the doors to our Dyson Cancer Centre, which will be an amazing place for our patients to receive care and for our staff to give care. We can't wait for you to see it.

Here's to a rewarding year for everyone and we look forward to sharing our achievements with you.

Performance Report

Overview of performance during 2022/23

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

About the Trust

Statutory background

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 en-suite 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, and it played a key part in helping ease the pressure on elective surgery backlogs in the early part of the COVID-19 pandemic. 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.

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 a number of 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
- Maternity services
- Rheumatology, pain and fatigue (from the RNHRD and Brownsword Therapies Centre)
- Specialist orthopaedics (surgery on joints and bones)
- Pulmonary hypertension

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. It is recognised as one of the most research-active medium sized acute Trusts in the country.

In common with other areas, our population is evolving:

- We have a growing population of people with more complex needs, particularly those who are more elderly, and are living with long-term conditions;

- There are, rightly, rising public expectations in terms of the quality and availability of public services;
- There are two universities located within the City of Bath, meaning that we have a large student population that is temporary and always changing.

Patients are at the heart of all we do, and we aspire to be responsive and compassionate at all times. We place great importance on gathering feedback from patients and carers and involving them in decisions and developments. This is embedded in the Trust through our Patient Experience Strategy supported by an Engagement Toolkit and a range of initiatives and practices. This includes our Patient Advice and Liaison Service (PALS), consultations and events, social media and other communications, membership, Governors and our volunteers. We had to adapt the way we engaged with patients and their families and carers during the pandemic, but we are now re-commencing face to face engagements with our Foundation Trust members and the wider community.

During 2022/23 our Trust Strategy set out our overall goals to achieve high quality care and patient experience, putting patients at the heart of all we do. It was built around five key strategic goals and reflected our core values. Our programme of whole organisation development "Improving Together" was key to its delivery.

As part of this approach we also identified a number of "breakthrough objectives" – areas identified as requiring focused improvement activity. These were:

- Recruit to vacancies
- Reduce hospital acquired infections.
- Reduce the number of patients waiting in hospital (non-criteria to reside)

In February 2023, following extensive internal and external consultation, we launched our new vision: “The RUH, where you matter”. We also agreed a number of strategic goals, or People Promises that we will be working to over the next five years:

- For the people we work with, creating the conditions to perform to our best – living by our values, investing in our teams and supporting diversity.
- For the people we care for, supporting people as and when they need it most – delivering high quality care, listening and acting on what matters most to them.
- For the people in our community, creating one of the healthiest places to live and work – working with our partners to make the most of our shared resources and reducing inequalities.

Detailed strategic objectives based on each of these People Promises have been agreed, as well as annual milestones along the five year journey. Delivery against these will be overseen by our Board of Directors.

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 Oversight Framework 2022/23 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 and 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 Board. Our reporting against national standards is robust and regularly audited as part of the Trust’s Quality accounts.

Introduction

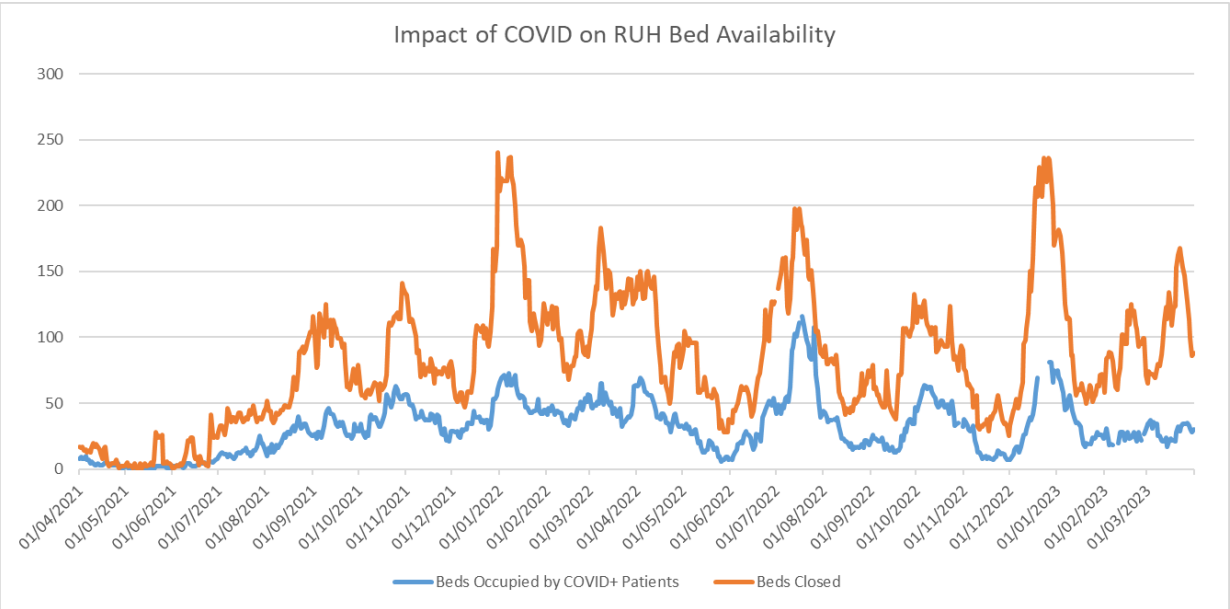
2022/23 has been a challenging year for the organisation but we have seen some real successes. This year the NHS has been focusing on its elective recovery programme of which the Trust has been one of the best performing hospitals within the South West. This has led to significant progress in reducing waiting times for planned procedures and is the spring board to further improvements during coming years.

The NHS has also been trying to ensure that 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. The Trust also noted risks, as identified through its internal audit programme, relating to Medicines Management, learning from incidents, DSP Toolkit, Risk Management and Payroll. 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

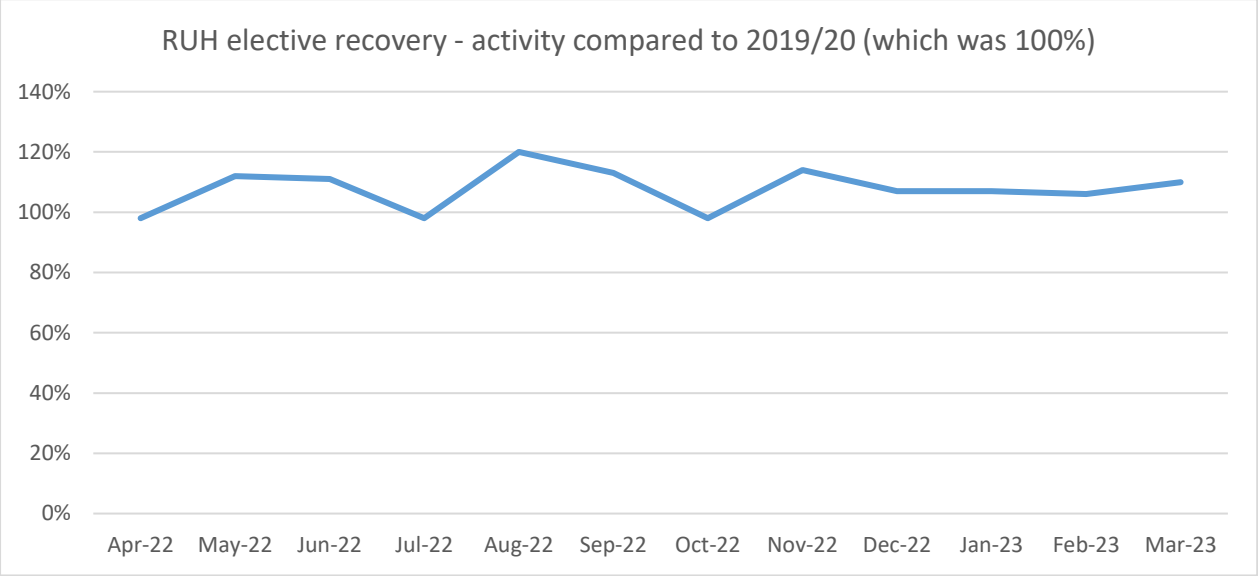
Covid-19 Summary

The following graph demonstrates that during the last during the last year, the Trust has been responding to at least 4 significant COVID outbreaks, which alongside norovirus, have led to periods where between 25% and 47% of the general and acute bed base has been impacted by the ongoing challenges. During the year the Trust has undertaken a significant capital investment programme to increase the number of side rooms and toilets to enhance Infection Control Measures.



Elective Care

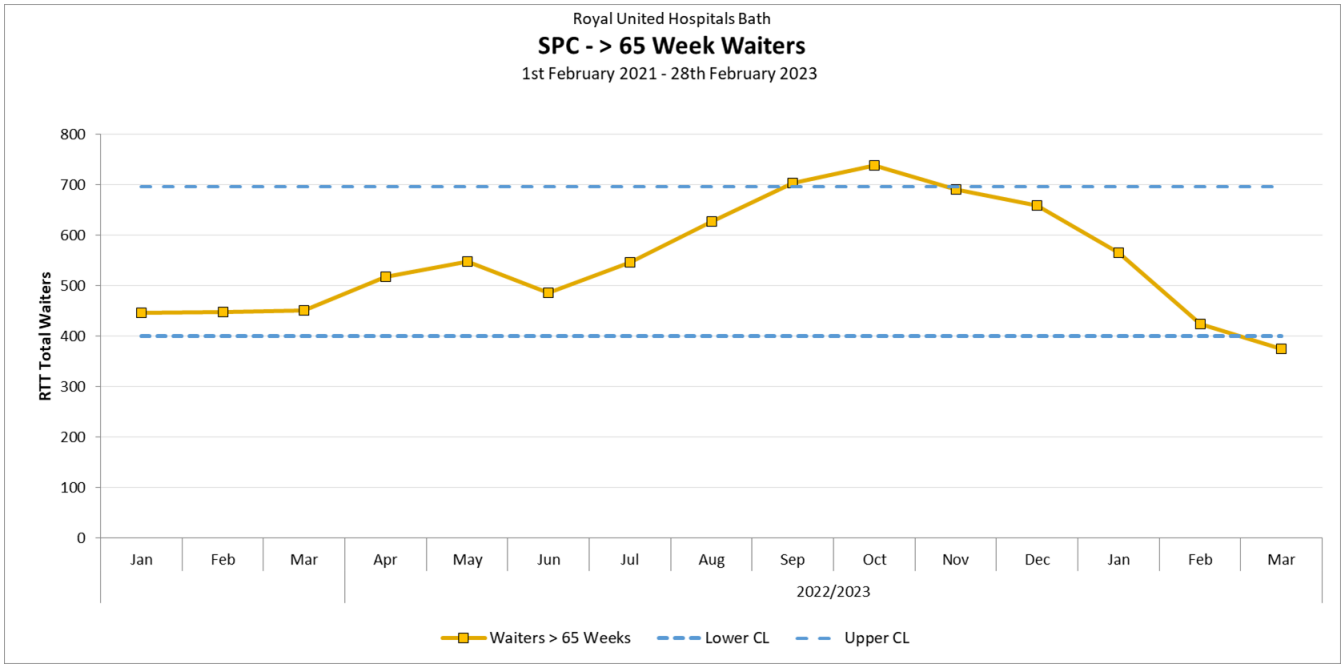
Elective recovery has been a priority for the wider NHS during 2022/23 and the RUH has had a number of successes in supporting this delivery. The headline measure has been for each NHS organisation to deliver 104% of the value weighted elective activity that they delivered in 2019/20. The below graph demonstrates that the Trust has been able to deliver 108% against this target during 2022/23. The RUH is one of the few organisations within the South West 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 2022/23 the Trust has been successful in treating all its patients who have been waiting for over 104 weeks for their care, and has reduced the number of patients waiting over 78 weeks from a maximum of 208 patients down to 25.

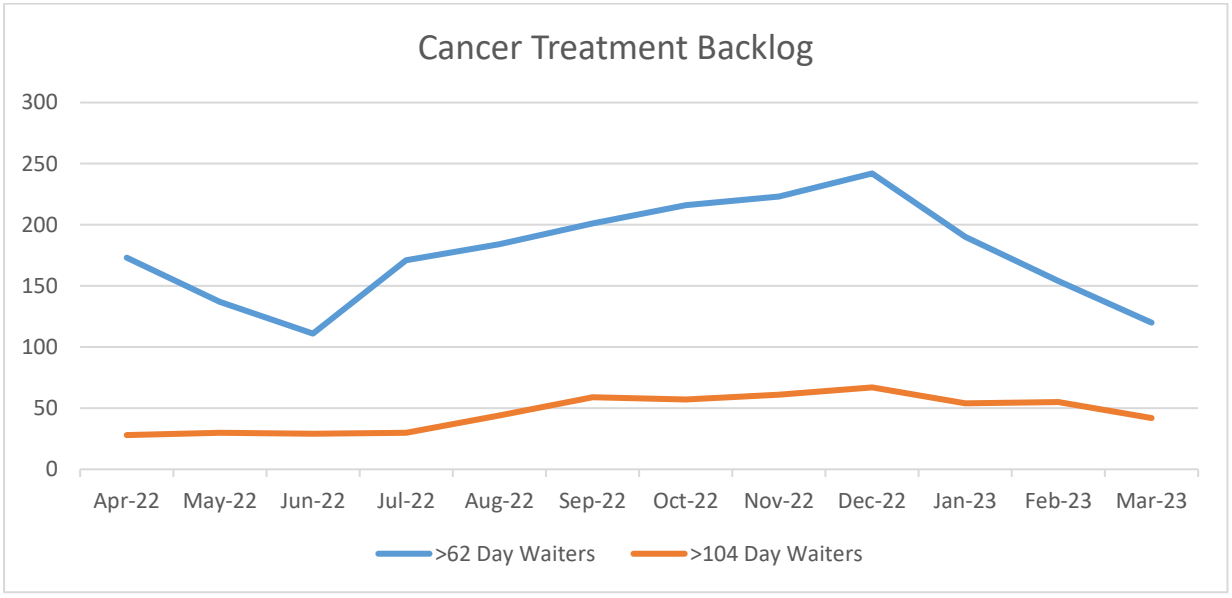
The Trust is now focused on trying to reduce the number of patients who are waiting over 65 weeks. As the below graph demonstrates, the Trust is also starting to deliver significant improvements in the number of patients waiting for treatment.



Cancer

Before the pandemic, the RUH was consistently enabling more than 80% of patients to begin their cancer treatment within 62 days of an urgent referral from a General Practitioner. This performance has been challenged more recently due to a combination of growing demand and reduced capacity during COVID. The Trust though was able to deliver some of the strongest performance within the South West, which meant that by March 2023, 72% of patients were being treated within 62 days.

The Trust has been working hard to reduce the backlog of patients who have been waiting over 62 days for their treatment and we have delivered significant improvements.

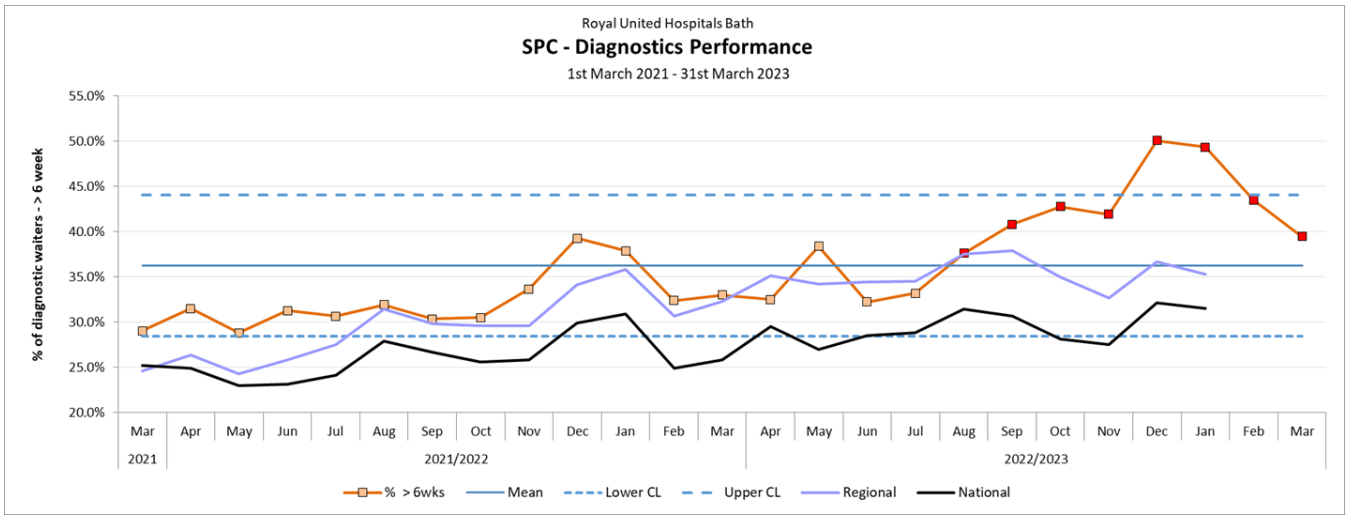


In 2023/24 the Trust will open the new Dyson Centre which is designed to support significant improvements in the hospital's treatment of cancer patients. The Trust has also agreed plans that will help to drive further improvements on cancer performance in the years ahead.

Diagnostics

Demand for diagnostic services has significantly increased over the last year, driven by additional cancer referrals and primary care demand. 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 additional community capacity.

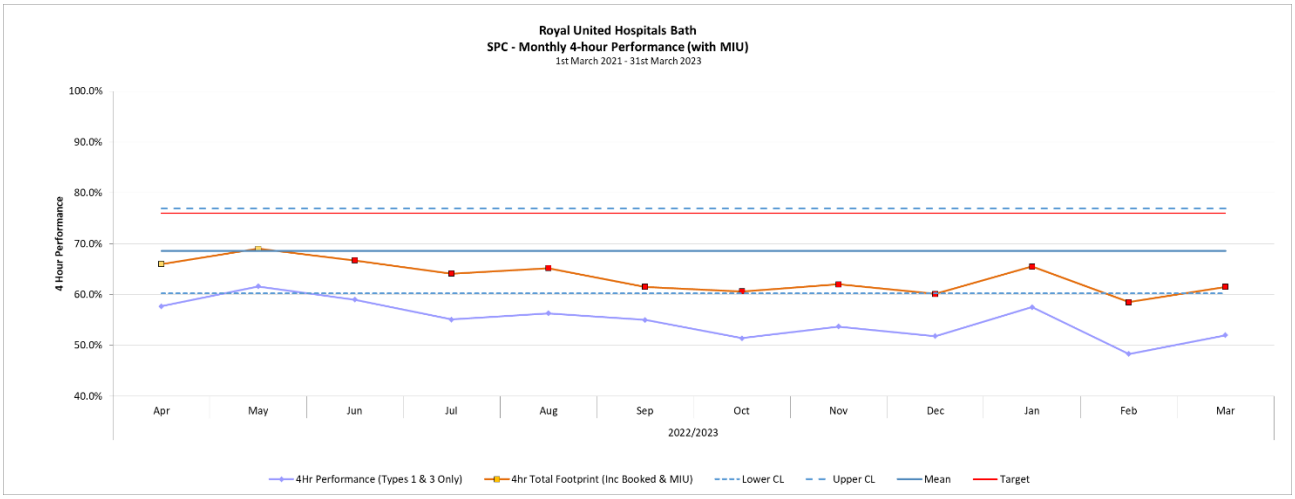
The graph below demonstrates the Trust's performance for the year. This shows improvements in performance in the last quarter of the year, as the new ways of working and additional capacity have come on-line.



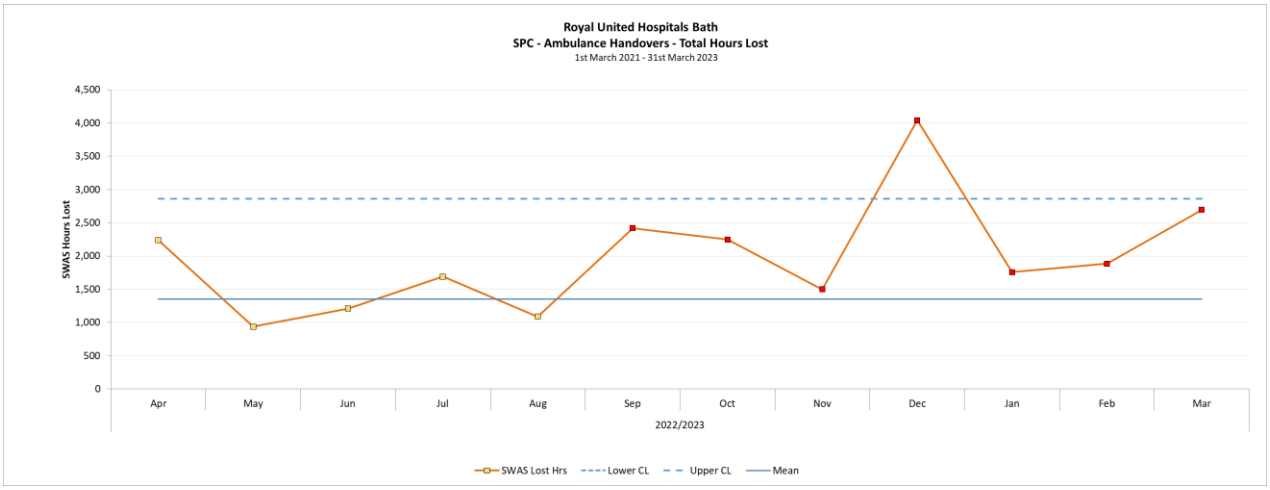
Over the next year the BSW system will support the introduction of additional capacity through the roll out of the Community Diagnostic Service which will help reduce the number of patients waiting.

Urgent Care

During 2022/23 the Trust continued to be monitored against the national access target of treating 95% of patients attending its Emergency Department within 4 hours of admission. The RUH has, alongside the rest of the NHS, seen significant challenges in the delivery of the 4 hour performance target.

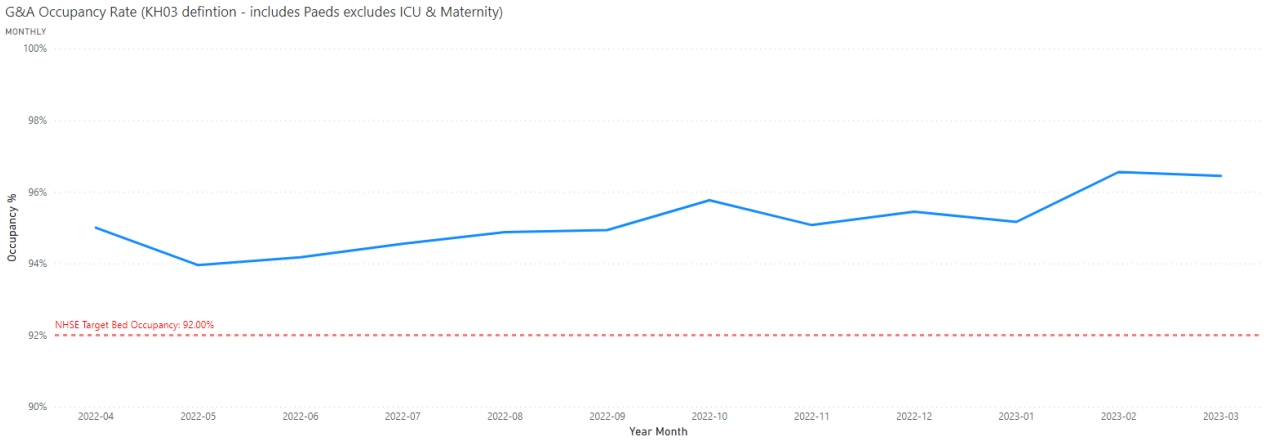


One of the other key urgent care measures is supporting timely ambulance handovers. The below graph demonstrates the number of hours where there has been a delay in handing patients over from the ambulance service to the hospital. The hospital has seen delays longer than it would like here and this remains a significant priority to resolve.

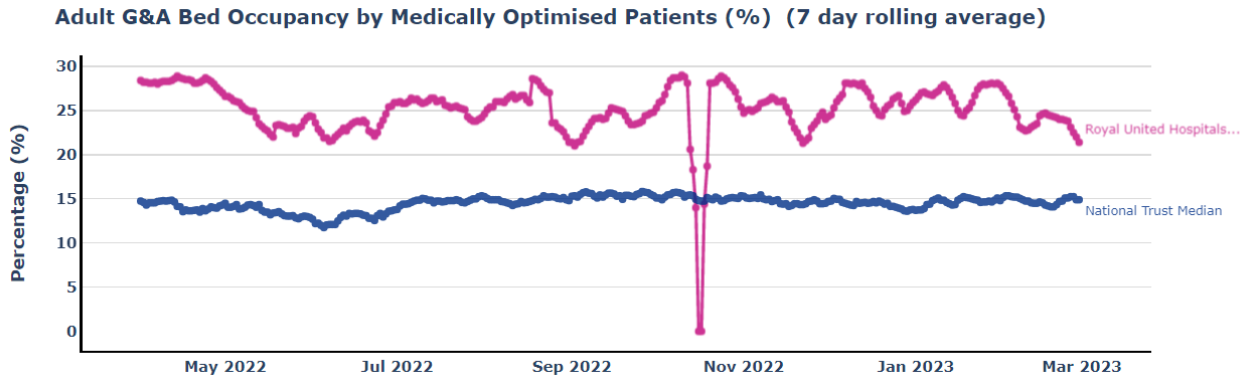


Bed occupancy

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. 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.

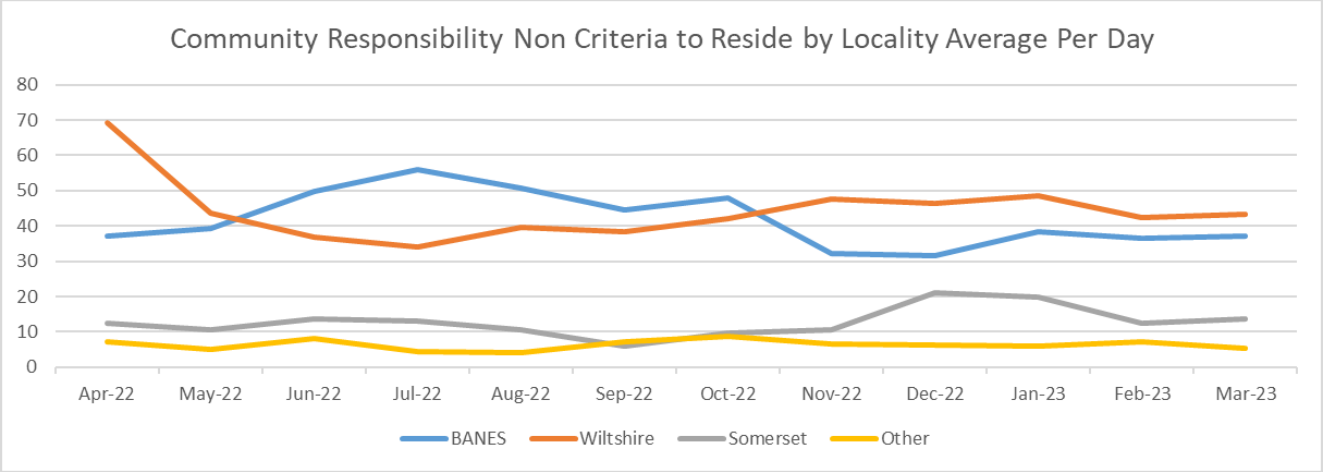


The high bed occupancy is driven by several factors, including the number of patients who are medically fit for discharge but are unable to leave due to insufficient care at home or in the community. The Trust has continued to be a national outlier for the number of patients who are medically fit for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



As this demonstrates the Trust has had nearly double the percentage of beds occupied NC2R patients than the national average. This has meant in practical terms, during 2022/23 the Trust had an average of 135 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.



The Trust has been working closely with the BaNES Integrated Care Alliance to deliver improvements within the NC2R position, with the position significantly improving from a highest point of 70 patients waiting in the summer to circa 30 patients in March 2023. The Trust is forecasting further improvements in early 2023/24. This has been achieved through:

- 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 is now targeting getting down to 48 hours.
- The RUH and BaNES Council developing a shared domiciliary care service – Both organisations identified a shortage of domiciliary care provision and worked together to utilise the strengths of both organisations to help introduce a new domiciliary care agency, United Care BaNES. This service is helping to increase the number of care hours delivered and thereby helping to reduce delays.
- Continued growth of ART+ (Active Recovery Therapy) – the service now supports community based reablement services by looking after up to 40 patients in their home based step down from the RUH.

<u>Emergency Department</u>

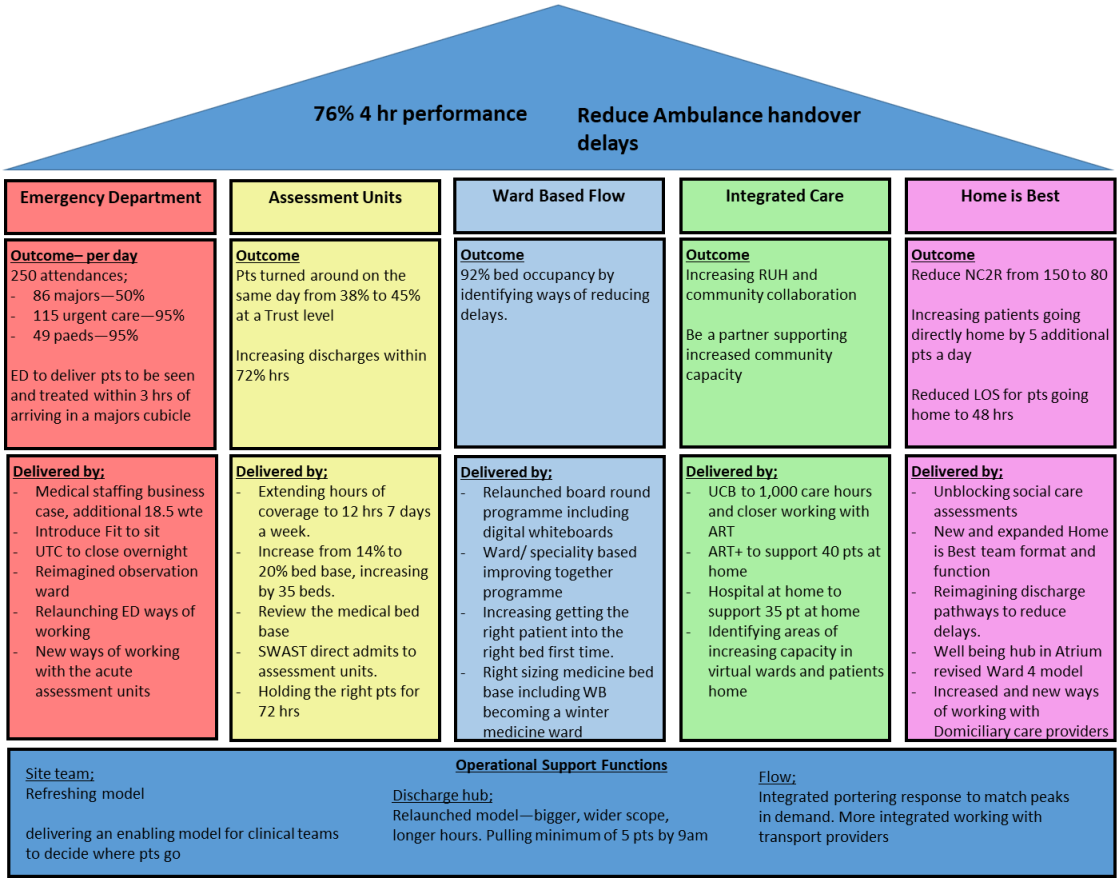
The RUH has seen emergency attendances through the Emergency Department (ED) return to the pre-pandemic levels with 93,000 attendances in 2019/20 and again in 2023/23. Although it is important to highlight that when there are peaks in COVID demand, the emergency attendances reduced during these periods and so it is likely the underlying activity is actually greater than pre-pandemic. The Trust also, on the 3rd of December 2022 had its most ever attendances into ED when 349 patients came to ED.

The ED has also seen a change in the type of patients who are attending, with a growth in the more complex patients i.e. those with greater need and a growth in the

number of people attending through the hospitals Urgent Treatment Centre. As the hospital has increased the GP direct access into Medical Assessment Unit, the Older Person Assessment Unit and the Surgical Assessment Unit, there has been a slight decrease in the number of patients who are attending with the mid-range HRGs. The Trust is currently reviewing staffing within the ED to ensure that it matches the nationally recognised best practice models and matches the regional benchmarking.

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. As part of the planning for 2023/24 the Trust has refreshed the strategy. The below diagram 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.

Breakthrough Objectives for 2023/24

Following a review of our operational and performance targets during 2022/23, we have agreed the following Breakthrough Objectives for 2023/24.

- To reduce the percentage of staff reporting that they have personally experienced discrimination at work from their manager, team leader or other colleagues
- To deliver 109% of 2019/20 elective activity
- To increase the percentage of patients attending the ED who are treated and admitted or discharged within four hours

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

Sulis Hospital Bath Limited ("Sulis"), Performance Review 2022-23

Overview

Royal United Hospital Bath NHS Foundation Trust ("RUH") acquired Sulis Hospital Bath in June 2021, following the divestment by Circle Health of the site due to the acquisition of BMI Bath Clinic and instruction of the Competition and Markets Authority. Since acquisition, 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 matters governance, clinical and financial – a Subsidiary Oversight Committee comprised of Sulis and RUH Executives and NED representation is assured of performance

Key strategic objectives for between June 2021 and end-March 2023:

- Increase NHS capacity to support waiting times in the region
- Sustain private work to support the financial and market position in the region
- Increase diagnostic capacity as a Community Diagnostic Centre (CDC) and surgical site

Highlights and Achievements

- Commencement of MRI services dedicated to the CDC and BSW's NHS patients achieved end-March 2023
- Establishment of a Modular Theatre for dedicated RUH's elective orthopaedic activity agreed and built. This allow year-round elective surgery to be undertaken in a ring-fenced environment with no risk to the loss of beds due to emergency bed pressures within RUH
- Work toward a 2nd Endoscopy suite and Physiological Measurements service as a CDC – Business cases accepted and implementation underway
- Growth of NHS and private activity achieved
- Integration with BSW-wide Trusts to accept long-wait patients and help reduce waiting times
- Integration with Trusts outside BSW to reduce waiting times
- Allocation of theatre sessions within Sulis to reduce wait times, under "job-plan" terms
- Integration of BEMS Fracture Clinic for NHS patients within Sulis to integrate with community services
- Invited to be in the first cohort of NHS and Independent Sector sites for Getting It Right First Time (GIRFT) Accreditation
- Introduction of same-day arthroplasty (joint replacements)
- Good governance oversight and clinical integration

- Introduction of innovative treatments, e.g. Regeneten
- Increase in staffing levels to meet increased demand and reduction in agency costs
- Integrated training opportunities established with NHS colleagues
- Excellent and improved staff and patient satisfaction survey results, through a challenging period of integration
- Mutual knowledge and experience sharing between the 2 sites, e.g. facilities, HR and the management of private patients

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 2022/23 the NHS has continued to work with significant pressures across our emergency services resulting from high levels of infection including; Norovirus, Strep A, RSV and COVID-19. Whilst there was a significant drive to regain momentum delivering elective services and address waiting times, high levels of infection created huge pressures for both emergency as well as elective services.

The impact of this across the RUH group was higher use of agency and bank staff to cover operational areas and at the RUH itself, managing high numbers of patients who although medically fit to be discharged remain 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. There has been funding for direct COVID-19 costs which have been fixed for 2022/23. This funding was used to support costs incurred for increased infection control measures, testing and care of patients with COVID-19. It was supplemented with £2 million to support the management of winter pressures and £3 million revenue support to help with the additional costs of running Critical Care across 2 locations within the hospital. The Trust was able to remain within the envelope of funding provided for these purposes.

Payments to the Trust for patient activity continued to operate on the same block basis introduced in 2021/22 to cover the majority of clinical activity undertaken in the organisation. The incentive funding stream made available to target increasing elective activity and creating additional capacity to help reduce waiting lists and minimise very long waits for treatment also continued into 2022/23.

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 £14.3 million through this scheme, which was used to cover the costs of providing extended services to treat patients including cost pressures arising from protecting elective care from the increasing demand over the winter.

Central income of £10 million has been accounted for to reflect the nationally agreed pay award settlement for 2022/23 (for which costs have also been recognised), £12 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 £19.3 million to reallocate the funds that they held in their capacity as Commissioner to each of the Providers.

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 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. However, the Group closed the year with a surplus of £10 million. Following required adjustments for national reporting, the BSW system reported an adjusted position for the Group of £10,000 surplus.

	2022/23 £000	2021/22 £000
Group surplus for the period from continuing operations as per the Statement of Comprehensive Income	**2,327**	**813**
Impairments charged to revaluation reserve	-1,810	836
Revaluations	9,815	2,882
Share of comprehensive income for Wiltshire Health and Care	0	56
Other reserve movements	(1)	0
Movement in fair value of charitable funds	(350)	723
Total comprehensive income for the period	**9,981**	**5,310**

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 to 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 2023/24 to support trusts to deliver as much of this activity as possible.

Capital investment

The Group invested £47.7 million in infrastructure and equipment during 2022/23, (£35.4 million in 2021/22). Separately the Trust also recognised capital assets of £28.9 million related to leases which are now capitalised in line with changes in the accounting standards. Within this £25.6 million relates to the updated Sulis Hospital Lease which was agreed within the financial year. Therefore total capital invested for 2022/23 was £76.6 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 support was also made available for projects to support additional capacity and further equipment to support elective recovery. The Trust also received considerable PDC for digital and digital diagnostic schemes in support of elective recovery and cyber.

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:

- £7.8 million on various estates schemes including Linac enabling works at the Trust and works to support additional bed capacity (including infection and control) and significant risks in critical infrastructure backlog expenditure.
- £26.5 million on the Cancer Centre which includes the main Kier related works, substation costs and enabling works.
- £4.1 million related to capital investment in Sulis Hospital which includes enabling works for new MRI scanner and medical equipment.
- £3.1 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.
- £4.1 million on medical equipment, including scopes, theatre and diagnostic equipment.
- £1.7 million for ward project to support additional bed capacity and elective recovery.
- £28.9 million which relates to right of use leases which are now required to be capitalised across the Group following implementation of new accounting standard in 2022/23

- £0.4 million on other capital assets

These are capitalised costs only.

Capital Impairments

The Trust had capital impairments totalling £1.3 million which related to reversal of an impairment on property valuation (£1.1 million in 2021/22).

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.

Environmental matters

Introduction

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. To achieve this, we 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
- Ensuring we are not stopping people meeting their needs

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, which the Sustainability team are currently

updating. This report is therefore interim to the publication of this document and we will report on progress using the table below.

Recapping on the last year

Area of focus	Objective	Achievements in the last 12 months
Managing our Carbon & Greenhouse Gases	To manage our carbon emissions to remain within safe limits in order to avoid irreversible climate change	• Achieved a 4% reduction of carbon emissions which the Trust is directly in control of. • Developed a Heat Decarbonisation Plan, to tackle gas used for heating on site as the biggest contributor to our carbon footprint. • Theatres sustainability working group has worked with Sustainability and Estates to decommission the Nitrous Oxide gas manifolds on site, transitioning from piped N2O to bottled delivery of the gas to patients. Thus reducing the emission of harmful Nitrous Oxide waste into the atmosphere from leaks in the manifold.
Adapting to Climate Change	Develop sites and services that are resilient to the adverse effects of climate change	• Climate Change has been put on the BAF (Strategic Risk Register) • The Trust will be working towards developing an adaptation plan, which will be approached regionally and written at the ICS level. • The Heat Decarbonisation plan ensures the delivery of 98% of heat through renewable sources, however to accommodate for the electricity capacity of the site and for extreme weather events, gas boilers will provide back-up resilience to the provision of heat across site.
Designing sustainable care models	To improve care whilst maintaining environmental, social and financial sustainability	• Clinical Strategy has been developed as part of the SaHF/NHP project which includes review and transformation of a number of care models, including care closer to home and Health on the High Street. • New lower carbon models of care have been introduced as part of COVID response such as virtual appointments.
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	• Fleet vehicles have continued to transition to electric alternatives. • Installation of electric vehicle charge points have continued. • The RUH Therapies team has offered to participate in the WECA FTZ E-Cargo Bike Trial. • The EV Salary sacrifice programme has gone live • Over 400 RUH members took part in the staff travel survey. • RUH Sustainability team has been working closely with the local council and transport organisations around Bath to ensure RUH staff transport needs are met.
Embedding sustainability	To become a thriving organisation that delivers benefits that extend beyond the traditional organisational boundaries whilst maintaining	• Sustainability has been integrated into the RUH Ward Accreditation scheme. • Working with the Bath, Swindon and Wiltshire Integrated Care System (ICS) to standardise sustainability across the region. • Hosted the Care for the Future art exhibition to raise the profile of delivering a Net Zero NHS. • The Sustainability team (and other interested staff across RUH) have undertaken Carbon Literacy training and will be able to deliver this across the organisation.

	the highest quality of care.	
Managing our assets & utilities	To manage the trust's operational assets in a way that continually improves their efficiency and longevity	• We continue to follow the energy strategy which includes heat decarbonisation, and ultimate electrification of the site. • Energy projects underway including; BMS upgrades; window replacements; and lighting upgrades, maximising CHP runtime, reduction of BMS set points, improving insulation of pipework. • Receipt of £300k of Salix funding to help deliver our energy infrastructure strategy and decarbonisation plan.
Using resources sustainably	To ensure that we do not extract or pollute at a greater rate than nature regenerates	• Compostable cups and crockery is being used across RUH controlled catering outlets saving on waste to landfill. • The use of reusable cups and containers are encouraged on site reducing plastic waste. • Sterile packaging used by Sterile Services has been replaced by metal containers saving environmental costs by 84%, and can withstand over 5000 use cycles. This reduces single use plastic disposal by 5.5 tonnes annually.
Creating a sustainable built environment	To ensure that sustainability underpins the design and construction of our capital projects	• Sustainability principles are underpinning the Estates solution for the New Hospitals Framework – Dyson Cancer Centre due to open June 2023. Brand new sustainable building replacing old inefficient parts of the estate. • The NHSI/E standard for NZC buildings is now available and we will be adopting this for all retrofit and new builds. • Solar photo-voltaic panels have been installed to the roof of the new Dyson Cancer Centre and will be commissioned as part of the building handover in Autumn 2023
Empowering our people	To create a supportive environment where all our people feel motivated and empowered to consider sustainability in everything they do	• 193 RUH Staff members have signed up to ACT behaviour change platform. • Set up training on ESR to educate staff on sustainability. • Ran a COP27 inspired 'Active Travel' day with competitions and prizes. This instigated a spike (of 22 people in one month) to sign-up for an e-bike. This has driven the decision to procure more e-bikes.
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	• Development of a Green Space strategy which will form a key part of the Estates Strategy. • NHS FOREST visited site and has written up a proposal for funding the planting of trees on the RUH site.

Key areas of Focus

Taking responsibility for our Carbon Footprint

We recognise that the Trust has a significant carbon footprint. Understanding where we are today as a baseline, and what our plan 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. These are:

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 3 scopes. Our progress will be monitored annually, with a revised strategy each 5 years.

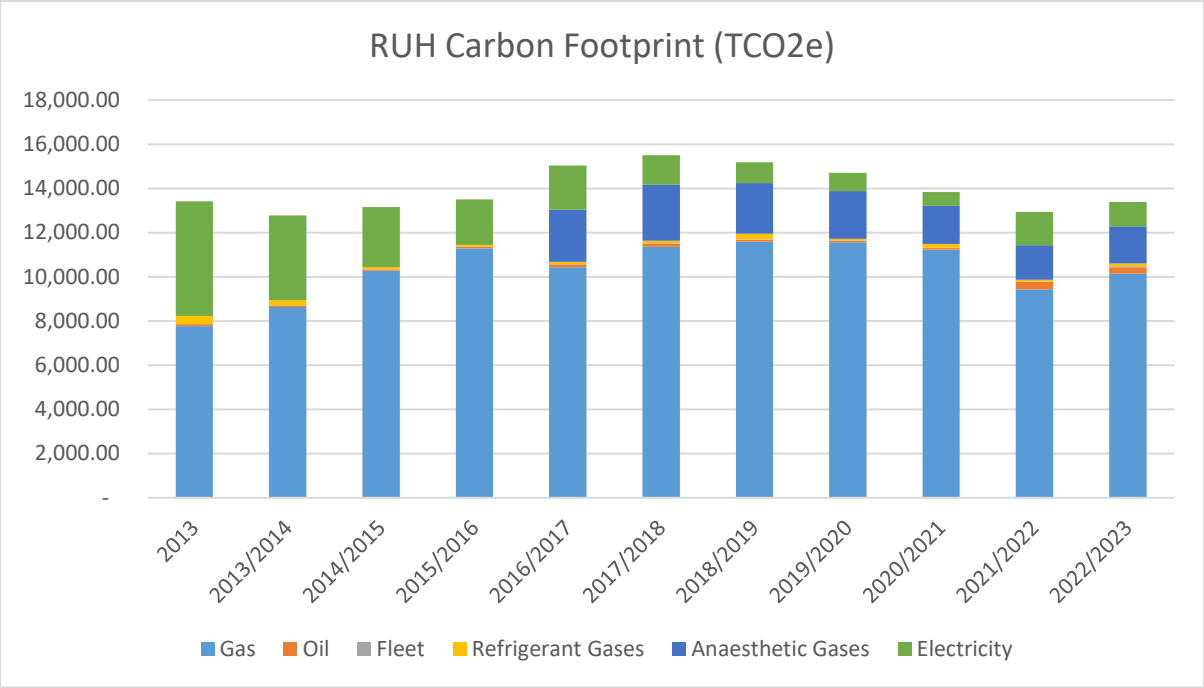


Figure 1: The Trust's Carbon Footprint for Scope 1 and 2 emissions over the last 7 years illustrating a small decline since 2017/2018 with a small uptick in emissions from gas in 2022/2023. The increase in gas emissions is due to the increased running of CHP to reduce the impact of rising energy costs. All these 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 at the RUH

The Trust monitors the Nitrogen Oxide levels onsite in order to understand the air quality in the area. Diffusion tubes are placed across the site and are analysed monthly. During 2022/23 year, the Sustainability Team continued to run initiatives to reduce air pollution on site including:

- Switch off when you drop off campaign in Estates contractors car park and at the main bus stop
- Launched the car sharing initiative Join My Journey
- Installation of fast electric vehicle charge points
- Procurement of further electric vehicles as we transition our fleet
- Issued 60 Cycle Scheme certificates

- Invested in an E-Bike Loan scheme. In the last financial year these have seen a total of 24 loan periods of use.

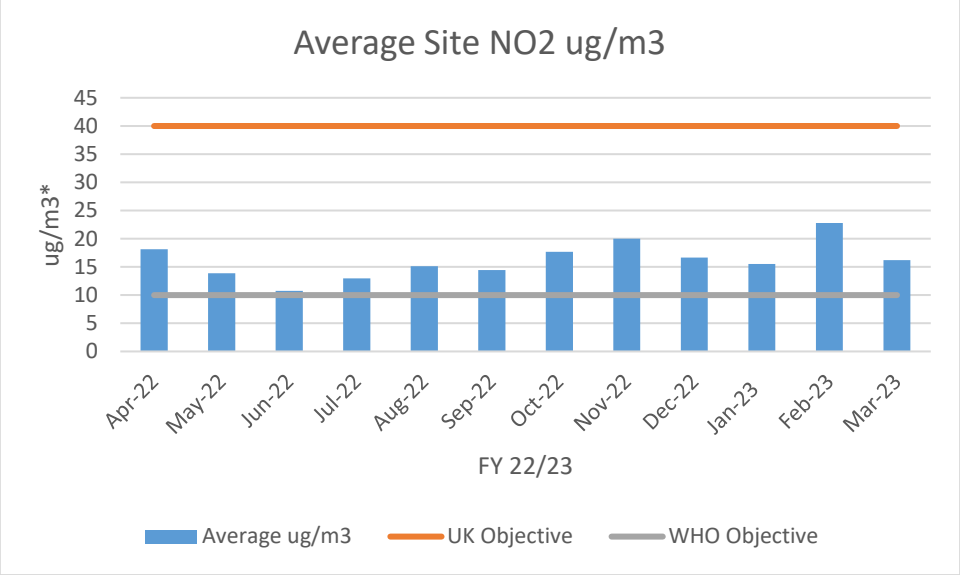


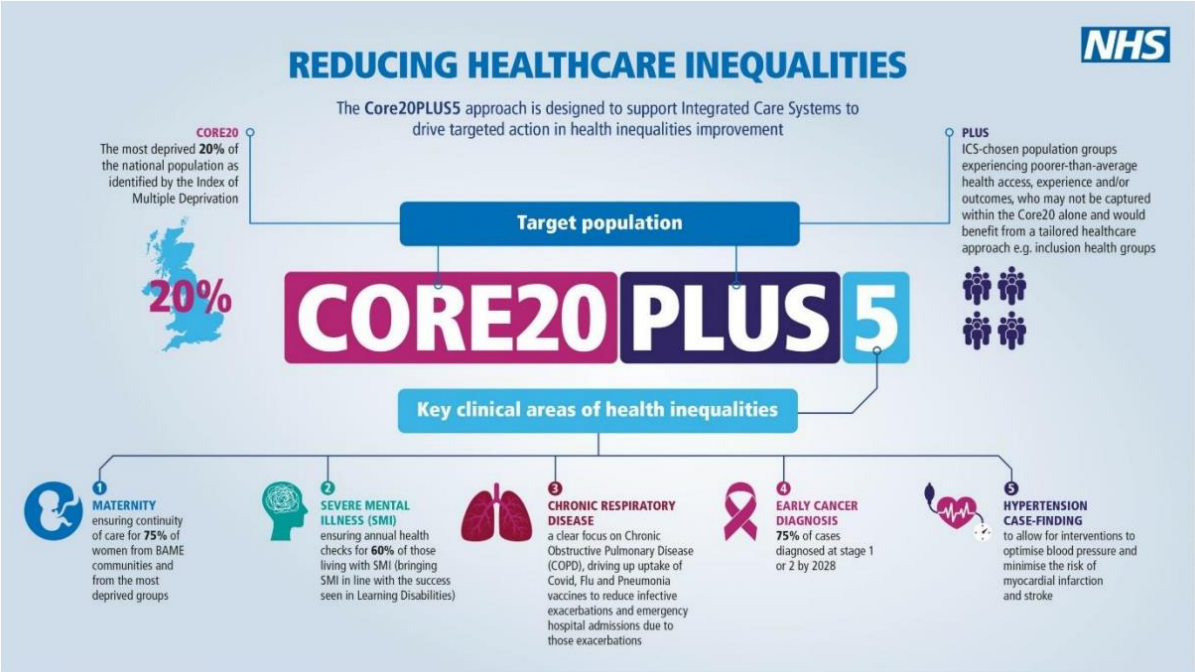
Figure 2: Average Nitrogen Dioxide levels across the site.

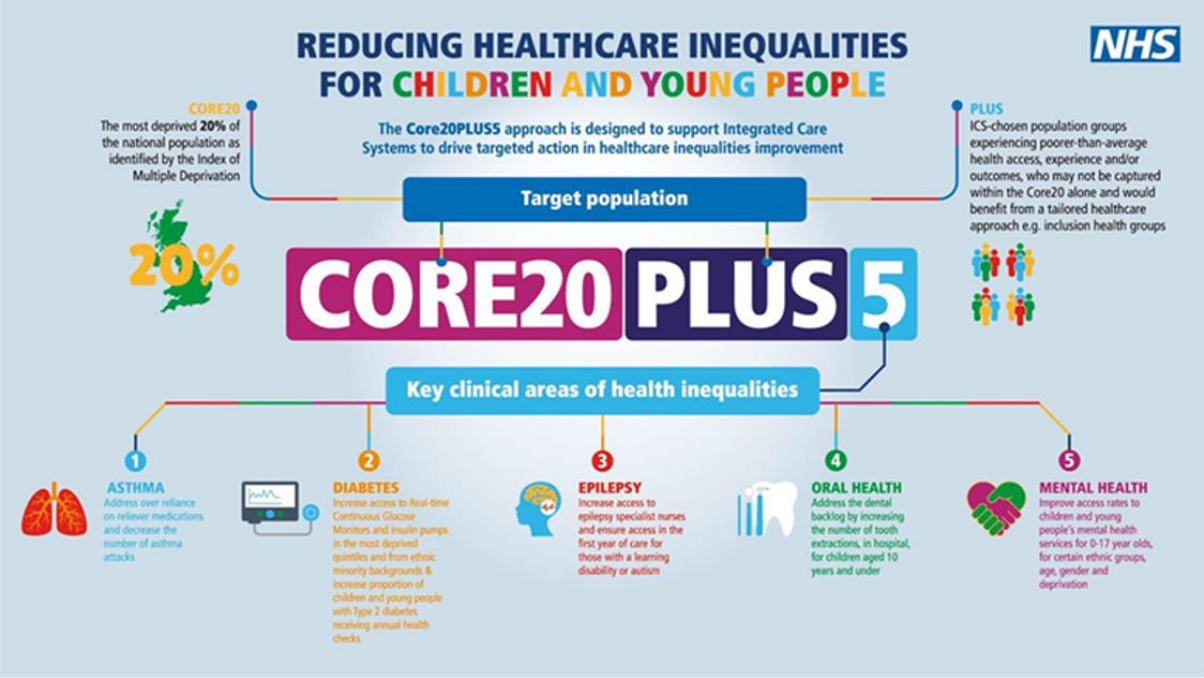
Tackling Health Inequalities

The communities within the BaNES, Swindon and Wiltshire remain some of the least deprived parts of the country. However, this overall average masks pockets of deep deprivation and inequality within each area, including two neighbourhoods which are within the most deprived 10% nationally. This wealth inequality has real impacts on health outcomes, with a female in Bathavon South (BaNES) having a life expectancy of 91 years, while a male from Trowbridge Central (Wiltshire) would generally expect to live to 73. Other factors, such as ethnicity and lifestyle choices, also impact on the prevalence of health inequalities.

Nationally, NHS England uses the Core20PLUS approach to support the reduction of health inequalities. The approach, pictured below works as follows locally:

- Core 20 – the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).
- PLUS (determined locally) –
    - BaNES: socially excluded groups, migrants, vulnerable children, rural communities
    - Swindon: people from ethnic minority backgrounds
    - Wiltshire: routine and manual workers
- 5 clinical areas of health inequality:
    - Adults: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case-finding
    - Children and younger people: asthma, diabetes, epilepsy, oral health, mental health.





A key priority for the Trust and its local partners in addressing these issues is improving the quality and quantity of data that is available about those sections of the local communities to which resources need to be targeted. For example, are there areas where earlier cancer diagnoses could lead to improved outcomes?

Currently, the Trust is working closely with partners to help tackle two main issues identified as key determinants of poor health within some of the more deprived communities – smoking and obesity.

Smoking has been identified as the single largest driver of health disparities between the most and least affluent quintiles, and across the BSW footprint, the prevalence of smoking for people in routine and manual occupations is over double the prevalence for people in managerial and professional occupations. The Trust is working particularly with primary care to treat tobacco dependency, taking advantage, for example, of engagements with expectant mothers, to focus on smoking cessation.

It is recognised that around two-thirds of adults in Swindon and Wiltshire live with excess weight or obesity, similar to the national average. Although BaNES is significantly below the national average, over half of adults are nevertheless affected. While the Trust can treat some of the effects of excess weight such as hypertension, diabetes, heart disease and stroke, again significant partnership working will be required to address the causes.

The Trust is participating in the refresh of the Joint Strategic Needs Assessments for both BaNES and Wiltshire with a view to prioritising actions to address these two important determinants of poor health outcomes at “place” or locality level.

At a more macro level, the Trust is leveraging 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 Trust, thereby increasing economic activity locally;
- Working with BaNES Council to help reduce vehicular traffic to and from the RUH site, thereby improving air quality for local people and reducing respiratory illnesses.

Social, community, anti-bribery and human rights

All Trust 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 taken into account 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 on at pages 81 and 82 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 2022/23, the Trust had no social, community or human rights violation issues.

Important events since the end of the financial year affecting the Trust

On 25 May 2023, the Trust became aware that pages from the organisation's external website carried cookies that were related to Meta Pixel. These had been intended for tracking recruitment campaigns, but had not been mentioned in the Trust's privacy notice on the use of cookies at the time of it being deployed. This meant that those visiting the site would not have been aware that their data could be tracked as a result of their visit. The issue came to light following contact from the Guardian newspaper.

The Information Commissioner's Office was notified of this breach as a result of the number of citizens who had been potentially affected (at least 1000). At the time of writing no response had been received from the ICO as to possible enforcement action against the Trust and other affected NHS organisations.

At the RUH, no patient level data was exposed, but it is likely that the following information would have been tracked by these cookies:

- Shopping preferences
- Device specifications
- Location
- Search history

Meta Pixel was immediately removed from the website, and an internal incident report compiled. A review of the Trust's cookies and privacy notice is being undertaken by IT and cyber security team. The DPO has been informed.

The web development team have been provided with additional training, including on cookies and compliance with Network and Information Systems regulations. The team are also undertaking a review of all processes and a Standard Operating Procedure is being provided to avoid similar errors in the future.

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 2023

Accountability report

Directors' report

Directors' responsibility for the annual report and accounts

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 Trust

Directors of the Royal United Hospitals Bath NHS Foundation Trust during 2022/23:

Alison Ryan	Chair
Jeremy Boss	Non-Executive Director Vice Chair and Senior Independent Director (until 31 March 2023)
Nigel Stevens	Non-Executive Director
Sumita Hutchison	Non-Executive Director
Anna Mealings	Non-Executive Director (until 31 August 2022)
Ian Orpen	Non-Executive Director
Antony Durbacz	Non-Executive Director
Paul Fairhurst	Non-Executive Director
Cara Charles-Barks	Chief Executive
Libby Walters	Deputy Chief Executive & Director of Finance
Bernie Marden	Medical Director (until September 2022)
Antonia Lynch	Chief Nurse
Simon Sethi	Chief Operating Officer
Alfredo Thompson	Director for People and Culture*
Jocelyn Foster	Director of Strategy
Brian Johnson	Director of Estates and Facilities*

*Non-voting members

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

Non-Executive Directors

Alison Ryan, Chair (Appointed: 1 April 2019)

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, and she sits on the Charities Committee. By way of interests, she was recently appointed as the South West Regional Chair for Organ Donation.

Jeremy Boss, Non-Executive Director* (Appointed: 6 March 2017)

*Vice-Chair and Senior Independent Director from 1 November 2020 until 31 March 2023)

Jeremy chaired the Audit and Risk, Finance and Performance and Charities Committees, and he was a member of the Board of Directors' Nominations and Remuneration Committee. In addition, he was also Board lead for End of Life and Learning from Deaths. He has a BSc (Hons) in Economics from the University of Warwick and is a Fellow of the British Computer Society and a Fellow of the Institute of Chartered Accountants in England and Wales (ICAEW) on whose governing council he has served. Jeremy's previous appointments include Chief Information Officer for both the Department of Energy and Climate Change and the Audit Commission. He is currently a Non-Executive Director and Audit Chair at the Driver and Vehicle Licensing Agency (DVLA), and an independent advisor to the Audit and Corporate Governance Committee of the Care Quality Commission. Jeremy's tenure on the Board ended on 31 March 2023. He remains Independent Chair of the Board of Sulis Hospital Bath Ltd.

Nigel Stevens, Non-Executive Director (Appointed: 1 April 2018)

*Vice-Chair and Senior Independent Director from 1 April 2023

Nigel was previously Chair of the Quality Governance Committee. He remains Chair of the Subsidiary Oversight Committee, and is a member of the Board of Directors' Nominations and Remuneration, Finance and Performance, and Audit and Risk Committees. He is also 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 was recently appointed as Chair of Transport Focus.

Sumita Hutchison, Non-Executive Director (Appointed: 1 September 2019)

Sumita has served since 1 November 2020 as chair of the Non-Clinical Governance Committee, and she 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.

Anna Mealings, Non-Executive Director (Appointed: 1 September 2019)

Anna served as inaugural Chair of the People Committee, and was a member of the Quality Governance, Finance and Performance and Board of Directors' Nomination and Remuneration Committees. She was also the Board lead for Freedom to Speak Up. Anna has a BCom degree in Economics, a BA in Anthropology and a MCom (Hons) in Strategic Employment Relations. She has extensive experience in human resources management, organisational effectiveness and change management across a range of private sector industries, including at a number of large multinational organisations. Anna left the Board on 31 August 2022 as a result of her relocation to Australia.

Ian Orpen, Non-Executive Director (Appointed: 7 September 2020)

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 also sits on the People and Non-Clinical Governance 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 (Appointed: 1 November 2020)

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 chairs the Audit and Risk Committee, and sits on the Finance and Performance and Non-Clinical Governance Committees. He leads on environmental matters, infrastructure and estates. In addition to his membership of the LiveWest Board, Antony is also a Governor at Bath Spa University and at Crispin School. His daughter is a specialist trainee in Obstetrics and Gynaecology in the Severn Deanery.

Paul Fairhurst, Non-Executive Director (Appointed: 1 October 2022)

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 Governance 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 produces with and for disabled people to enable them 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.

Executive Directors (voting)

Cara Charles-Barks, Chief Executive (Appointed: September 2020)

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 Bachelors and Master's Degrees in Nursing as well as an MBA from the University of Adelaide. Cara is a member of the Advisory Panel of Nourish, an organisation that promotes healthy eating and nourishment for those going through illness or medical treatment. 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, Deputy Chief Executive & Director of Finance (Appointed: June 2018)

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. Libby served as Interim Chief Executive of the Trust between 1 June and 7 September 2020. By way of declared interests, her husband works 2 days a week as a Radiology Porter and on the radiology portering bank.

Bernie Marden, Medical Director (Appointed: April 2018)

Bernie was a Consultant Paediatrician and Neonatologist at the RUH for 15 years and he had previously been Head of the Women and Children's Division and Paediatric Clinical Lead. He was the Trust's Chief Clinical Information Officer leading on the clinical IT transformation strategy, and he also served as Caldicott Guardian. He holds a Masters' degree in Medical Law and Ethics and is an Honorary Clinical Senior Lecturer at the University of Bristol. Bernie left the RUH in September 2022 to take up the role of Chief Medical Officer at Somerset Integrated Care Board.

Richard Graham, Interim Chief Medical Officer (Appointed 1 September 2022)

Richard is a Consultant Radiologist practising general radiology with subspecialist expertise in diagnostic and interventional musculoskeletal radiology, sports imaging and nuclear medicine. He is a Visiting Professor in Health and Applied Sciences at the University of West of England and he leads the nuclear medicine community in the UK as President of the British Nuclear Medicine Society. He is an officer in the Royal Navy Reserve where he has been Head of Medical Branch and Commanding Officer of HMS Flying Fox in Bristol. He was deployed twice as a Consultant Radiologist to Camp Bastion in Afghanistan. Richard stepped in as interim Chief Medical Officer following Bernie Marden's departure – before that he was Deputy Medical Director – and he acted in that role until 1 January 2023.

Andrew Hollowood, Chief Medical Officer (Appointed: January 2023)

Andy joined the RUH on 1 January 2023. He is a cancer surgeon by background, specialising in gastric cancer, and he previously worked as Deputy Medical Director at the University Hospitals of 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 Non-executive director of 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.

Antonia (Toni) Lynch, Chief Nurse (Appointed: 1 April 2021)

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 wife is a Matron at the Great Western Hospitals NHS Foundation Trust

Simon Sethi, Chief Operating Officer (Appointed: 17 January 2021)

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. In terms of declared interests, he is a director of Sulis Hospital Bath Ltd., and his wife is Director of Transformation at North Bristol NHS Trust.

Jocelyn Foster, Director of Strategy (Appointed: July 2012)

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 for 2022/23 was a financial interest in Veloscient Ltd, a company dedicated to facilitating structured data capture for a range of markets, including healthcare, and as a complaints panellist for the Dental Complaints Service .

<u>Executive Directors (non-voting)</u>

Alfredo Thompson, Director for People and Culture (Appointed 31 January 2022)

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. He has no declared interests.

Brian Johnson, Director of Estates and Facilities (Appointed: 1 April 2019)

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 also currently shares his time at the RUH with the role as Director of Estates for Salisbury NHS Foundation Trust under an agreement between both organisations.

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 Donations

The Trust has made no political donations over the course of the year. No political donations were made during 2021/22.

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 2023, the Group achieved the following performance (seen overleaf):

Better payment practice code	Actual Foundation Trust Number	Actual Foundation Trust £'000
Non NHS		
Total bills paid in the year	93,791	343,672
Total bills paid within target	89,229	323.968
Percentage of bills paid within target	**95.1%**	**94.3%**
NHS		
Total bills paid in the year	1,433	16,846
Total bills paid within target	1,158	12,284
Percentage of bills paid within target	**80.8%**	**72.9%**
Total		
Total bills paid in the year	**95,224**	**360,518**
Total bills paid within target	**90,387**	**336,252**
Percentage of bills paid within target	**94.9%**	**93.3%**

Performance against the Code for 2021/22 is set out below:

Better payment practice code	Actual Foundation Trust Number	Actual Foundation Trust £'000
Non NHS		
Total bills paid in the year	88,013	294,409
Total bills paid within target	84,630	275,249
Percentage of bills paid within target	**96.2%**	**93.5%**
NHS		
Total bills paid in the year	1,467	12,775
Total bills paid within target	1,175	9,217
Percentage of bills paid within target	**80.1%**	**72.1%**
Total		
Total bills paid in the year	**89,480**	**307,184**
Total bills paid within target	**85,805**	**284,466**
Percentage of bills paid within target	**95.9%**	**92.6%**

Total interest paid to suppliers under the Late Payment of Commercial Debts Act 1998 was £0k (£0k in 2021-22).

Disclosures relating to NHS Improvement's Well-Led framework

The Group has had regard to NHS Improvement's Well-Led framework (together with the CQC's revised Well-Led assessment framework, (updated in June 2017) when arriving at its evaluation of the organisation's performance, internal control and assurance framework.

The Board of Directors, working as a group and through its committees, has used the 8 Key Lines of Enquiry (KLOEs) that underpin the Well Led framework as a means of ensuring that the Trust's governance arrangements are fit for purpose. Examples of how it has how it has measured itself against each of the KLOEs are as follows:

1. Leadership capacity and capability – with the support of external consultants, the Board has spent time thinking about and taking steps towards working more cohesively to provide the leadership that the organisation needs, making use of recognised management development techniques. It has also championed the Improving Together quality improvement methodology as a way of building leadership capacity and creating a culture of continuous improvement across the organisation.
2. Vision and strategy – During 2022/23, the Board continued with the conversation that had commenced in the previous year about updating the Trust's vision statement and strategic narrative. One of the key aims of this work was to gain an understanding of the extent to which the whole organisation had a shared sense of ownership of the Trust's strategic direction and values. This work resulted in the agreement of the "RUH where you matter" statement, as well as the approval of a strategic narrative around the Trust's ambitions for the people we work with, care for and in our community.
3. Culture – A key aspect of the updated People Plan that was approved in 2022/23 was the development of a Restorative Just Culture across the organisation – one that moved away from blame and punishment towards learning and engagement. The plan also signalled a renewed focus on promoting equality, diversity and inclusion, as well as equipping the People Directorate to provide effective support to staff across the board.
4. Clarity of roles and systems of accountability – The Trust has a clear and well-defined governance and accountability structure starting with the Board at the top, through the executive team and the Trust Management Executive and into the clinical divisions and corporate directorates. These structures are set out in the Integrated Governance Framework, and are constantly fine-tuned to ensure that they remain aligned to the Trust's strategic direction.

5. Management of risks, issues and performance – The Trust has in place a comprehensive Strategic Framework for Risk Management which was refreshed during 2022/23, taking account of input from the Trust's internal auditors. This framework sets out the process by which risks are identified, articulated, rated and managed across the organisation, including the process around the development and use of the Board Assurance Framework. It also sets out the Trust's risk appetite and tolerance levels.
6. Appropriate information being processed, challenged and acted on – The Board has a comprehensive annual timetable which includes monthly scrutiny of the Integrated Performance Report, reporting by exception on operational and financial performance, quality and workforce issues. This report includes both quantitative and qualitative information on performance against all the key performance indicators, as well as highlighting areas where improvements are required and how these are being delivered.
7. Patient, public and staff engagement – As the restrictions that were necessitated by the COVID19 pandemic continue to ease, steps are being taken to return to in person forms of engagement with external stakeholders. All public Board meetings during 2022/23 were held in person, as were the majority of Council of Governor meetings. Membership meetings continued to be held virtually, but it is expected that these will return to in-person in 2023/24. The Chief Executive and the Executive Team continued to host regular video messages as well as monthly all staff briefs and question and answer sessions.
8. Robust systems for learning, continuous improvement and innovation – Roll out and training on the quality improvement methodology Improving Together was paused for some of the year, but it has now been re-set, with more of a focus on its practical application to the issues facing the organisation than on the technical aspects of the programme itself. The overall aim of Improving Together is to empower all staff to take responsibility for identifying issues and making improvements in their areas.

Enhanced quality governance reporting

<u>Improving Patient and Carer Experience</u>

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.

They tell us that feeling heard and valued has a positive impact on their experience of the hospital.

Our aim is to continuously improve patient and family experience and strengthen the patient voice in every service across the hospital.

In partnership with patients, families and the local community, the Trust has developed a patient and carer engagement and experience strategy, which supports the Trust goal for the 'People We Care for'. This supports staff to work with patients and their families and carers to in the development and design of new services, improving existing services and overall patient and carer experience.

This information has been used to develop our three commitments to all patients:

- 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 has also helped us to identify areas where we know from patient feedback that we do less well. As a result the Trust has been able to focus on projects to improve the patient experience, such as:

- **A review of Outpatient clinic letters** led by Chris Dyer, Geriatric Consultant with clinical staff and support from patient experience. Patients and clinical staff worked together to ensure that the information in the clinic letters was given to patients in a way that they can understand. Patients have told us that they find the letters more informative, supportive and useful.

- **Keeping patient property safe** – we recognise the impact both physically and psychologically to patients, families and carers if property is lost or mislaid whilst in the hospital environment. Over the last year, we have focussed on improving the safekeeping of patient property. This has included updating the patient property documentation, raising awareness of the impact on patients and families when property is lost, sharing how items are lost and what staff can do to minimise the loss of patients belongings. More recently, we have introduced green patient property boxes that are labelled with the patient details and where items such as glasses, hearing aids, etc. can be kept safe.

- **The 'Waiting Room' experience** – we appreciate that a patient's experience of waiting often begins before the patient arrives in the waiting room, however we recognise that what happens in the waiting room still sets the tone for the patient's overall experience, including the patient's observations of the care they receive. This year we have worked with two outpatient departments to review the waiting rooms, signage, information, etc. and shared this with the clinical and administrative teams so that improvements can be made.

- **Improving Deaf Awareness** – we have recently set up a Trust wide Deaf Awareness group to make sure that we continue to make improvements for the experience of people who are deaf or have a hearing impairment. Future

plans include working with patients to ensure that all our services are accessible and deaf aware.

- Reinstating the **Family Liaison Facilitator team** to support communication between patients on wards and their families. The team provides practical support such as by setting up virtual visits for family members within and outside the hospital, arranging follow up calls after discharge and helping with special requests for patient activities.

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:

- Friends and Family Test (FFT) cards and online feedback
- Patient Advice and Liaison Service (PALS) Concerns and Complaints
- Patient stories
- 'See It My Way' films
- Hospital questionnaires, telephone interviews, focus groups,
- Ward and outpatient observations as part of the Trust Accreditation standards
- Patient Led Assessment of Clinical Environments (PLACE)
- Social media – NHS website/Twitter/Facebook
- 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?'*

On average 96% of patients who completed the questionnaire in 2022/23 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.

Timeliness is one of the main reasons for negative feedback from patients. Patients reported long waits in the hospital for care and treatment, medication and long waits in some specialties to be seen in outpatients. As set out elsewhere in this report, the Trust is prioritising measures to reduce backlogs on care through, for example, increasing elective care capacity at Sulis Hospital and taking advantage of opportunities to provide care differently, either making use of digital initiatives where appropriate, or treating patients at locations other than the RUH.

The numbers of patients/families who provide feedback to the hospital is low in numbers as the main method of feedback is through the FFT cards. Later this year, the hospital is setting up a text messaging service. Patients will be sent a text after their hospital stay or outpatient appointment/attendance in the Emergency

department (ED) asking the FFT question and the reason for their answer. This will mean more patients will be able to share their experience of the hospital and the staff will be able to see what patients said in real-time via an electronic ‘dash-board’, so they can understand what patients are experiencing and use this information to celebrate what they are doing well and identify any improvements that need to be made.

Patient Stories

Every other month, a patient/carer or staff story is shared at the Board of Directors. This is the first item on the Board agenda and staff involved in the care of the patient attend the virtual Board meeting to share what has changed as a result of the patient/carer story. Their story is either filmed, voice-recorded or the patient/family member shares their experience in person by attending the Board meeting.

Listening to patient/ family stories gives us 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, we heard from the husband of a patient who was discharged under the care of the ‘Hospital at Home’ team. His wife spent several weeks as an inpatient at the RUH. DT praised the Hospital@Home team for their support, flexibility and adaptability to ensure DT was supported to look after his wife safely at home. The funding for the service was non-recurrent at the time however due to its success funding has been identified to continue with the service.

- In September, the staff in Ophthalmology spoke about how the team had introduced nurse led injections releasing doctors from this activity. The clinic gives 150 injections a week. In the last year, the unit had increased from one nurse injector to six. The Healthcare Assistant role had been developed to assist trained nurses to see patients in outpatients to help with the backlog of appointments. The nursing team had also developed a one-stop clinic for patients listed for cataract surgery so that all eye tests are completed on the day of the clinic appointment thereby reducing the number of times patients come to the RUH for their treatment.

- In November, a patient with a learning disability and her mum shared their experience of the hospital. The patient lived independently with 24-hour carers. Her mum highlighted the importance of involving the family when her daughter had to attend the hospital as she said that sometimes she did not feel listened to or supported. She also highlighted the difficulties her daughter had in accessing toilet facilities. Because of this story and previous stories, the hospital opened its first ‘Changing Places’ facility which is easily accessible on the ground floor of the hospital. Changing Places are toilet facilities for children, young people and

adults with profound or multiple disabilities and are fitted with a hoist and changing bench. The facility is available for any disabled users who need it.

See It My Way

In 2022/23, we continued with our very successful 'See it my Way' programme and recorded a film during 'Dying Matters' awareness week in May. The film called *'What matters to you?'* was produced in partnership with Bath and North East Somerset and Wiltshire Together and highlighted the importance about talking about dying, death and bereavement covering areas such as organ donation and having difficult conversations with loved ones about their wishes for the end of their life.

The film is used for staff education and training.

Complaints handling

Our Patient Advice and Liaison Service (PALS) aims to resolve patient and carer concerns and answer questions regarding treatment and care within 48 hours. The Trust sees complaints as a valuable source of feedback as it shows us where our services have not provided high quality care and gives early signs of service failures. The process of learning from complaints continued to be prioritised in 2022/23 and a focus on ownership of the learning at divisional level. The Trust is keen to hear from patients and their families when their care and treatment goes well but also when concerns have been raised so that we can use this information to learn and improve.

The Trust is also committed to ensuring that the opportunity to provide 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 an initial contact/triage call made by the Head of Complaints to the patient/family wanting to share their concerns. This supports the **NHS Complaints Standards – summary of expectations** document produced in December 2022. This highlights the importance of welcoming complaints in a positive way ensuring that the process is 'responsive to the needs of each individual'. Early 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 326 complaints compared to 392 in the previous year. This was a slight decrease in the number of complaints received but is well above the number received in previous years and continues to present a challenge for the complaints team and clinical colleagues in terms of workload and timely responses. The majority of complaints related to communication issues and clinical care and concerns.

We have developed and published guidance on our internal website to help staff effectively manage concerns informally where possible. Staff are also trained in how

to manage the formal complaint process, including complaint meetings. This training has been given to junior doctors as well as junior and senior ward staff.

Complaints are logged and tracked on Datix; the Trust's reporting system, which is also used for incident reporting. There is a 35-day local target for responding to formal complaints and performance against this target is included in the quarterly Patient Experience reports to the Quality Board and the Board of Directors and in the Trust's annual complaints report. Less complex complaints may be responded to in a quicker timeframe, but more complex complaints may be better resolved through face-to-face meetings may take longer. The Trust encourages the use of such meetings as a means of resolution.

Clinical leads and managers are responsible for investigating and responding to complaints made in their respective areas. The Divisional Directors of Nursing and Midwifery have oversight of all complaints, the investigations and the Trust's response. All formal complaints are reviewed by the Chief Nurse or Medical Director and responses signed by the Chief Executive. Complaints are discussed at nursing and governance meetings and the learning from complaints is included in the quarterly Patient Experience report to Quality Board and the Board of Directors.

As an independent sector provider, Sulis Hospital is not subject to the NHS Complaints System or Standards. It has its own 3-stage process, details of which are set out on its website. In summary, the expectation is that the majority of relatively minor concerns will be dealt with at the department level, but if resolution is not possible, or the patient is dissatisfied with the outcome, the matter can be escalated for a more formal investigation to the Quality and Assurance Team.

Under the 3rd stage of the process, a complainant can ask for an independent review. For NHS patients, this would mean referral to the Parliamentary and Health Service Ombudsman, who will decide first of all whether or not the case warrants investigation, and if so what sanction to impose in the event that it is upheld. For self-pay or private insurance patients, on the other hand, their concerns can be referred to the RUH Complaints Manager for an independent review, but in the event that they remain dissatisfied with the outcome, the matter can be further escalated to the Independent Sector Complaints Adjudication Service (ICSAS).

Full details of the number, type and resolution of complaints received at Sulis Hospital during 2022/23 will be reported within their Quality Account to be published by 30 June 2023.

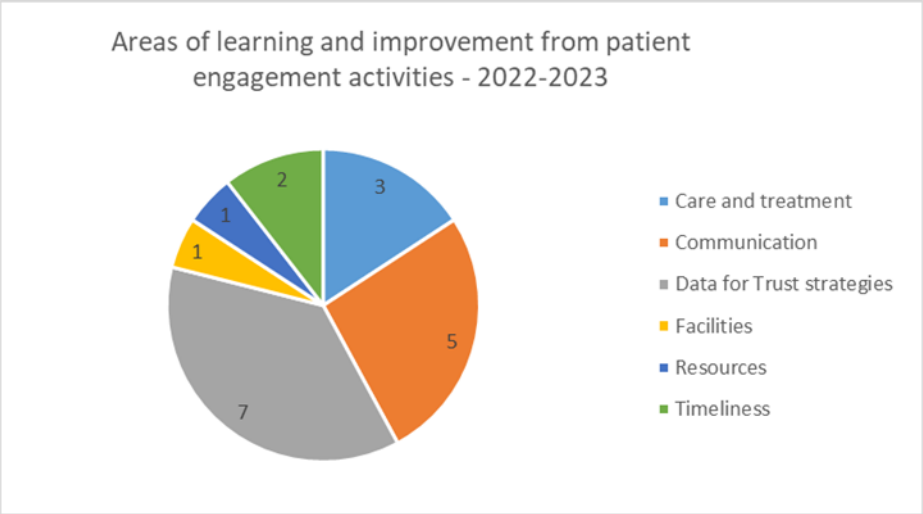
Patient Engagement to Improve Services

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.

During 2022/23, the Patient Experience Team supported 60 teams to collect patient and carer feedback (via questionnaires, telephone interviews and virtual focus group

meetings) and to use the information to improve their service. This is an increase from 38 RUH teams supported by the Patient Experience Team during 2021/22.

In particular, areas of learning from patient experience that led to improvements were in the areas of:



Some of these projects were nominated for the **Improving Patient Experience Awards 2022/23**, which provided an opportunity to celebrate the good practice:

The winner of this year's top award was the Emergency Department Paediatric Team who were nominated by Paediatric Senior Sister Sarah Potter, for their work in developing a dedicated children's emergency department to provide urgent care to some of the RUH's youngest patients.

The project has seen a separate area for children created within the hospital's main A&E department. It has been specially designed and decorated to make the emergency department less intimidating for young people and comes complete with wall-mounted play equipment for little ones as well as a Teen Room kitted out with games console.

These physical improvements were supported with the recruitment of additional children's nurses and increased training for all emergency department staff.

Feedback from parents and carers has been overwhelmingly positive. One praised the new children's area as being 'calm and friendly', while another called it 'amazing…so child-friendly'. One parent said of the staff: "Their professionalism and care was nothing but outstanding."

Other award winners were:

- Leah Moyle, Palliative Support Worker. Leah nominated the Palliative Care Team who are recognised for their project to provide butterfly memory boxers and knitted hearts to the families of patients nearing end of life.

- Jonathan Frost, Consultant Gynaecological Oncologist, and Laura Davies Engagement Lead (HICO), who nominated the Holistic Integrated Care of Ovarian

Cancer (HICO) Team. The HICO project's aim was to improve patient experience and improve health outcomes for older patients with ovarian cancer.

- Margi Jenkins, Critical Care Matron and Ian Kerslake, Clinical Lead for Intensive Care, who nominated the Critical Care Team for the development of the Critical Care Follow-Up clinic, which identifies any ongoing needs or concerns that patients may have following their stay in the unit and provides them with access to support services.

Detailed information on patient experience and actions taken to improve patient experience is included in the quarterly patient experience reports available on the Patient Experience Matters section of the Trust's website.

Responding to Patient Experience Feedback

Written Patient Information Leaflets

During 2022-23 the Trust's **Patient Readers Panel** reviewed 99 written patient information leaflets from across the Trust. These leaflets are written by staff for patients and the Patient Readers Panel review the leaflets to ensure they can be understood by patients and their families and carers, there are no gaps in information and that the information is relevant to patients.

The Patient Readers Panel consists of over 50 patients and carers who feedback their views on the patient information leaflets via email. The information they provide is collated by the Patient Experience Team and shared with leaflet authors, who can then consider the feedback and update the leaflets before they are published for use by staff with patients.

Appointment letters

We hear from patients that not all of them like to receive printed information in the post with their appointment letters. They feel that this is wasting NHS money, some of the information becomes out-of-date quickly and that they would prefer to receive the information by email or text.

A new system is being implemented which will allow patients to receive their outpatient letters via email. The system will also be used for text reminders for appointments. Future developments will allow patients to manage their own appointments. The initial stage of the pilot has been planned during 2022-23 and will be implemented in the coming year.

In addition for those patients who prefer to receive their appointment information by post the Patient Experience Team and Outpatient Steering Group have worked with patients to identify what information they feel is essential to receive with their appointment letter to help them to prepare for their appointment and which information can be taken out. This has reduced the number of pages of additional outpatient appointment information from six pages to two (one A4 piece of paper) and reduced inaccuracies in information as it becomes out-of-date by referring patients to the relevant pages on the Trust's website.

Waiting in outpatient clinics

'Waiting for long hours without any reassurance regarding what is happening.' FFT feedback.

In response to patients telling us about long waits in outpatient department waiting rooms, the following actions have been taken:

- patients are advised in their appointment letters how long they may have to wait for their appointment in clinics,
- there are also information boards in waiting rooms which displays current wait times
- outpatient nursing teams also verbally keep patients updated if clinics are overrunning.

Waiting for new and follow-up appointments

Patients have contacted the Patient Advice and Liaison Service (PALS) when they have been waiting beyond their expected time for an outpatient appointment date.

As a result, outpatient departments have increased the number of appointments by holding weekend clinics to support with the backlog of appointments, virtual and telephone appointments continue to be held where appropriate, and outpatient appointment wait times are being updated monthly on the Trusts external webpages to inform patients of expected wait times.

Stakeholder relations

<u>West of England Academic Health Science Network (WEAHSN)</u>

The Government established Academic Health Science Networks (AHSNs) 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 the West of England AHSN (WEAHSN) 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. For example, the RUH has worked with partners funded by the WEAHSN 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. Furthermore, the RUH was one of eight early implementers of the Royal College of Physicians Structured Judgement review process and are working collectively with the other earlier

implementers to deliver the national Learning form Deaths programme requirements.

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.

The last year, like the last two, saw changes to the way in which volunteers gave their time to the hospital. Many of our previous volunteers were in the high risk and vulnerable groups and so unable to come to the hospital. However, the Trust was overwhelmed with offers of support from the local community.

The Trust worked in partnership with 3SG, a compassionate community social enterprise in providing a team of volunteers for the large vaccination centre at Bath racecourse. The delivery of over 1,000 vaccines a day was made possible by the large numbers of local volunteers signing up to help.

Volunteers at Bath radio were able to adapt their services during the pandemic by offering a regular 'senior moments' slot on the radio for elderly patients to listen to during their stay in hospital, Sunday service from the Spiritual Care Centre team and regular story telling sessions.

Undergraduate and postgraduate medical training

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 9000 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.

Primary care services

During 2022/23, 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.

Community services

In July 2016, Wiltshire Health and Care (a limited liability partnership (LLP) 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. Since launch, the Trust's relationships with its partners across Wiltshire have been strengthened, and opportunities for improved pathway development have been realised – including the rolling out of the Home First pathway with Wiltshire Health and Care. Home First builds on a successful active rehabilitation project, helping patients with therapy requirements to return home from hospital earlier than would otherwise have been the case. The partnership has supported the RUH in its efforts to reduce delays in discharging patients who, though medically fit to leave hospital, still require some support. This relationship was particularly helpful in addressing the need for as many of the hospital's beds to be freed up in anticipation of surges in demand caused by the COVID-19 outbreak.

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. NHS Providers in particular has provided a strong representative voice for provider organisations during the COVID-19 pandemic and its aftermath, both with government and NHS leadership, but also in informing the public. 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.

Although the roll out of training on the Trust's organisational development and improvement methodology, Improving Together was suspended during the pandemic, this has now resumed. The Trust remains committed to this methodology, and the approach to training staff has been altered to focus more on supporting managers to train their own teams. The original aim of building the RUH's staff into an army of improvers remains, and Improving Together now forms the basis for Board and Committee reporting, as well as the identification and management of

strategic risk. The methodology proved particularly helpful in helping the Trust to identify and agree its new strategic priorities.

Consultation with local groups and organisations

As the restrictions necessitated by the COVID-19 pandemic continued during the early part of 2022/23, much of the Trust's routine engagement with local groups and organisations remained suspended or resumed virtually. That said, the support and good wishes from both our existing and new volunteers, our Foundation Trust members, the Friends of RUH and the supporters of our own charity, the Forever Friends Appeal, among many others, were greatly appreciated.

Statement as to disclosure 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

The remuneration report has been prepared in accordance with sections 420 to 422 of the Companies Act 2006; regulation 11, parts 3 and 5 of Schedule 8 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulation 2008 (SE 2008/410); parts 2 and 4 of schedule 8 of the Regulations as adopted by NHS Improvement in the NHS Foundation Trust Annual Reporting Manual 2017/18; and relevant elements of the *NHS Foundation Trust Code of Governance*.

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'. The Trust deems this to be the Executive and Non-Executive members of the Board of Directors.

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 Director for People and Culture are in attendance at meetings of the Committee to provide advice, but are not present during any discussions relating to their own remuneration. Benchmarking data, taken from the 'NHSI Guidance on pay for very senior managers in NHS trusts and foundation trusts' (including Annex A), is adopted for comparisons.

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 Hospital Director is agreed and set by the RUH Chief Executive in conjunction with the other members of the Sulis Board.

Senior Managers' Remuneration Policy

With the exception of the Chief Executive, Executive Directors and apprentices, 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 Medical Director 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 Medical Director. The previous Medical Director was eligible to apply for discretionary performance-related pay under Medical Terms and Conditions but was previously excluded from eligibility for the Directors' Bonus Payments Scheme. This situation was rectified in March 2020, when the Nominations and Remuneration Committee approved a proposal to amend the Medical Director's contract, to better reflect the relative amount of his time spent on his management responsibilities compared to his duties as a consultant.

The remuneration of the Chief Executive and Executive Directors is determined by the Board of Directors' Nominations and Remuneration Committee taking into account 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. 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)

Pay component	Cost of Living uplift (annual)	Bonus payment (annual)	Relevant Senior Managers
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.	Up to 10% of salary, non-consolidated, determined by the Nominations and Remuneration Committee. Awarded based upon assessment of individual and Trust performance. (this aspect of senior manager remuneration ended during 2022/23)	All Executive Directors of the Trust including the Chief Executive.

<u>Performance Assessment of Chief Executive and Executive Directors</u>

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 previously comprised, where applicable, a cost of living uplift (offered

in line with any guidance from NHS England) and, at the Committee's discretion, a Directors' non-consolidated bonus payments scheme of up to 10% of the individual Executive Director's salary for outstanding performance over the last 12 months. 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.

During 2022/23, the Board of Directors' Remuneration and Nomination Committee decided to close the bonus scheme. On this basis, executive directors were consulted on new contractual arrangements, and these were subsequently agreed.

Objectives for each Executive Director are set at the start of the financial year and are linked to the Trust's True North 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 are 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 5 October 2022 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 3% increase for all Very Senior Managers (VSMs), and the new contractual recommendations to replace the bonus scheme. The meeting was chaired by Alison Ryan, Chair, and was attended by Ian Orpen, Jeremy Boss, Nigel Stevens, Sumita Hutchison, Anna Mealings and Paul Fairhurst.

The Chief Executive and the Director for People and Culture both attended the meeting but withdrew during the discussion about Executive Directors' pay. The 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 November 2019, NHS Improvement published a document entitled *Structure to align remuneration for Chairs and non-executive directors of NHS trusts and NHS foundation trusts.* In it, they published research on the pay rates for chairs and non-executive directors of trusts and foundation trusts of different sizes, comparing them to rates paid to directors of private sector companies with similar turnovers. They then made recommendations aimed at aligning pay to directors of trusts and foundation trusts based on their turnover.

In January 2021, the Council of Governors met to review non-executive pay rates in light of this guidance, which recommended a base rate of £13,000 for all Non-

Executive Directors. As a result of this process they agreed the following rates to take effect from 1 April 2021:

- Base fee for all NEDs - £13000
- Extra payment for Senior Independent Director (SID) - £1500
- Extra payment for Chair of Audit and Risk Committee - £1500
- Extra payment for Chair of the other Committees - £1000 (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 at pages 65 to 67 of this report.

Annual Report on Remuneration

Service Contracts

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	NHS FT terms of office	Current term of Office	Notice period
Alison Ryan **Chair**	01-Apr-2019-31-Mar-2025	1-Apr-2022-31-Mar-2025	3 months
Jeremy Boss **Non-Executive Director**	06-Mar-2017-31-Mar-2023	09-Feb-2020-31-Mar-2023	3 months
Nigel Stevens **Non-Executive Director**	01-April 2018-31 Mar 2024	01-April 2021-31 Mar 2024	3 months
Sumita Hutchison **Non-Executive Director**	04-Sept-2019-31-Aug-2025	01-Sept-2022-31-Aug-2025	3 months
Ian Orpen **Non-Executive Director**	07-Sept-2020-31-Aug-2023	07-Sept-2020-31-Aug-2023	3 months
Antony Durbacz **Non-Executive Director**	07-Sept-2020-31-Aug-2023	07-Sept-2020-31-Aug-2023	3 months
Paul Fairhurst Non-Executive Director	01-Oct-2022-30-Sept-2025	01-Oct-2022-30-Sept-2025	3 months
Libby Walters **Deputy Chief Executive & Director of Finance**	04-Jun- 2018	N/A	6 months
Simon Sethi **Chief Operating Officer**	17-Jan-2021	N/A	6 months
Andrew Hollowood **Chief Medical Officer**	14-Nov-2022	N/A	6 months
Antonia Lynch **Chief Nurse**	01-Apr-2021	N/A	6 months
Jocelyn Foster **Director of Strategy**	30-Jul-2012	N/A	6 months
Alfredo Thompson **Director for People and Culture***	31-Jan-2022	N/A	6 months
Brian Johnson **Director of Estates and Facilities***	01-Apr-2019	N/A	6 months

*Indicates non-voting members of the Board of Directors

Disclosures in accordance with the Health and Social Care Act

Director and governor expenses

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

Directors' expenses

£4000 worth of taxable expenses were paid to 6 Executive Directors and £1,300 to 4 Non-Executive Directors during the reporting period. No taxable expenses were paid to either Executive or Non-Executive Directors during 2021/22. The full list of Executive and Non-Executive Directors who served during 2022/23 is set out from pages 29 to 34 of this report.

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). £921.10 was paid to 11 out of the 25 governors in the period 1 April 2022 to 31 March 2023 (none was paid in the period 1 April 2021 to 31 March 2022).

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.

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 **Chief Executive**	220-225	-	-	52.5-55	270-275
Libby Walters **Director of Finance & Deputy Chief Executive**	165-170	-	-	37.5-40	205-210
Bernie Marden	40-45	35-40	-	25-27.5	

Medical Director (departed 01/09/2022)					105-110
Richard Graham **Acting Chief Medical Officer** (01/09/2022 – 31/12/2022)	50-55	10-15	-	37.5-40	105-110
Jocelyn Foster **Director of Strategy**	135-140	-	-	32.5-35	165-170
Brian Johnson **Director of Estates and Facilities**	125-130	-	-	30-32.5	155-160
Simon Sethi **Chief Operating Officer**	125-130	-	-	35-37.5	165-170
Antonia Lynch **Chief Nurse**	135-140	-	-	32.5-35	170-175
Alfredo Thompson **Director for People and Culture**	130-135	-	-	2.5	130-135
Andrew Hollowood **Chief Medical Officer** (started 14/11/2022)	45-50	20-25	-	5-7.5	75-80
Alison Ryan **Chair**	45-50	-	-	-	45-50
Jeremy Boss **Non-Executive Director**	15-20	-	-	-	15-20
Nigel Stevens **Non-Executive Director**	10-15	-	-	-	10-15
Sumita Hutchinson **Non-Executive Director**	10-15	-	-	-	10-15
Anna Mealings **Non-Executive Director** (left 31/10/2022)	10-15	-	-	-	10-15
Ian Orpen **Non-Executive Director**	10-15	-	-	-	10-15
Antony Durbacz **Non-Executive Director**	10-15	-	-	-	10-15
Paul Fairhurst **Non-Executive Director** (started 01/10/2022	10-15	-	-	-	10-15

Remuneration for Senior Managers for 2021-22:	**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 **Chief Executive**	190-195	-	15-20	55.0-57.5	265-270
Libby Walters **Director of Finance & Deputy Chief Executive**	145-150	-	10-15	2.5	155-160
Bernie Marden **Medical Director**	105-110	85-90	15-20	60-62.5	270-275
Jocelyn Foster **Director of Strategy**	115-120	-	5-10	30-32.5	155-160
Claire Radley **Director of People** (left 31/01/22)	90-95	-	5-10	17.5-20	120-125
Alfredo Thompson **Director for People and Culture** (joined 31/01/22)	20-25	-	-	-	20-25
Brian Johnson **Director of Estates and Facilities**	105-110	-	5-10	25-27.5	140-145
Simon Sethi **Chief Operating Officer**	135-140	-	5	70-72.5	205-210
Alison Ryan **Chair**	45-50	-	-	-	45-50
Jeremy Boss **Non-Executive Director**	15-20	-	-	-	10-15
Nigel Stevens **Non-Executive Director**	10-15	-	-	-	10-15
Sumita Hutchinson	10-15	-	-	-	10-15

Non-Executive Director					
Anna Mealings **Non-Executive Director**	10-15	-	-	-	10-15
Ian Orpen **Non-Executive Director** (wef 09/09/2020)	10-15	-	-	-	5-10
Antony Durbacz **Non-Executive Director** (wef 01/11/2020)	10-15	-	-	-	5-10

Total Pension Entitlement

	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 2022 (bands of £5,000)**	**Lump Sum at Pension Age, Related to Accrued Pension at 31 March 2022 (bands of £5,000)**	**Cash Equivalent Transfer Value at 1 April 2021**	**Real Increase in Cash Equivalent Value Transfer**	**Cash Equivalent Transfer Value at 31 March 2022**	**Employer's Contribution to Stakeholder Pension**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Cara Charles-Barks **Chief Executive**	2.5-5	0-2.5	45-50	50-55	643	37	708	29
Jocelyn Foster **Director of Strategy**	2.5-5	0-2.5	25-30	20-25	388	27	432	18
Andrew Hollowood **Chief Medical Officer***	0-2.5	0-2.5	85-90	195-200	1,692	13	1,752	10
Brian Johnson **Director of Estates and Facilities**	0-2.5	0-2.5	5-10	0-5	85	16	118	18
Antonia Lynch **Chief Nurse**	2.5-5	0-2.5	45 - 50	90 – 95	866	36	921	18
Bernie Marden **Medical Director***	0-2.5	0-2.5	75 – 80	150-155	1,410	29	1,507	12

Simon Sethi **Chief Operating Officer**	2.5-5	0-2.5	30-35	45-50	389	17	424	19
Alfredo Thompson **Director for People and Culture**	0-2.5	0-2.5	30-35	0-5	425	26	379	19
Libby Walters **Director of Finance & Deputy Chief Executive**	2.5-5	0-2.5	60 - 65	115 - 120	987	38	1,046	22
Richard Graham **Acting Chief Medical Officer***	0-2.5	2.5-5	60-65	115-120	896	31	1,017	10

*Not in post for the full year

No directors received any taxable benefits during 2022/23. The Trust does not pay its directors long-term performance-related bonuses.

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

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.

The Trust does not provide any additional benefits to any of its directors in the event of early retirement, not does it provide separate details in relation to any right that a senior manager has under more than one type of pension.

One of the five strategic goals is to ‘be an outstanding place to work where staff can flourish’. The Trust’s People Strategy enables the delivery of this goal. Senior managers’ remuneration (for these purposes including executive directors and members of the Trust’s Management Board) is benchmarked annually using NHS Improvement data, with the ultimate aim of ensuring the stability of the senior teams. Performance pay for executive directors drives shared responsibility and is dependent on achievement of individual and collective objectives that are aligned with the Trust Strategy and True North goals. Senior managers on Agenda for

Change bands are subject to the nationally agreed terms and conditions including pay.

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.

Statement of consideration of employment conditions elsewhere in the Trust

Pay and conditions of employees are taken into account 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

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 2022-23 was £220,000 - £225,000 (2021-22 £210,000 - £215,000). This is a change between years of 4.88% (2021-22 0%).

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 2022-23 was from £26 to £317,273 (2021-22 £21 to £248,838). 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 6.37%. 7 employees received remuneration in excess of the highest-paid director in 2022-23 (2021-22 8).

	21/22	22/23	%age difference
Salary of Highest paid director	£ 194,535.12	£ 220,351.51	13.271
Bonus of the highest paid director	£ 15,562.80	£ -	-100.00
Total of annualised Pay - the highest paid director / FTE employees	£ 45,907.33	£ 50,332.05	9.638
Total of performance pay and bonus's - highest paid director / FTE employees	£ 9.57	£ -	-100.00

Highest Paid Director Bonus - The difference has decreased due to no bonus being paid in 2022/2023.

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.

2022/2023	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 2021-22 or 202-23 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. (31 March 2022: none).

	Term of Appointment	Board of Directors	Audit Committee	Non-Clinical Governance Committee	Quality Governance Committee	Nominations and Remuneration Committee	Subsidiary Oversight Committee	Charities Committee	Finance and Performance Committee	People Committee
					Attendance/maximum					
Non-Executive Directors										
Alison Ryan, **Chair**	1/04/2019-31/03/2025	7/7	-	-	3/3	3/3	-	4/4	2/2	-
Jeremy Boss, **Vice Chair and Senior Independent Director**	06/03/2017-31/03/2023	6/7	-	-	-	3/3	-	3/4	9/10	-
Nigel Stevens	01/04/2018-31/03/2024	4/7	3/4	-	3/3	3/3	4/4	-	7/10	-
Sumita Hutchison	04/09/2019-31/08/2025	6/7	4/4	4/4	-	3/3	-	1/4	-	4/5
Anna Mealings	04/09/2019-03/09/2022	1/4	-	-	3/4	1/3	-	-	1/2	5/5
Ian Orpen	07/09/2020-06/09/2023	5/7	-	4/4	7/7	3/3	3/4	-	-	4/5
Antony Durbacz	01/11/2020-31/10/2023	7/7	4/4	3/4	-	2/3	-	-	10/10	-
Paul Fairhurst	01/10/2022 – 30/09/2025	2/3	-	-	4/4	1/1	-	-	5/6	1/1
Executive Directors										

	Term of Appointment	Board of Directors	Audit Committee	Non-Clinical Governance Committee	Quality Governance Committee	Nominations and Remuneration Committee	Subsidiary Oversight Committee	Charities Committee	Finance and Performance Committee	People Committee
Attendance/maximum										
Cara Charles-Barks, **Chief Executive**	01/09/2020-ongoing	6/7	-	-	2/7	-	2/4	-	9/10	3/5
Libby Walters **Deputy Chief Executive & Director of Finance**	01/06/2018 – ongoing	7/7	4/4	-	-	-	4/4	4/4	9/10	-
Antonia Lynch **Chief Nurse**	01/04/2021 – ongoing	7/7	-	-	4/7	-	2/4	2/4	-	3/5
Bernie Marden **Medical Director**	01/04/2018 – 25/08/22 – On Secondment to Somerset ICB until 31/03/23	7/7	0/1	-	3/3	-	-	-	2/4	1/4
Richard Graham **Interim Medical Director**	01/09/22 – 14/11/22	3/3	1/1	-	0/1	-	-	-	0/2	0/1
Andrew Hollowood **Chief Medical Officer**	14/11/22 – ongoing	2/2	1/2	-	3/3	-	-	-	1/4	-
Jocelyn Foster **Director of Strategy**	01/07/2012 - ongoing	6/7	-	4/4	-	-	4/4	4/4	-	2/5

	Term of Appointment	Board of Directors	Audit Committee	Non-Clinical Governance Committee	Quality Governance Committee	Nominations and Remuneration Committee	Subsidiary Oversight Committee	Charities Committee	Finance and Performance Committee	People Committee
Attendance/maximum										
Simon Sethi **Chief Operating Officer**	15/01/2021 - ongoing	7/7	-	-	-	-	1/4	-	7/10	-
Alfredo Thompson, **Director for People and Culture**	31/01/2022 - ongoing	7/7	-	-	-	1/1	4/4	-	-	5/5
Brian Johnson **Director of Estates and Facilities**	01/04/2019 – ongoing	7/7	-	4/4	-	-	-	-	-	3/5

Cara Charles-Barks

Chief Executive (Accounting Officer)

27 June 2023

Staff report

Analysis of staff numbers

An analysis of average staff numbers is outlined below. 2021 figures relate to the Trust only, while 2022/23 include the Group:

	Permanent Number	Other Number	2022/23 Total Number
Medical and dental	577	18	**595**
Ambulance staff	2	1	**3**
Administration and estates	845	123	**968**
Healthcare assistants and other support staff	1,570	153	**1,723**
Nursing, midwifery and health visiting staff	1,611	175	**1,786**
Nursing, midwifery and health visiting learners	-	-	**-**
Scientific, therapeutic and technical staff	492	12	**504**
Healthcare science staff	151	2	**153**
Social care staff	-	-	**-**
Other	-	7	**7**
Total average numbers	**5,248**	**491**	**5,739**
Of which:			
Number of employees (WTE) engaged on capital projects	13	2	**15**

Analysis of staff numbers 2021/22

	Permanent Number	Other Number	2021/22 Total Number
Medical and dental	659	17	**676**
Ambulance staff	-	-	**-**
Administration and estates	878	147	**1,025**
Healthcare assistants and other support staff	1,559	214	**1,773**
Nursing, midwifery and health visiting staff	1,448	214	**1,662**
Nursing, midwifery and health visiting learners	-	-	**-**
Scientific, therapeutic and technical staff	478	10	**488**
Healthcare science staff	144	3	**147**
Social care staff	-	-	**-**
Other	-	-	**-**
Total average numbers	**5,166**	**605**	**5,771**
Of which:			
Number of employees (WTE) engaged on capital projects	25	2	**27**

Analysis of staff costs for 2022/23

	Permanent	Other	2022/23 Total	2021/22 Total
	£000	£000	£000	£000
Salaries and wages	256,950	598	**257,548**	232,764
Social security costs	26,092	-	**26,092**	22,470
Apprenticeship levy	1,166	-	**1,166**	1,269
Employer's contributions to NHS pension scheme	39,640	-	**39,640**	36,994
Pension cost - other	99	-	**99**	192
Other post-employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	14,192	**14,192**	11,888
NHS charitable funds staff	767	-	**767**	663
Total gross staff costs	**324,714**	**14,790**	**339,504**	**306,240**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**324,714**	**14,790**	**339,504**	**306,240**
Of which				
Costs capitalised as part of assets	-	1,153	**1,153**	1,892

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 2022	Adjusted FTE days lost to Cabinet Office definitions	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
5317	63922	1,940,720	103,696	12.0

NHS Sickness Absence Figures for NHS 2022-23 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 2022

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 2022/23

The RUH Board agreed the RUH People Plan in July 2022, and we continue to pursue improvements for our workforce (‘our RUH people’) knowing that in doing so the experiences of our patients will be improved.

THE RUH People plan organises itself around 3 key areas:

Capacity – making sure we fill our vacancies, encourage flexible working through our Staffing Bank (Staffing Solutions).

Capability – equipping our workforce with the skills required and planning for the future workforce.

Culture – making the RUH a great place to work.

All underpinned by improved, user-friendly processes, such as a quicker time to hire for new starters.

We are a Team

In this financial year we have continued to be a member of the Disability Confident Scheme and continue with our level 2 Disability Confident employer accreditation.

The Trust has expanded its celebration of the diversity of staff, with a conference for Black History month and continued work to celebrate all protected characteristics in a meaningful way.

Families and children of staff working during key religious holidays, (Christmas, Passover, Ramadan etc.) can receive a letter from the Chief Executive acknowledging their family member’s contribution to the running of the hospital.

<u>Gender Analysis</u>

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

- Directors
- Other Senior Manager
- Employees

Position as at 31 March 2023

	Female	Male	Total
Directors	4	4	8
Other Senior Managers (Band 8A+)	78	33	111
Employees	4607	1425	6032
Total	4689	1462	6151

Staff Surveys

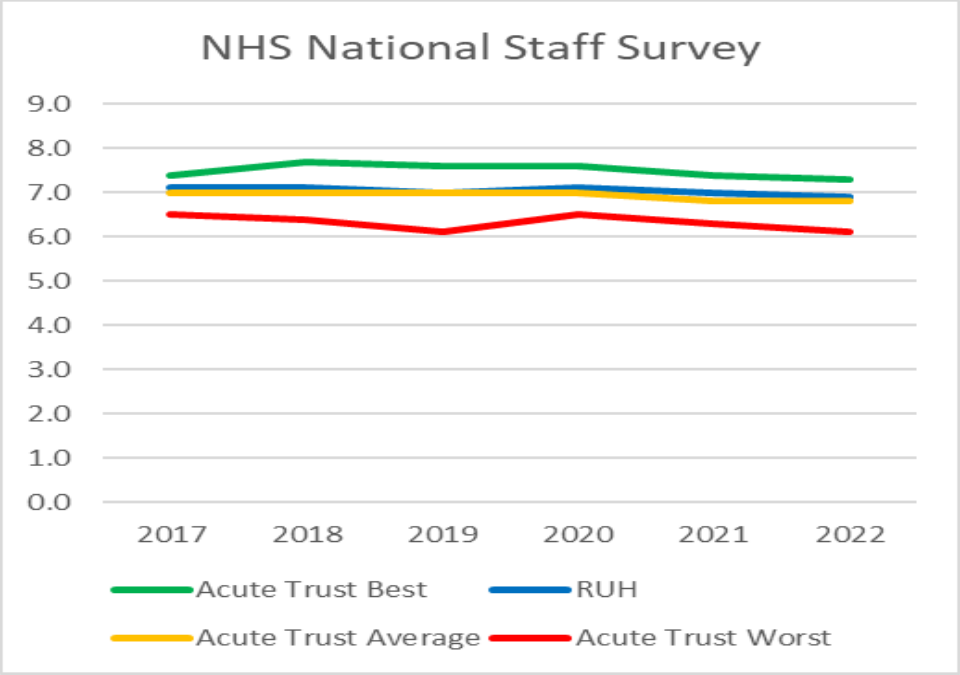
We use data from the annual NHS Staff Survey to inform our priorities and plans, complemented by quarterly internal surveys ('Pulse' Survey). This surveys are the reviewed alongside the RUH people, and complimented by continuous team development programmes and listening events.

NHS Staff Survey 2022 – 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 2022 and 52% responded, over 800 people more than the previous year. This an improvement on last year's response rate of 44%.

Generally, our results aligned to, or improved from, 2021 and benchmark well against the average, our aspiration is to achieve top quartile.



The NHS Staff Survey engagement score for 2022 at the RUH was 6.9 this is a decline from 2021 position, but we remain above the national average. In six of the nine overall themes the results were above the national average, and in a further two we were equal to the average. However, we have seen a decline across five themes from the scores in 2021, this is consistent across most NHS organisations, a decline in scores between 2021 and 2022.

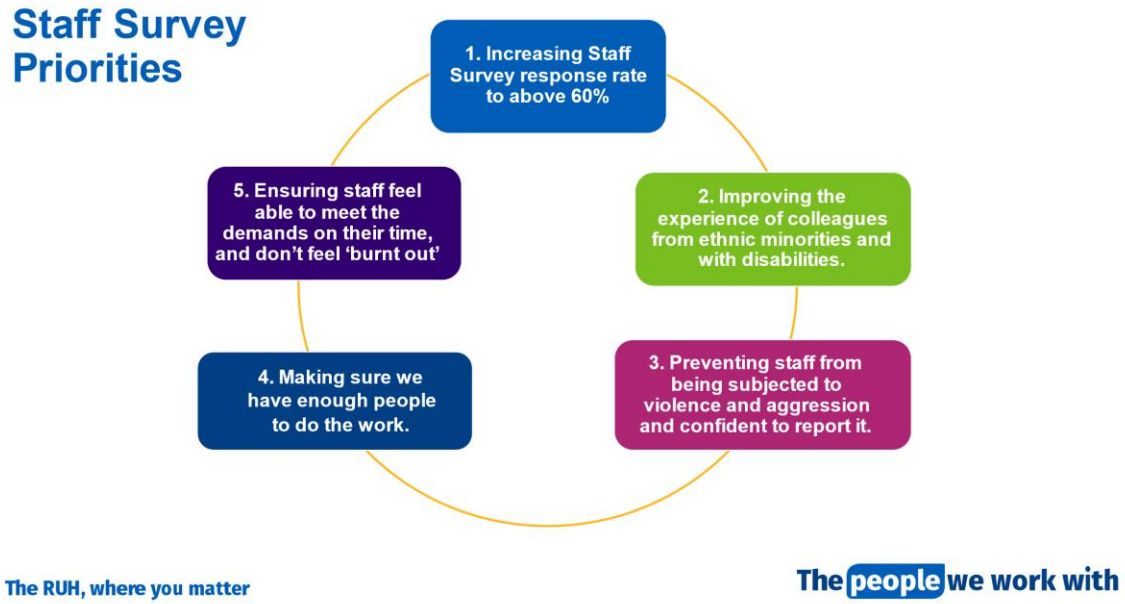
The summary by theme is detailed below. It is important to note that our scores are significantly less positive for colleagues with protected characteristics.

Monitoring of the Trust's staff engagement work is through the People Committee.

Higher level benchmarking ranks the RUH as fourth in the South West Region. Positive areas to note are:

- As people who work at the RUH we are proud of the standard of care the RUH provides. At the RUH 68% of us said we'd be happy for our friends or relatives to be treated here, which is significantly above the national average, but there is room for improvement. ·
- Many people are positive about how we treat each other with civility and respect; more than three quarters of respondents recognised our colleagues are polite, understanding and kind to each other, validating the impact of our ongoing kindness and civility project. ·
- More of us feel supported to develop our potential and feel that there are opportunities to show initiative at the RUH.

The five key priorities drawn from the data of the 2022 Staff Survey are:



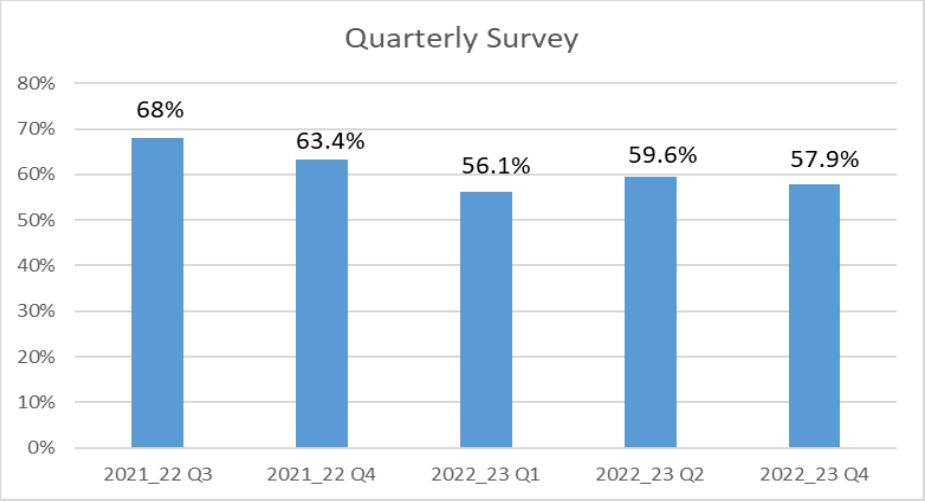
Making a Difference (pulse survey)

During 2022 we extended our quarterly surveys to bank staff and students.

The Making a Difference model gives a staff engagement score out of 5.

Our average engagement score during 2022/23 was 3.85. We place a significant focus on the feedback regarding whether the RUH is a good place to work.

On average, during 2022/23 57.85% of staff gave feedback that the RUH is a good place to work:



The latest Making a Difference survey results show that the top three scoring enablers of staff engagement for our people are Role Clarity, Trust and Teamwork.

The three lowest enablers of staff engagement are Resources, Workload and Perceived Fairness which triangulates with quantitative data from listening events, ED&I and FTSU.

Relevant union officials

The total number of employees who were relevant union officials during 2022/23 was:

Number of employees who were relevant union officials 22/23	Full-time equivalent employee number
16	5739

Percentage of time spent on facility time during 22/23

Percentage of time	Number of employees
0-1%	4
1-50%	10
51-99%	1
100%	1

Percentage of time spent on facility time during 21/22

Total cost of facility time	£98,759
Total pay bill	£323,281,000
% of total pay bill spent on facility time	0.03%

Paid trade union activities during 22/23

Time spent on paid trade union activities as a percentage of total paid facility time hours	14.58%

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 2022 (Table 1); all off-payroll workers engaged at any point during the year ended 31 March 2022 (Table 2); and any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022 (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: Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2023, for more than £245 (1) per day:

	Number
Number of existing engagements as of 31 March 2023	162
Of which, the number that have existed:	
for less than one year at time of reporting	21
for between one and two years at time of reporting.	13
for between two and three years at time of reporting	11
for between three and four years at time of reporting	12
for four or more years at time of reporting.	105

Note

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2022 and 31 March 2023, for more than £245 (1) per day

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 31 March 2023	162
Of which	
No. not subject to off-payroll legislation (2)	32
No not subject to off-payroll legislation and determined as in-scope of IR35 (2)	0

Subject to off-payroll legislation and determined as out of scope of IR35 (2)	130
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

Note

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

(2) 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 2022 and 31 March 2023

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year (1)	1
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements	37

Note

1 There should only be a very small number of off-payroll engagement of board members and/or senior officials with significant financial responsibility.

2 As the total figure includes both on-payroll and off-payroll engagements, no entries here should be blank or zero.
In any cases where individuals are included within the first row of this table the department should set out:

- Details of the exceptional circumstances that led to each of these engagements.
- Details of the length of time each of these exceptional engagements lasted.

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.

Table 4: Exit packages 2022/2023

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	2	7	9
£10,000 - £25,000	-		0
£25,001 - £50,000	2	-	2
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
>£150,000	-	-	-
Total number of exit packages by type	**4**	**7**	**11**
Total resource cost (£'000)	**147**	**31**	**178**

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

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

Details of exit packages for 2021-2022:

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	8	8
£10,000 - £25,000	-	-	-
£25,001 - £50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
>£150,000	-	-	-
Total number of exit packages by type	**0**	**8**	**8**
Total resource cost (£'000)	**0**	**31**	**31**

	2021-2022	
	Agreements	Total Value of Agreements
		£0
	Number	
Voluntary redundancies including early retirement contractual costs.	-	-
Mutually agreed resignations (MARS) contractual costs.	-	-
Early retirements in the efficiency of the service contractual costs.	-	-
Contractual payments in lieu of notice.	8	31
Exit payments following Employment Tribunals or court orders.	-	-
Non-contractual payments requiring MHT approval.	-	-
Total	**8**	**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 2022/23.

Equality and Health Inequality Assessments are undertaken when writing or refreshing policies and our Staff Networks review and comment on policies as part of the consultation process.

We have four staff networks, Fusion, (representing staff from ethnic minorities), Equal Abilities (staff with disabilities) and LGBT+ and allies, (lesbian, gay, bisexual, and transgender) and a Women's network. The networks also help us to increase inclusivity through celebratory events such as Black history month and LGBT+ History month, providing opportunities for staff to both educate and share their culture 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.

We are below our target in relation to numbers of Black, Asian, and ethnic minority staff at Band 8a but exceeding our targets in Bands 8b and above and have developed positive action approaches to support staff into Band 8a. We are focused on improving the opportunities for staff from all backgrounds.

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 2022. 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 has increased further, continuing to be in favour of men. Male employees in medical staff group are earning an average of £12.20 per hour more than their female colleagues. This is an increase of £2.52 compared to the 2021 median average.

- The medical and dental staff group is the only pay group that has an almost 50/50 split in representation. All other levels are majority female.

- This year has also seen a sharp increase in the gender pay gap across bonus payments with an 18.43% gap favouring men when looking at the median average bonus payments between male and female employees. This is a significant increase from parity (no gap) in 2021.

- A decrease of the median pay gap for the Trust overall, favouring women with female employees paid 1.31% more on average than male. Last year's gap was 2.49% favouring women.

The Trust recognises that more work needs to be done to address the inequalities experienced by female employees. Our current reporting cycle means we are working with data that is 12 months prior. We will change the reporting cycle of our gender pay gap for March 2023, so that the report is released in the same year of the results, so that actions can be implemented before the next reporting date.

The goal is that by 2024, the NHS staff survey results 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, alongside a reduction in the gender pay gap for medical and dental staff.

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 *NHS Foundation Trust Code of Governance*.

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 as the restrictions imposed during the COVID-19 pandemic have eased, in-person meetings resumed during 2022/23. The Board 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 during most of 2022/23, were ordered under the five goals that underpinned the Trust's Vision:

- Recognised as a listening organisation, patient centred and compassionate.
- Be an outstanding place to work where staff can flourish
- Quality improvement and innovation each and every day.
- Work together with our partners to strengthen our community.
- Be a sustainable organisation that is fit for the future.

From November 2022 onwards, this categorisation was changed to reflect the new People groups around which the Trust's new vision was 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 and Away Days and individual training needs are assessed through the appraisal process. 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; participation in meetings involving members, such as at the Annual Members' Meeting, at the Members' *Caring for You* events; and Executive Director attendance at Governor Constituency meetings. The COVID-19 pandemic meant that some of these events were held differently, but the Board continued to prioritise engagement with the Council of Governors, with the Chair setting up a regular programme of informal catch-ups with groups of Governors in between the formal Council meetings. These catch-ups have been retained as a good source of engagement aside from the formal meetings.

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 of the Trust are considered to be independent in accordance with the NHS Foundation Trust Code of Governance as published by NHS Improvement (as was). 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.

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.

One new Non-Executive Director, Paul Fairhurst, was appointed in 2022/23. In June 2022, the Council of Governor's Nominations Committee met to commence the process for appointing a Non-Executive director to replace Anna Mealings who had indicated that she would not be seeking re-appointment at the end of her first 3 year term. A person specification was agreed on the balance of skills, knowledge and experience currently on the Board, and where there may be gaps. The gender and diversity of the Board was also to be taken into account in the process.

59 applications were received in response to the advertisement, which was placed on NHS Jobs and a few other websites, and following a longlisting exercise, this number was whittled down to 17. Six candidates were interviewed for the role in August 2022, but a panel comprising the Trust Chair, 2 public governors and a staff governor as well as an external member – a chair from another NHS organisation. All the candidates also attended two stakeholder panels comprising other governors and directors. At the end of the process, the Nominations Committee recommended to the Council of Governors that Paul Fairhurst be appointed to the Board. This recommendation was accepted, and Paul Fairhurst joined the Board on 1 October 2022.

The Nominations Committee, at its meeting in November 2022 approved the commencement of the process to appoint a replacement for Jeremy Boss who in March 2023 reached the end of his 2nd 3 year term. It was agreed that the new director would also have a financial background, with a view to them eventually taking over as Chair of the Audit and Risk Committee. At the same meeting, the Committee also approved a recommendation from the Chair that an additional Non-Executive Director, with a clinical background be appointed. The rationale behind was to help strengthen and deepen the clinical perspective at Board and Board Committee discussions.

Shortlisting for both roles took place in January 2023, and interviews and stakeholder sessions were held on 7 and 8 February, following which Paul Fox and Hannah Morley were recommended to the Council of Governors for the finance and clinical roles respectively. These were accepted and both directors commenced their terms on 1 April 2023.

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 holds a minimum of four away day sessions during the year, which provide an opportunity for the Board to debate strategic issues in an informal setting. The Board of Directors also 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, previously Management Board) 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. TME also has delegated authority to approve business cases for the establishment of new clinical posts, service developments and capital projects up to a specified limit. In addition, it has continued in its role of monitoring progress against the completion of projects of key organisational importance in line with the Improving Together methodology.

During 2022/23 work was done to assess ways of strengthening the collective grip that the executive team and divisional management had on the organisation's operational performance, as a result of which it was decided to re-set both the membership and focus of the group. Meetings now 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 is chaired by Antony Durbacz. 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; and
- 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 2022/23.

Non-Clinical Governance Committee (NCGC)

The Non-Clinical Governance Committee is chaired by Sumita Hutchison. The 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 2022/23, 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. The Committee also continued to test the extent to which the Trust is able to take advantage of digital developments, the importance of which has been highlighted during the pandemic.

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 also 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 2022/23, the Committee had a keen focus on the safety of the Trust's maternity services, and helped ensure that it took full account of the learning from the various investigations into such services elsewhere in the country. The Trust's approach to infection prevention and control was also a key area of focus.

People Committee

Paul Fairhurst took over as Chair of the People Committee from Anna Mealings. This Committee's original role was to provide assurance to the Board that all people-related risks are being appropriately managed, and that the Trust's employment processes are fit for purpose and legally compliant. However, in 2022/23 the focus of its work shifted towards 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.

Finance and Performance Committee

Nigel Stevens temporarily took over as Chair of the Finance and Performance Committee as Jeremy Boss left the Board. 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. Going forward, one of the committee's key areas of focus will be on the Trust's relationship with its BSW partners, and the changing approaches to commissioning, contracting, joint working and the allocation of resources. 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 the newest Board Committee, having been established in June 2021, following the acquisition of Sulis Hospital. It 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.

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 (recently successfully rebranded as 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.

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.

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.

2022/23 Governor Elections
During 2022/23 the Trust held a constituency-wide election to elect two Staff Governors and seven Public Governors across five constituencies. Governors were elected into each constituency, with the exception of North Wiltshire, whose only candidate withdrew. A by-election was held for North Wiltshire in January 2023 which resulted in an unopposed election.

Each constituency, with the exception of the North Wiltshire and the Rest of England and Wales constituencies had a contested election and there was a noticeable decline in participation which ranged from 10.6% to 13.5%. The full election report is available from the Membership Office at ruhmembership@nhs.net.

The Trust commenced the year with five Governor vacancies, three of which have now been filled through the election process. Two Stakeholder Governor vacancies remain 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.

The Governor's terms of appointment can be seen in the table below:

Governors by constituency – 1 April 2022 to 31 March 2023
There are 21 Governor positions in total. As at 31 March 2023, there were 19 Governors in post (11 public, 5 staff and 3 appointed) and 2 vacancies.

Name	Constituency	Term of Appointment
Mike Midgley	City of Bath	01/11/2016 - 31/10/2019 01/11/2019 - 31/10/2022
Nesta Collingridge-Padbury	City of Bath	02/11/2020 - 31/10/2023 (stood down April 2022)
Nicola James	City of Bath	01/11/2022 - 31/10/2025
Viv Harpwood	City of Bath	01/11/2022 - 31/10/2024
Melanie Hilton	North East Somerset	01/11/2019 - 31/10/2022
Suzanne Harris	North East Somerset	02/11/2020 - 31/10/2023
Anna Beria	North East Somerset	01/11/2022 - 31/10/2025
Anne Martin	Somerset (Mendip)	01/11/2016 - 31/10/2019 01/11/2019 - 31/10/2022 01/11/2022 - 31/10/2025
John Osman	Somerset (Mendip)	02/11/2020 - 31/10/2023
Peter McCowen (Deputy Lead Governor, Lead Governor from November 2022)	North Wiltshire	02/11/2020 - 31/10/2023

Peter Buttle	North Wiltshire	29/04/2021 - 31/10/2022
Nick Gamble	North Wiltshire	01/03/2023 - 31/10/2025
Gill Little (Lead Governor)	South Wiltshire	01/11/2019 - 31/10/2022
Horace Prickett	South Wiltshire	27/10/2021 - 31/10/2023
Di Benham	South Wiltshire	01/11/2022 - 31/10/2025
Ramal Royal	Rest of England & Wales	01/11/2022 - 31/10/2025
Narinder Tegally	Staff	01/11/2019 - 31/10/2022 01/11/2022 - 31/10/2025
Sophie Legg	Staff	01/11/2019 - 31/10/2023
Julie Stone	Staff	02/11/2020 - 31/10/2023
Baz Harding-Clark	Staff	02/11/2020 - 31/10/2023
Beas Bhattacharya	Staff	01/11/2022 - 31/10/2025
Cllr Alison Born	BaNES Council	20/05/2021 - 20/05/2024
Cllr Johnny Kidney	Wiltshire Council	01/10/2017 - 30/09/2023
Dr Brynn Bird	BSW CCG	01/04/2020 - 30/06/2022
Dr Catrinel Wright	BSW ICS (Wiltshire)	20/05/2021 - 20/05/2024
Vacancy	BSW ICS (BaNES)	-
Vacancy	University of Bath	-

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 £921.10 was paid to 11 (out of 25 Governors) in the period from 1 April 2022 to 31 March 2023. No expenses were paid to any Governors in the period from 1 April 2021 to 31 march 2022.

Council of Governor Meetings

The Council of Governors has met formally four times during the year. Attendance is detailed in the table below, 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.

Three out of four Council of Governor meetings were held in person at various venues around Bath with one held virtually using MS Teams during 2022/23. The Trust website was updated with the details of each meeting to allow for public viewing. Among the decisions taken in 2022/23 were the following:

- Approved an increase to the Chair's remuneration.
- Approved amendments to the Constitution.
- Appointed Peter McCowen, Public Governor as Lead Governor.

- Approved the appointment of Paul Fairhurst, Non-Executive Director to replace Anna Mealings.
- Approved the appointment of Paul Fox, Non-Executive Director to replace Jeremy Boss.
- Approved the appointment of Hannah Morley, Non-Executive Director to enhance clinical oversight.
- Appointed Nigel Stevens, Non-Executive Director as Senior Independent Director and Vice Chair.

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 2022/23

The following table sets out Governor Attendance at Council of Governor meetings during the period 1st April 2022 to 31st March 2023. 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.

Name	Council of Governors Meeting Attendance			
Mike Midgley	1/2		**Non-Executive Directors**	
Nesta Collingridge-Padbury	0/0		Alison Ryan (Chair)	4/4
Melanie Hilton	1/2		Jeremy Boss	1 (0)
Suzanne Harris	2/4		Nigel Stevens	2 (0)
Anna Beria	2/2		Sumita Hutchison	2 (0)
Anne Martin	2/4		Anna Mealings	1 (0)
John Osman	2/4		Anthony Durbacz	3 (0)
Peter McCowen	4/4		Ian Orpen	2 (0)
Peter Buttle	1/2		Paul Fairhurst	3 (0)
Nick Gamble	0/0			
Gill Little	1/2		**Executive Directors**	
Horace Prickett	4/4		Cara Charles-Barks	1 (0)
Di Benham	2/2		Libby Walters	2 (0)

Ramal Royal	2/2		Simon Sethi	1 (0)
Narinder Tegally	2/4		Joss Foster	0 (0)
Sophie Legg	4/4		Alfredo Thompson	1 (0)
Julie Stone	2/4		Brian Johnson	0 (0)
Baz Harding-Clark	2/4		Bernie Marden	0 (0)
Beas Bhattacharya	1/2		Toni Lynch	1 (0)
Cllr Alison Born	3/4		Andy Hollowood	1 (0)
Cllr Johnny Kidney	2/4			
Dr Brynn Bird	0/1			
Dr Catrinel Wright	0/4			

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 2023, the Trust had 16,353 members, made up of 10,846 public members (patients, carers and the public) and 5,507 staff members. The Trust has a number of channels for engaging and communicating with its members, including:

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

Ongoing restrictions relating to the Covid-19 pandemic and operational pressures have meant that the Trust has continued to be limited in the scale and scope of its engagement activities during 2022/23. A number of virtual events were held including an All Constituency Governors and Members' Meeting on 31 May 2022. During these events Members had the opportunity to interact with Governors and were updated on a wide range of RUH activities including the status of the RUH, Covid and Elective Recovery Plans and our success following the acquisition of Sulis Hospital Bath.

Following the sad passing of Her late Majesty Queen Elizabeth II the Trust's AGM which was due to be held on 19 September, was postponed as a mark of respect for The Queen and The Royal Family. The Annual General Meeting was instead held virtually on 29 September.

Recruitment of new members has remained constrained due to the continued prevalence of Covid-19 and limited resources, however a small number of members have been recruited by our Governors and via our online application form.

Membership size and movements 2022/23:

Public constituency			**Staff constituency**	
As at 1st April 2022	11,030		As at 1st April 2022	4,466
As at 31st March 2023	10,846		As at 31st March 2023	5,507

Analysis of current membership		
Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	1	158,589
17-21	150	48,182
22+	9,940	619,589
Ethnicity:		
White	9,159	728,501
Mixed	84	25,972
Asian or Asian British	188	11,684
Black or Black British	125	10,700
Other	35	9,361
Socio-economic groupings*:		
AB	3,249	88,630
C1	3,191	105,102
C2	2,178	75,775
DE	2,210	76,389
Gender analysis		
Male	3,655	408,177
Female	7,066	418,180
The analysis section of this report excludes:		
- 755 public members with no dates of birth, 1255 members with no stated ethnicity and 125 members with no gender		
General exclusions: Out of Trust Area, Suspended Members, Inactive Members		

NHS Foundation Trust Code of Governance

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 NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code 49 issued in 2012. (A new Code of governance for NHS provider trusts came into effect on 1 April 2023, and its implications will be reflected in the 2023/24 annual report)

For each item below, the information, its reference in the Code of Governance and its location within the Annual Report are shown. The reference to “ARM” indicates a requirement not of the Code of Governance, but of the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

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).

Table 1 – Code of Governance sections included in the Annual Report

Ref No	Code Provision	Annual Report and Accounts Section
A.1.1	The schedule of matters reserved for the Board of Directors 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 taken by each of the Boards, and which are delegated to the Executive management of the Board of Directors.	Directors' Report
A.1.2	The annual report should identify the Chairperson, the Deputy Chairperson, and the Chief Executive, the Senior Independent Director and the chairperson and members of the Nominations, Audit and Remuneration Committees. It should also set out the number of meetings of the Board and those committees and individual attendance by Directors.	Directors' Report
A.5.3	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
FT ARM	The annual report should include a statement about the number of meetings of the Council of Governors and individual attendance by governors and Directors.	Directors' Report
B.1.1	The Board of Directors should identify in the annual report each Non-Executive Director it considers to be independent, with reasons where necessary.	Directors' Report
B.1.4	The Board of Directors should include in its annual report a description of each Director's skills, expertise and experience. Alongside this, in the annual report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS Foundation Trust.	Directors' Report
FT ARM	The annual report should include a brief description of the length of appointments of the Non-Executive Directors, and how they may be terminated.	Directors' Report & Remuneration Report
B.2.1	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to Board appointments.	Directors' Report & Remuneration Report

Ref No	Code Provision	Annual Report and Accounts Section
FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a Chair or Non-Executive Director.	Directors' Report
B.3.1	A Chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the annual report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next annual report.	Directors' Report
B.5.6	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.	Governance of the Trust
FT ARM	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. 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. * 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). ** As inserted by section 151 (6) of the Health and Social Care Act (2012)	This power has not been exercised.
B.6.1	The Board of Directors should state in the annual report how performance evaluation of the Board, its committees, and its Directors, including the chairperson, has been conducted.	Directors' Report
B.6.2	Where there has been external evaluation of the Board and/or governance of the Trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the Trust.	There has been no external evaluation of the Trust

Ref No	Code Provision	Annual Report and Accounts Section
C.1.1	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, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Annual Governance Statement
C.2.1	The annual report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	Annual Governance Statement
C.2.2	A trust should disclose in the annual report: a) If it has an internal audit function, how the function is structured and what role it performs; or b) If it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Annual Governance Statement
C.3.5	If the Council of Governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the Board of Directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	Not applicable
C.3.9	A separate section of the annual report should describe the work of the Audit Committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • If the external auditor provides non-audit services, the value of the non-audit services provided and an	Governance of the Trust – Audit and Risk Committee

Ref No	Code Provision	Annual Report and Accounts Section
	explanation of how auditor objectivity and independence are safeguarded.	
D.1.3	Where an NHS Foundation Trust releases an executive Director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the Director will retain such earnings.	Not applicable
E.1.4	Contact procedures for members who wish to communicate with governors and/or Directors should be made clearly available to members on the NHS Foundation Trust's website and in the Annual Report.	Governance of the Trust
E.1.5	The Board of Directors should state in the annual report the steps they have 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, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	Governance of the Trust
E.1.6	The Board of Directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Governance of the Trust
FT ARM	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Governance of the Trust
FT ARM	The annual report should disclose details of company Directorships or other material interests in companies held by governors and/or Directors where those companies or related parties are likely to do business,	Directors' Report

Ref No	Code Provision	Annual Report and Accounts Section
	or are possibly seeking to do business, with the NHS Foundation Trust. As each NHS Foundation Trust must have registers of governors' and Directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 7.33 as Directors' report requirement.	

Table 2: "Comply or explain" assessment of compliance with the 2014 Code of Governance

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 NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Code Ref	Summary of requirement	RUH Compliance
A.1.4	The Board should ensure that adequate systems and processes are maintained to measure and monitor the NHS Foundation Trust's effectiveness, efficiency and economy as well as the quality of its health care delivery.	**Confirmed:** the Board of Directors receives detailed monthly reports on operational performance, quality and finance. There is a Board Assurance Framework and a system of internal controls in place as detailed in the Annual Governance Statement.
A.1.5	The Board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance.	**Confirmed:** the Board of Directors receives the latest version of the Integrated Performance Report at each of its meetings. This provides detailed information on the Trust's operational, financial, quality and workforce related performance, measured against both mandated and internally agreed targets and metrics.

A.1.6	The Board should report on its approach to clinical governance.	**Confirmed:** All three clinical divisions (Medicine, Surgery, Women's & Children's) hold regular, formal divisional clinical governance meetings and report to the Quality Board, which is jointly chaired by the Chief Nurse and the Medical Director. This Board is responsible for ensuring that the Trust has effective and efficient arrangements in place for quality assessment, quality improvement and quality assurance. Quality Board in turn reports to the Quality Governance Committee, a Board Committee, which is responsible on the Board's behalf for gaining assurance on the Trust's overall approach to clinical and quality governance. Apart from updated from Quality Board, QGC receives regular updates on incidents, claims and inquests, learning from deaths and patient experience amongst others. The divisional governance leads also attend QGC meetings to discuss the key issues that they are facing and how these are being managed.
A.1.7	The Chief Executive as the Accounting Officer should follow the procedure set out by NHS Improvement for advising the Board and the Council and for recording and submitting objections to decisions.	**Confirmed:** the Chief Executive is aware of this provision in the Accounting Officer Memorandum.
A.1.8	The Board should establish the constitution and standards of conduct for the NHS Foundation Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life.	**Confirmed:** the Trust has a Constitution, which was last updated in October 2019. Staff are required to sign the Trust's Code of Conduct. The Board of Directors annually confirms its adherence to the Nolan standards of public life and the Fit and Proper Person Requirements.
A.1.9	The Board should operate a code of conduct that builds on the values of the NHS Foundation Trust and reflect high standards of probity and responsibility.	**Confirmed:** The Trust has a Code of Conduct based on the Trust's values. There are separate codes of conduct for the members of the Board of Directors and Council of Governors. The Board of Directors' Code of Conduct reflects the requirements of the Fit and Proper Persons Test.
A.1.10	The NHS Foundation Trust should arrange appropriate insurance to cover the risk of legal action against its Directors.	**Confirmed:** the Trust is a member of NHS Resolution and is covered by its indemnity scheme. The Trust's NHS Foundation Trust Constitution states that providing Directors act honestly and in good faith, any legal costs

		incurred in the execution of their functions will be met by the Trust.
A.3.1	The Chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A Chief Executive should not go on to be the Chairperson of the same NHS Foundation Trust.	**Confirmed:** The Trust Chair and Chief Executive are compliant with this provision. The Trust's Chair meets the independence criteria.
A.4.1	In consultation with the Council, the Board should appoint one of the independent Directors to be the Senior Independent Director.	**Confirmed:** The Vice Chair is the Senior Independent Director. The current Vice-Chair and Senior Independent Director, Nigel Stevens, took up office on 1 April 2023.
A.4.2	The Chairperson should hold meetings with the Non-Executive Directors.	**Confirmed:** The Trust Chair holds regular meetings with Non-Executive Directors.
A.4.3	Where Directors have concerns that cannot be resolved about the running of the NHS Foundation Trust or a proposed action, they should ensure that their concerns are recorded in the Board minutes.	**Confirmed:** All discussions at the Board of Directors' meetings are contained in the minutes of each meeting.
A.5.1	The Council of Governors should meet sufficiently regularly to discharge its duties.	**Confirmed:** The Council of Governors meets quarterly which accords with other NHS Foundation Trusts. There is provision to hold additional meetings if required.
A.5.2	The Council of Governors should not be so large as to be unwieldy.	**Confirmed:** The size of the Council of Governors is considered to be appropriate and is regularly reviewed.
A.5.4	The roles and responsibilities of the Council of Governors should be set out in a written document.	**Confirmed:** A document setting out the roles and responsibilities of the Council of Governors is available from the Trust's public website and is also set out in the NHS Foundation Trust's Constitution.
A.5.5	The Chairperson is responsible for leadership of both the Board and the Council but the Governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive to their meetings and inviting attendance by other Executives and Non-Executives, as appropriate.	**Confirmed:** Members of the Board of Directors (both Executive and Non-Executive) are in attendance at Council of Governor meetings. Executive and Non-Executive Directors are invited to Governor Working Group meetings.
A.5.6	The Council should establish a policy for engagement with the Board of	**Confirmed:** The Trust has a Board of Directors' and Council of Governors'

	Directors for those circumstances when they have concerns.	engagement policy which sets out the process for governor(s) to raise concerns.
A.5.7	The Council should ensure its interaction and relationship with the Board of Directors is appropriate and effective.	**Confirmed:** The Board of Directors and Council of Governors keep this relationship under review through open discussions at Council of Governor meetings.
A.5.8	The Council should only exercise its power to remove the Chairperson or any Non-Executive Directors after exhausting all means of engagement with the Board.	**Confirmed:** The process for removing the Chair and Non-Executive Directors is set out in the Trust's Constitution. Governors are aware of this provision and of the consequences of exercising this power.
A.5.9	The Council should receive and consider other appropriate information required to enable it to discharge its duties.	**Confirmed:** The Trust is compliant with this provision and provides extensive information to the Council of Governors via regular reports and through the Council's various working groups and at its formal meetings.
B.1.2	At least half the Board, excluding the Chairperson, should comprise Non-Executive Directors determined by the Board to be independent.	**Confirmed:** The Trust is compliant with this provision. All Non-Executives are considered to be independent. Other than the Chair and Chief Executive, the Board consists of six non-executive and four voting executive directors.
B.1.3	No individual should hold, at the same time, positions of Director and governor of any NHS Foundation Trust.	**Confirmed:** The Trust is compliant with this provision, which is incorporated into its Constitution. Directors and governors are aware of this provision.
B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of Executive and Non-Executive Directors.	**Confirmed:** This provision is set out in the Trust's Board of Directors/Council of Governors' Nominations and Remuneration Committees' Terms of Reference.
B.2.2	Directors on the Board of Directors and governors on the Council should meet the "fit and proper" persons test described in the provider licence.	**Confirmed:** The Trust has undertaken appropriate checks to assure itself that every member of the Board of Directors meets the "fit and proper persons" criteria as described in the provider licence. Governors have confirmed that they meet the requirements of the Fit and Proper Persons criteria and the Council of Governors' Nominations and Remuneration Committee Terms of Reference are clear that candidates must meet the criteria.
B.2.3	The Nominations Committee(s) should regularly review the structure, size and composition of the Board and make	**Confirmed:** Both the Board of Directors' and Council of Governors' Nominations and Remuneration Committee's Terms of Reference include this requirement.

	recommendations for changes where appropriate.	
B.2.4	The Chairperson or an Independent Non-Executive Director should chair the Nominations Committee(s).	**Confirmed:** This provision is set out in the Nominations and Remuneration Committee's Terms of Reference. The Trust Chair chairs the committee.
B.2.5	The Governors should agree with the Nominations Committee a clear process for the nomination of a new Chairperson and Non-Executive Directors.	**Confirmed:** This is made explicit in the Terms of Reference for the Council of Governors' Nominations and Remuneration Committee.
B.2.6	Where an NHS Foundation Trust has two nominations committees, the nominations committee responsible for the appointment of Non-Executive Directors should consist of a majority of Governors.	**Confirmed:** The Council of Governors' Nominations and Remuneration Committee comprises a majority of Governors as set out in the Terms of Reference.
B.2.7	When considering the appointment of Non-Executive Directors, the Council should take into account the views of the Board and the Nominations Committee on the qualifications, skills and experience required for each position.	**Confirmed:** The Council of Governors' Nominations and Remuneration Committee's Terms of Reference includes this requirement.
B.2.8	The annual report should describe the process followed by the Council in relation to appointments of the Chairperson and Non-Executive Directors.	**Confirmed:** This is set out in the Directors' Report section of the Annual Report.
B.2.9	An independent external adviser should not be a member of or have a vote on the Nominations Committee(s).	**Confirmed:** This provision is complied with via Trust's Nominations and Remuneration Committees' Terms of Reference.
B.3.3	The Board should not agree to a full-time Executive Director taking on more than one Non-Executive Directorship of an NHS Foundation Trust or another organisation of comparable size and complexity.	**Confirmed:** The Trust is compliant with this provision. This is monitored through the declaration of interests' process.
B.5.1	The Board and the Council of Governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.	**Confirmed:** The Board of Directors and Council of Governors receive high quality information appropriate to their functions at their respective meetings and upon request.
B.5.2	The Board, and in particular Non-Executive Directors, may reasonably	**Confirmed:** The Board of Directors' minutes provide evidence of executive and Non-

	wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the Board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.	Executive Directors' challenge. In addition, the Board Committees provide the opportunity to test systems and processes in more detail and to provide assurance to the Board.
B.5.3	The Board should ensure that Directors, especially Non- Executive Directors, have access to the independent professional advice, at the NHS Foundation Trust's expense, where they judge it necessary to discharge their responsibilities as Directors.	**Confirmed:** The Chief Executive is aware of this provision and will make available independent professional advice as required.
B.5.4	Committees should be provided with sufficient resources to undertake their duties.	**Confirmed:** This is considered as part of the Committees' annual reviews of their effectiveness.
B.6.3	The senior Independent Director should lead the performance evaluation of the Chairperson.	**Confirmed:** The Senior Independent Director leads the performance evaluation of the Trust's Chair.
B.6.4	The Chairperson, with assistance of the Board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for Non-Executive Directors relevant to their duties as Board members.	**Confirmed:** The Board of Directors regularly discusses whether there are any development needs and these are addressed by the Board of Directors' programme of seminars, away days and external training events. The Chair and the Head of Corporate Governance take account of individual NED performance evaluations, as well as feedback from the Directors themselves, in devising development programmes.
B.6.5	Led by the Chairperson, the Council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	**Compliant:** The Chair meets with governors on a one-to-one basis to discuss their performance. The Chair leads the assessment of the collective performance of the Council of Governors annually. Information on discharge of responsibilities is included in the Governors' Annual Report and the Lead Governor also reports on this topic at the Annual Members' Meeting.
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the Council, for the removal from the Council of any Governor who consistently and unjustifiably fails to	**Confirmed:** The Trust's Constitution sets out the criteria and process for removing a Governor.

	attend the meetings of the Council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	
B.8.1	The Remuneration Committee should not agree to an Executive member of the Board leaving the employment of an NHS Foundation Trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the Board first having completed and approved a full risk assessment.	**Confirmed:** The Trust Chair (Chair of the Board of Directors' Nominations and Remuneration Committee) is aware of this requirement.
C.1.2	The Directors should report that the NHS Foundation Trust is a going concern with supporting assumptions or qualifications as necessary.	**Confirmed:** The monthly finance report to the Board of Directors confirms that the Trust is a going concern. A statement confirming the going concern statement is included within this annual report.
C.1.3	At least annually and in a timely manner, the Board should set out clearly its financial, quality and operating objectives for the NHS Foundation Trust and disclose sufficient information, both quantitative and qualitative, of the NHS Foundation Trust's business and operation, including clinical outcome data, to allow members and Governors to evaluate its performance.	**Confirmed:** The Trust's Annual Report is presented to the Annual Members' Meeting and is available from the Trust's website. The Trust presents its annual Operating Plan at the appropriate Public Board Meeting and this is subsequently published on its website. The Trust also publishes its annual Quality Account on its website once this has been approved by the Board and commented on by external stakeholders.
C.1.4	a) The Board of Directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS Foundation Trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing,	**Confirmed:** The Board of Directors is aware of this requirement.

	health care delivery performance or reputation and standing of the NHS Foundation Trust. b) The Board of Directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS Foundation Trust's financial condition; • the performance of its business; and/or the NHS Foundation Trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS Foundation Trust.	
C.3.1	The Board should establish an Audit Committee composed of at least three members who are all independent Non-Executive Directors.	**Confirmed:** The Trust's Audit Committee comprises three independent Non-Executive Directors.
C.3.3	The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors.	**Not applicable:** The external auditors were not re-appointed during 2022/23.
C.3.6	The NHS Foundation Trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS Foundation Trust.	**Confirmed:** The Council of Governors approved the recommendation to appoint Deloitte as the Trust's external auditors for the period from 1 April 2021 to 31 March 2024 at the meeting held in March 2021.
C.3.7	When the Council ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHS Improvement informing it of the reasons behind the decision.	**Confirmed:** The Trust Chair is aware of this requirement.
C.3.8	The Audit Committee should review arrangements that allow staff of the NHS Foundation Trust and other individuals, where relevant, to raise, in confidence, concerns about possible	**Confirmed:** The Audit Committee receives regular reports from the Trust's Counter Fraud Service. The People Committee provides assurance to the Board of Directors on the Trust's Raising Concerns Policy. Sumita

	improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	Hutchison is the Trust non-executive lead on Freedom to Speak Up, and is a member of the Audit and Risk Committee.
D.1.1	Any performance-related elements of the remuneration of Executive Directors should be designed to align their interests with those of patients, service users and taxpayers and to give these Directors keen incentives.	**Confirmed:** The Board of Directors' Nominations and Remuneration Committee was responsible for determining the eligibility for Executive Directors to receive performance-related bonuses after a review of each executive Director's performance. However, this element of Executive Director remuneration was discontinued during 2022/23.
D.1.2	Levels of remuneration for the Chairperson and other Non- Executive Directors should reflect the time commitment and responsibilities of their roles.	**Confirmed:** The Council of Governors' Nominations and Remuneration Committee determine the remuneration of the Chair and other Non-Executive Directors after taking account of the time commitment and responsibilities of their roles. This is periodically reviewed.
D.1.4	The Remuneration Committee should carefully consider what compensation commitments (including pension contributions and all other elements) their Directors' terms of appointments would give rise to in the event of early termination.	**Confirmed:** This will be undertaken if and when required.
D.2.2	The Remuneration Committee should have delegated responsibility for setting remuneration for all Executive Directors, including pension rights and any compensation payments.	**Confirmed:** The Terms of Reference of the Board of Directors' Nominations and Remuneration Committee make it clear that this responsibility rests with the Committee.
D.2.3	The Council should consult external professional advisers to market-test the remuneration levels of the Chairperson and other Non-Executives at least once every three years and when they intend to make a material change to the remuneration of a Non-Executive.	**Confirmed:** The Council of Governors' Nominations and Remuneration Committee takes account of external benchmarking data as part of their work in determining the level of remuneration for the Chair and other Non-Executive Directors. Chair and Non-Executive Director remuneration has changed as a result of more recent benchmarking and in taking account of guidance issued in November 2019 on Chair and non-executive remuneration.
E.1.2	The Board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between	**Confirmed:** The Trust has a Membership development and engagement strategy.

	governors and any local consultative forums.	
E.1.3	The Chairperson should ensure that the views of governors and members are communicated to the Board as a whole.	**Confirmed:** Governors are encouraged to attend Board and Board committee meetings as observers and to raise questions received from or based on comment from their constituencies.
E.2.1	The Board should be clear as to the specific third party bodies in relation to which the NHS Foundation Trust has a duty to co-operate.	**Confirmed:** The Trust meets this requirement. Strong relationships are maintained with principal stakeholders.
E.2.2	The Board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.	**Confirmed:** The Trust meets this requirement. Details are set out in the Directors' report section of this annual report.

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

Across the 2022/23 financial year (and during the 2021/22 financial year), the Trust was placed in segment 2 under the Single Oversight Framework. This segmentation information is the Trust's current position as at 1 April 2023. 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 the Chief Executive's responsibilities as the accounting officer of the Royal United Hospitals Bath NHS Foundation Trust

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 the 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 the 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 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 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 trusts' 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 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 Improvements *NHS Foundation Trust Accounting Officer Memorandum*.

Cara Charles-Barks,

Chief Executive

27 June 2023

Annual governance statement 2022/23

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 the 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 the Royal United Hospitals Bath NHS Foundation Trust for the year ended 31 March 2023 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 Management Board, the Divisional Boards and the Board 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 rating allocated to each risk) are reviewed monthly by the Management Board, which comprises executive directors, divisional senior management and other senior corporate leaders. The Management Board takes on 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 Board of Directors also identifies risks as part of the self-certification documentation submitted to NHS Improvement.

Board Committees

The Board of Directors has established six 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:

<u>Audit and Risk Committee</u>

- 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.

<u>Quality Governance Committee</u>

- 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

This is the newest of the Board Committees and was created as a result of the Trust's acquisition of Sulis Hospital Bath and the consequent establishment of Sulis Hospital Bath Ltd as a wholly owned subsidiary of the RUH. The overall role of the SOC is to 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. One Committee may also recommend that another Committee gives consideration to a matter that has been brought to its attention that would be of relevance to that other committee.

The Trust's most recent external well-led review which was carried out in February 2018 noted that the processes and structures for providing assurance to the Board of Directors were particularly strong, and at the last Care Quality Commission inspection in June 2018, the Trust was assessed as Good under the Well Led domain, with governance processes found to be effective in ensuring that the quality of care and safety of patients are monitored.

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.

Divisional Boards

The three clinical Divisions (Medicine, Surgery, and Family and Specialist Services (FASS)) have each established a Governance Committee, which is responsible for reviewing and managing risks within their respective divisions. There is also a well-established Estates and Facilities Board which has oversight of the various activities undertaken within that division. The Trust has a Quality Board in place which is jointly chaired by the Chief Nurse and the Medical Director, and it acts as the operational group responsible for supporting the management of clinical risk issues. The Health and Safety Committee acts as the operational committee for supporting the management of health and safety risks.

Leadership of the Risk Management Process

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 as follows:

Chief Nurse

- Designated Director with responsibility for the implementation of governance frameworks and risk management.

Director of Finance

- Designated Director with responsibility and accountability for financial risk.

- Designated as Senior Information Risk Officer (SIRO) responsible for maintaining and assuring the framework for managing information governance-related risks.

Chief Medical Officer

- Director Lead for medical risk for the Trust. Also acts as Chief Clinical Information Officer and Caldicott Guardian.

Estates and Facilities: whilst overall responsibility sits with the Chief Executive, there is a Director of Estates and Facilities with designated responsibility for:

- Health and safety and ensuring effective physical and human precautions are in place to control health and safety risks.

The role of the Executive Directors is to ensure that appropriate arrangements and systems are in place to achieve:

- Identification and assessment of risks
- Elimination or reduction of risks to an acceptable level
- Compliance with internal policies and procedures, statutory and external requirements
- Effective management of risks.

These responsibilities are managed 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. This is achieved through risk training programmes and the provision of practical support to divisional teams.

Staff empowerment and risk management training

Risk management training is provided through the induction programme for all new staff. The corporate training programme ensures that all new staff gain an overview of the Trust's risk management systems and processes and understand their responsibilities for reporting incidents. The corporate induction is supplemented by local induction programmes by managers. The Trust's mandatory training programme includes health and safety, manual handling, fire awareness, infection control, safeguarding patients, resuscitation and information governance. In addition, the Head of Risk and Assurance provides tailored training for individual roles and works closely with staff across the Trust to ensure that they understand their responsibilities and accountabilities for managing risk in their areas. The approach is informed by various sources of information, including incident reports, key quality indicator reports, survey feedback and comments, risk analyses and national guidance and best practice.

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 Trust has defined that in most circumstances, an acceptable risk is one which falls in the 'insignificant' (green) category. This covers all areas of business, but is easiest to define and quantify in financial terms, where the Trust is willing to risk the collective loss of budget of up to 0.25% of the total annual budget to achieve the Trust's objectives. The Board of Directors has reviewed the BAF and identified a "target risk rating" for each risk, which represents the level of risk the Trust is willing to accept in relation to that specific issue.

The Board of Directors undertakes a quarterly review and discussion of 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 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 Chief Nurse reports key messages emerging from the Quality Board's deliberations to the Quality Governance Committee to ensure Board visibility of these emerging themes and how they are being disseminated across the organisation.

Incidents are dealt with in accordance with the Incident Reporting and Management Policy and Procedure. An anonymised summary of all new Serious Incidents is included in the Quality Report which is presented at each Board of Directors' meeting and is published on the Trust's website. The Board of Directors also receives a quarterly Incidents, Claims and Inquests report which contains more detailed analysis of trends and learning, and is considered in the private Board of Directors' meeting. The Serious Incident Panel, a sub-group of Trust Quality and Safety Group, has specific responsibility for ensuring that such incidents are appropriately investigated and that learning from them is derived and shared across the Trust.

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 review their respective risks at each meeting and their comments are reported to the Board of Directors, 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 BAF risks are also regularly reviewed at the Board of Directors' Away Days which are held quarterly. The Framework is fully refreshed at the start of each financial year, with the Board holding a workshop to agree on the key areas of focus.

Risks to data security

The Trust manages its risks to data security through a number of different methods. The Director of Finance acts as senior information risk owner (SIRO). The SIRO

chairs an information governance group (IGG) which is responsible for setting the framework for information governance standards in the Trust and ensuring the delivery of action plans to improve compliance. The Trust's Caldicott Guardian role is held by the Medical Director who is a member of the Information Governance Group. Their role is to ensure the protection of patient information, and that this is accessed only to the extent that is necessary.

The Information Governance Group's purpose is to drive the broader information governance agenda and provide the Trust Board with assurance that effective information governance best practice mechanisms are in place across the organisation, including ensuring that the Trust complies with all applicable legal and regulatory requirements in this area.

Risks to data security realised in year, and any information governance incidents that were recorded are detailed under the 'Information Governance' section.

Description of the principal risks facing the Trust

The Trust Management Executive identified the Trust's current top clinical and operational risks at its March 2023 meeting as including:

Ambulance handover delays and delays in providing emergency care:

- In March 2023, the trust lost a total of 2,693 hours in ambulance handovers – meaning that patients were either having to wait in ambulances for long periods and the crews were unable to get to other patients who could have been seriously ill. The main reason for this is the difficulty in finding suitable for patients so that they can be moved out of the ED. During the period in question, the Trust's bed occupancy rate stood at 97% - the highest in the region – caused by a combination of bed closures as a result of infection control issues, and the number of medically fit patients who could not be discharged. Taken together, both factors at times meant that 59% of beds were not available to support flow through the hospital.

  The risk to patients being left untreated for considerable periods in ambulances are clear, and there is also the risk to those patients in emergency situations to whom ambulances cannot reach because they are stuck outside the ED.

  A combination of short and longer term actions are being taken to address this problem. In the short term, the Trust is working with its community and local authority partners to access nursing and care home capacity as well as domiciliary support to enable medically fit patients to be safely discharged, while in the longer term, a number of innovative models, such as direct control of empty nursing homes, involvement in the provision of domiciliary care, and supporting patients remotely in their own homes are being explored and implemented.

- **Referral to treatment:** Like a number of other trusts, many of the Trust's patients have continued to experience significant delays in accessing elective care, such as for hip, knee and other orthopaedic procedures, as well as other types of surgery. As at March 2023, 375 patients had been waiting over 65 weeks, and 25 over 78 weeks. Although both of these figures represent improvements on previous months, many patients continue to wait long periods, with some conditions deteriorating in the meantime.

  The waits in some specialities such as orthopaedics have been caused by the fact that the main orthopaedic ward at the RUH site has had to take on medical patients as a result of recent winter pressures. In other areas like gastroenterology the difficulties have been caused by a shortage of suitably qualified clinical staff across the country.

  Stes being taken to address these risks include the continued use of Sulis Hospital to help clear the backlog of elective work, both for the RUH, but increasingly on behalf of other local NHS providers as well. It should be noted, however, that Sukis is unable to handle some of the more complex cases, and therefore part of the longer term solution must be for more capacity to be developed on the RUH site. Solutions are also being sought with regard to the staffing issues, but steps are also being taken to ensure that theatre and clinic time is utilised as productively as possible.

- **Trust financial position** – The Trust achieved its year-end target to achieve a break even position and even delivered a small surplus. It also delivered its £14.8 million savings plan in full, although only £7.7 million of this was delivered on a recurrent basis. Going forward, into 2023/24, however, the Trust faces an even more challenging savings target, amounting to around £27.5m or 4.8% of total expenditure, and the Trust will also be required to clear its underlying deficit of £44 million.

  A long term financial plan is being developed to return the Trust to a sustainable financial position over 5 years, through a combination of savings, cost reductions and meeting activity targets, but there are risks that the various assumptions that have been made may not materialise as expected. The Trust has invested in additional expertise to support delivery of these programmes, and the Executive Team and the Board will monitor progress closely. The Trust is also working closely and collaboratively with BSW partners, and all the constituent organisations will support each other to try to ensure that services are delivered across the system within the funding available, and that all partners remain viable.

- **Estate backlog maintenance position** – During 2022/23, the Trust's backlog maintenance position (meaning the total amount of capital investment that would be needed to bring an NHS building/asset up to condition B – as good as new) amounted to £60 million, having risen by more than £5 million in one year. The total backlog maintenance (BLM) increases year on year as assets depreciate, and it reduces as the Trust invests in maintenance of new buildings. NHS capital funding is constrained nationally – the national BLM has risen from £4.5 billion in 2004 to £10.2 billion in 2021/22, and now represents almost 92% of the entire annual running costs for the whole of the NHS estate.

  The RUH for its part has only been able to spend an average of £1.9 million annually on BLM over the last 3 years, and in 2023/24 it has only allocated £1.1 million for this purpose. The extent of the RUH's BLM is 27% greater than the national benchmark value, while its total critical infrastructure risk is 33% greater – the Trust is in the highest quartile on both measures.

The rapidly deteriorating backlog maintenance position at the Trust has resulted in several growing risks, such as increased infection prevention and control risk across clinical areas, added fire risks due to damaged fire doors in several areas, and an increased likelihood of theatre air handling units failing. While each of these risks have been assessed, recorded on Datix and control measures are in place for each of these risks, there are limited means for reducing the risk without significant capital investment.

These and other key risks will continue to be managed throughout 2023/24.

Governance

The Board has an established process for assuring itself of the validity of its Corporate Governance Statement required under NHS Foundation Trust Condition 4(8)(b). Appropriate sources of assurance are provided to the Board, thereby allowing it to self-certify compliance with the Statement.

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), regular member newsletters, and the Annual Members' Meeting.

- **Meetings with partner organisations**, including monthly commissioner contract review meetings and other meetings with Clinical Commissioning Groups (including quality and performance meetings and clinical commissioning reference board), Council representatives, voluntary sector and local universities.
- **ICS partners,** including monthly meetings that bring together Chairs, Chief Executives, Finance Directors and other key staff.
- **Staff** – 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 Trust operates an evidence-based approach to the effective and safe deployment of staff to ensure that the right people are in the right place at the right time and with the right skills. It also ensures that in clinical areas sufficient numbers of clinical staff are deployed to ensure that patients receive safe care. This evidence base includes data from benchmarking sources such as the Model Hospital, national guidance from bodies such as NHS England/Improvement and professional regulatory bodies, the professional judgement of senior nurses and medical heads of division as well as the regular reporting and monitoring of outcomes for patients, and the experiences of patients and staff. Regular reports from the Trust's Freedom to Speak Up Guardian also provide insights into issues that may be causing concern among staff.

The Board of Directors receives a monthly quality dashboard providing oversight and assurance on a range of workforce and quality indicators, and also includes details of compliance against the Well Led key lines of enquiry. Aspects of these dashboards, particularly the workforce metrics around statutory and mandatory training, retention, turnover, sickness absence and appraisal compliance are reported to the People Committee for more in-depth scrutiny.

At an operational level there is a daily review of staffing in light of demands due to seasonal changes, acuity and activity. This is a dynamic process and is overseen by senior nursing staff. Where skill mix reviews are conducted they are subject to quality impact assessments. The Trust has well established governance arrangements for the development and implementation of short, medium and long-term workforce planning and strategies.

Workforce planning within the RUH is a significant part of the annual business planning process in which the Trust's clinical and corporate divisions are heavily involved. The development and outputs of the workforce annual planning process is overseen by the Executive Performance Review Process.

The Trust works collaboratively with BSW partner organisations on a range of joint workforce issues and on plans for the implementation locally of the long-term NHS plan.

Compliance with the Care Quality Commission

The Trust is compliant with the registration requirements of the CQC. The Trust was registered with no compliance conditions on 1 April 2010.

The Care Quality Commission conducted an announced inspection of the Trust in June 2018. The inspection report was published on 26 September 2018, giving the Trust an overall rating of 'Good'. A short notice inspection of the Emergency Department was carried out in January 2021. This had no impact on either the Trust's overall ratings or those of the ED itself. The CQC team returned in March 2022 to assess the extent to which their recommendations had been implemented, and were overwhelmingly satisfied with the progress that had been made on the majority of issues.

In August 2022, the Trust received an unannounced inspection of some of its medical wards in relation to concerns that had been raised about the quality and safety of medical care. Following the visit, the CQC issued a Letter of Intent, notifying the Trust of possible enforcement action, under Section 31 of the Health and Social Care Act 2008, due to concerns identified in relation to safeguarding. An improvement plan was put in place following this inspection, and progress in implementing the safeguarding actions from this plan is being reviewed through the Trust Quality and Safety Group and the Quality Governance Committee, with an update to be provided to the Board of Directors in May 2023. The Letter of Intent has been withdrawn.

The Trust has published on its website an up-to-date register of interests for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months, as required by the '*Managing Conflicts of Interest in the NHS'* guidance.

Compliance with NHS pension scheme regulations

As an employer with staff who are 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 to 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.

Compliance with equality, diversity and human rights legislation

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

Compliance with obligations under the Climate Change Act

The Trust has undertaken risk assessments and has a sustainable development management plan in place. These are currently under review to take into account the UK Climate Projections 2018 (UKCP 18) as published in November 2018, ensuring that the Trust meets its obligations under the Climate Change Act and the Adaptation Reporting Requirements.

Review of economy, efficiency and effectiveness and the use of resources

The Board of Directors has received regular reports about the economy, efficiency and effectiveness of the use of resources. The reports provide detail on the financial, clinical and operational performance of the Trust, and they highlight any areas through benchmarking or the traffic light system where there are concerns.

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.

NHS England assigns ratings based on its assessment of the Trust under its Single Oversight framework. The Trust's performance against the Single Oversight Framework targets is reported monthly to the Board. The Trust further obtains assurance of its systems and processes and tests its benchmarking by working with other NHS and external organisations, and also through organisations such as NHS Providers where foundation trusts share good practice.

Information governance

Information governance remains a high priority for the Trust. The Trust has a Caldicott Guardian (Medical Director) and a Senior Information Risk Officer (SIRO), the Deputy Chief Executive and Director of Finance.

All staff are governed by a Code of Confidentiality and access to data held on IT systems is restricted to authorised users. Information governance training is incorporated into a corporate induction programme for all new employees and all staff are required to undertake information governance training annually to national standards as part of the Trust's mandatory training package. Compliance against this requirement is monitored by the Information Governance Team, and regular updates are provided to the Management Board.

The annual information governance self-assessment exercise has taken place using the Information Governance Toolkit provided by Connecting for Health. The Information Governance Toolkit's requirements relate to the following areas:

- Information governance management;

- Confidentiality and Data Protection Assurance;
- Information Security Assurance;
- Clinical Information Assurance;
- Secondary Use Assurance;
- Corporate Information Assurance.

In June 2022, 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 with minor improvement opportunities'. Following the submission that was subsequently made in June 2022, the Trust was assessed as 'Standards Met'.

Between 1 April 2022 and 31 March 2023, the Trust has not had occasion to report any potentially serious information governance incidents to the Information Commissioner's Office (ICO).

Quality Governance Arrangements

The Trust has robust quality governance arrangements in place, which incorporate the monitoring and delivery of the Trust's ambitious patient safety priorities and the quality account priorities. The Board of Directors is responsible for ensuring the quality and safety of services provided by the Trust and has developed a robust quality governance structure and reporting mechanisms to ensure that quality objectives are identified, monitored and, where performance is below the expected standard, action is taken to address the issue.

The Trust Management Executive is the key operational delivery group in the Trust that oversees operational performance against quality indicators and receives regular information on quality and patient safety work. The Trust Quality and Safety Group, which is accountable to TME, has responsibility to formulate the quality improvement strategic direction. The Trust Quality and Safety Group ensures that the Board of Directors, via the Quality Governance Committee, is aware of risks to the quality of care being delivered and plans to mitigate these risks, and poorly performing services and the actions being taken to improve them. In addition the Trust Quality and Safety Group has oversight each month of progress with all the CQUIN schemes.

The Trust's participation in national and regional patient safety initiatives sets the tone for the rest of the organisation and demonstrates that quality improvement is a top priority. The Trust hosts and has a close working relationship with the West of England Academic Health Science Network. The Trust is also a member of NHS Quest, a member network for NHS Foundation Trusts who wish to focus on improving quality and safety.

It is the role of the Quality and Non-Clinical Governance Committees to "test" the Trust's systems and processes in order to assure the Board of Directors that there

are robust systems in place for monitoring quality and safety and ensuring that there are appropriate controls in place to ensure the accuracy of data.

Disclosure on processes to gain assurance in relation to quality and accuracy of elective waiting time data

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.

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.

Capabilities and culture

The Trust has established the Quality Improvement Centre under the leadership of the Chief Nurse which brings together staff responsible for patient safety, quality improvement and assurance, clinical audit, risk management and patient experience to support the delivery of the Quality Strategy throughout the Trust.

Complaints are seen as an opportunity to learn and the Trust is keen to ensure that this remains the focus. The Trust has adopted a more personal approach to resolving concerns which involves meeting with complainants to discuss their concerns as a preferred alternative to or in conjunction with responding in writing.

Systems and processes

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 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.

Data monitoring and reporting on quality

- 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.
- 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.

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 other 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 results of my review of the effectiveness of the system of internal control by the Board of Directors, Audit and Risk Committee, Quality Governance Committee, Non-Clinical Governance Committee and the Management Board. When issues are identified, plans are put in place to address any weaknesses and ensure that any learning is embedded in the organisation. This ensures that the system is subject to continuous improvement.

The Trust's Assurance Framework provides me with evidence of the effectiveness of controls that manage the risks to the organisation achieving its strategic objectives, have been reviewed and are being actively managed. 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 (Audit and Risk, Non-Clinical and Clinical Governance, People and Finance and Performance Committees). The 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.

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 Quality Board 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 Quality Board receives a quarterly progress report on the outcome of the clinical audit programme.

The Audit and Risk 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.

KPMG (appointed in October 2021) are the providers of internal audit for the Trust, and in 2022/23, they completed 10 internal audit reports. The areas the reports covered included:

- Salary payments outside of standard terms and conditions
- Risk Management
- Governance – learning from COVID
- Learning from incidents
- General Ledger controls
- DNAR (ReSPECT Process)
- DSP Toolkit
- Improving NHS Financial Sustainability
- Medicines Management

The Head of Internal Audit's opinion for the period based 1 April 2022 to 31 March 2023 is one of significant assurance with minor improvements required.

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

The processes outlined below are well established and ensure the effectiveness of the systems of internal control and data quality through:

- Board of Directors' review of the Board Assurance Framework, including the risk register and internal audit reports on its effectiveness
- Audit Committee, Finance and Performance, People, Clinical and Non-Clinical Governance Committees' review of the effectiveness of the Trust's systems and processes
- Review of serious incidents and learning by the Operational Governance Committee and internal audit report on its effectiveness
- Review of progress in meeting the Care Quality Commission's essential standards by the Quality Board
- Clinical Audits
- National Patient and Staff Surveys
- Internal audits of effectiveness of systems of internal control
- Internal Audit of Committee Governance and Effectiveness
- Well-Led Framework Governance Self-Assessment

Conclusion

In making its corporate governance statement, the Trust will have assured itself of the validity of the statement through identification of the information and evidence available to support each part of the statement, and testing the robustness of this with the Audit Committee prior to the Board of Directors approving the final statement.

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.

Annual Governance Statement signed

Cara Charles-Barks, Chief Executive (Accounting Officer), 27 June 2023

Accountability report signed

Cara Charles-Barks, Chief Executive (Accounting Officer), 27 June 2023

Deloitte.

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 2023 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 income statement;
- 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 39.

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.

Deloitte.

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 tax, valuations, pensions, IT, forensic and industry 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 resignised in the correct finncial 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.
- accruals recorded at 31 March 2023 and the timing of their recognition at year-end is subject to potential management bias: we tested a sample of accruals to supporting documentation to assess whether the liability had been incurred as at 31 March 2023.

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.

Deloitte.

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.

Our work in respect of the foundation trust's arrangements is not complete at the date of our report on the financial statements. We will report the outcome of our work on the foundation trust's arrangements and include any additional exception reporting in respect of significant weaknesses in our audit completion certificate and our separate Auditor's Annual Report. We are satisfied that the remaining work is unlikely to have a material impact on the financial statements.

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 2023 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.

Delay in certification of completion of the audit

In cases where we have not completed our work to issue a statement on consolidation schedules and, if applicable, our work on VfM at the time of issue of our audit report on the financial statements:
We cannot formally conclude the audit and issue an audit certificate until we have completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the Matters on which we are required to report by

exception – Use of resources section of our report). We are satisfied that our remaining work in these area is unlikely to have a material impact on the financial statements or on our value for money conclusion.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Royal United Hospitals Bath NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Michelle Hopton (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Bristol, United Kingdom
29 June 2023

Royal United Hospitals Bath NHS Foundation Trust – Audit certificate issued subsequent to opinion on financial statements

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements
In our audit report for the year ended 31 March 2023 issued on 29 June 2023 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2023 and of the group's and foundation trust's income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

Foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2023 on 29 June 2023, we had not completed our work on the foundation trust's arrangements, and had nothing to report in respect of this matter as at that date.

Certificate of completion of the audit
In our audit report for the year ended 31 March 2023 issued on 29 June 2023, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources and the work necessary to issue our statement on consolidation schedules. We have now completed our work in these areas.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave our opinion or on our exception reporting on the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

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
25 August 2023

Royal United Hospitals Bath NHS Foundation Trust

Annual accounts for the year ended 31 March 2023

Royal United Hospitals Bath NHS Foundation Trust

These accounts, for the year ended 31 March 2023, 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 **27th June 2023**

Consolidated Statement of Comprehensive Income

For the year ended 31 March 2023

		Group	
		2022/23	2021/22
	Note	£000	£000
Operating income from patient care activities	3	485,743	436,373
Other operating income	4	39,478	46,996
Operating expenses	6, 8	(515,975)	(475,651)
Operating surplus from continuing operations		**9,246**	**7,718**
Finance income	10	1,135	183
Finance expenses	11	(784)	(201)
PDC dividends payable		(7,339)	(6,769)
Net finance costs		**(6,988)**	**(6,787)**
Other gains / (losses)	12	69	(118)
Surplus for the year from continuing operations		**2,327**	**813**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(1,810)	836
Revaluations	18	9,815	2,882
ventures	21	-	56
Other reserve movements		(1)	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value (losses)/gains on financial assets mandated at fair value through OCI	22	(350)	723
Total comprehensive income for the period		**9,981**	**5,310**

Statements of Financial Position

As at 31 March 2023

	Note	Group 31 March 2023 £000	Group 31 March 2022 £000	Trust 31 March 2023 £000	Trust 31 March 2022 £000
Non-current assets					
Intangible assets	14	7,600	8,586	6,626	7,612
Property, plant and equipment	16	288,156	247,728	287,367	246,129
Right of use assets	20	51,167	-	50,332	-
Investments in associates and joint ventures	21	56	56	-	-
Other investments / financial assets	22	6,483	10,157	3,941	3,241
Receivables	26	1,996	2,627	2,327	2,762
Total non-current assets		**355,458**	**269,154**	**350,593**	**259,744**
Current assets					
Inventories	25	7,003	5,791	5,823	4,581
Receivables	26	28,784	12,387	25,724	9,028
Cash and cash equivalents	27	47,106	53,151	41,102	48,542
Total current assets		**82,893**	**71,329**	**72,649**	**62,151**
Current liabilities					
Trade and other payables	28	(70,664)	(55,816)	(66,160)	(52,509)
Borrowings	30	(2,155)	(905)	(1,953)	(846)
Provisions	32	(263)	(170)	(190)	(170)
Other liabilities	29	(2,407)	(6,717)	(810)	(5,221)
Total current liabilities		**(75,489)**	**(63,608)**	**(69,113)**	**(58,746)**
Total assets less current liabilities		**362,862**	**276,875**	**354,129**	**263,149**
Non-current liabilities					
Borrowings	30	(54,502)	(7,008)	(54,315)	(6,661)
Provisions	32	(1,525)	(1,856)	(1,525)	(1,857)
Total non-current liabilities		**(56,027)**	**(8,864)**	**(55,840)**	**(8,518)**
Total assets employed		**306,835**	**268,011**	**298,289**	**254,631**
Financed by					
Public dividend capital	SOCIE	236,187	207,344	236,187	207,344
Revaluation reserve	SOCIE	46,645	39,906	46,645	39,906
Income and expenditure reserve	SOCIE	13,388	7,125	15,457	7,381
Charitable fund reserves	24	10,615	13,636	-	-
Total taxpayers' equity		**306,835**	**268,011**	**298,289**	**254,631**

The notes on pages 154 to 217 form part of these accounts.

Name **Cara Charles-Barks**
Job title **Chief Executive**
Date **27th June 2023**

Statements of Cash Flows

For the Year ended 31 March 2023

	Note	Group 2022/23 £000	Group 2021/22 £000	Trust 2022/23 £000	Trust 2021/22 £000
Cash flows from operating activities					
Operating surplus		9,246	7,718	14,016	7,042
Non-cash income and expense:					
Depreciation and amortisation	6.1	19,267	15,086	16,117	14,775
Net impairments	7	(1,297)	1,162	(1,297)	1,162
Income recognised in respect of capital donations	4	(1,229)	(600)	(4,509)	(1,340)
(Increase) / decrease in receivables and other assets		(16,101)	7,171	(16,261)	8,100
(Increase) / decrease in inventories		(1,212)	(1,555)	(1,337)	(345)
Increase in payables and other liabilities		11,293	15,723	10,337	14,565
Increase / (decrease) in provisions		(253)	223	(332)	224
Movements in charitable fund working capital		432	97	-	-
Other movements in operating cash flows		(139)	(63)	-	-
Net cash flows from operating activities		**20,007**	**44,962**	**16,734**	**44,183**
Cash flows from investing activities					
Interest received		979	27	979	27
Purchase of financial assets / investments		-	-	(290)	(3,651)
Purchase of intangible assets		(1,527)	(2,076)	(1,527)	(1,131)
Sales of intangible assets		-	750	16	750
Purchase of PPE and investment property		(46,786)	(33,492)	(47,068)	(33,177)
Sales of PPE and investment property		104	3	-	3
Receipt of cash donations to purchase assets		1,078	829	4,509	853
Cash inflows from Charitable Fund investing activities		3,384	-		-
Cash from acquisitions / disposals of subsidiaries		-	(789)		-
Net cash flows used in investing activities		**(42,768)**	**(34,748)**	**(43,381)**	**(36,326)**
Cash flows from financing activities					
Public dividend capital received		29,666	22,909	29,667	22,909
Public dividend capital repaid		(823)	-	(823)	-
Movement on loans from DHSC		(313)	(2,967)	(313)	(2,697)
Capital element of lease liability repayments		(3,857)	(456)	(1,560)	(821)
Interest on loans		(133)	(168)	(133)	(157)
Interest element of lease liability repayments		(636)	(44)	(462)	(25)
PDC dividend paid		(7,170)	(6,799)	(7,170)	(6,799)
Cash flows from (used in) other financing activities		(18)	165	(3)	-
Net cash flows from financing activities		**16,716**	**12,640**	**19,203**	**12,410**
Decrease / (increase) in cash and cash equivalents		**(6,045)**	**22,854**	**(7,444)**	**20,267**
Cash and cash equivalents at 1 April - brought forward		**53,151**	**30,297**	**48,542**	**28,275**
Prior period adjustments			-		
Cash and cash equivalents at 1 April - restated		**53,151**	**30,297**	**48,542**	**28,275**
Cash and cash equivalents at 31 March	27	**47,106**	**53,151**	**41,098**	**48,542**

Consolidated Statement of Changes in Equity for the year ended 31 March 2023

Group	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £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**
Other transfers between reserves		-	(1,266)	1,266	-	**-**
Impairments	7	-	(1,810)	-	-	**(1,810)**
Revaluations	18	-	9,815	-	-	**9,815**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	22	-	-	-	(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**

Consolidated Statement of Changes in Equity for the year ended 31 March 2022

Group		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 2021 - brought forward		**184,435**	**37,350**	**6,219**	**11,788**	**239,792**
(Deficit)/Surplus for the year		-	-	(1,051)	1,864	**813**
Impairments	6	-	836	-	-	**836**
Revaluations	18	-	2,882	-	-	**2,882**
Share of comprehensive income from associates and joint ventures	21	-	-	56	-	**56**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	22	-	-	-	723	**723**
Public dividend capital received	cashflow	22,909	-	-	-	**22,909**
Other reserve movements		-	(1,162)	1,901	(739)	**-**
Taxpayers' and others' equity at 31 March 2022		**207,344**	**39,906**	**7,125**	**13,636**	**268,011**

Statement of Changes in Equity for the year ended 31 March 2023

Trust		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**
Other transfers between reserves		-	(1,266)	1,266	**-**
Impairments	6	-	(1,810)	-	**(1,810)**
Revaluations	18	-	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**

Statement of Changes in Equity for the year ended 31 March 2022

Trust		Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward		**184,435**	**37,350**	**6,219**	**228,004**
Surplus/(deficit) for the year		-	-	-	**-**
Impairments	6	-	836	-	**836**
Revaluations	18	-	2,882	-	**2,882**
Public dividend capital received	cashflow	22,909	-	-	**22,909**
Other reserve movements		-	(1,162)	1,162	**-**
Taxpayers' and others' equity at 31 March 2022		**207,344**	**39,906**	**7,381**	**254,631**

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 24.

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 2022/23 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. .

The amounts consolidated are drawn from the published financial statements of the subsidiaries.

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.

The financial risks of the LLP to the Members are limited to nil as per the signed members agreement, and is accounted for in the Trust's accounts using the equity method.

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 income is earned from NHS commissioners in the form of fixed payments to fund the continued delivery of agreed services provided by the Trust

In 2022/23 fixed payments are set at a level assuming the achievement of elective activity targets. 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 differs from the agreed level set in the fixed payments, the variable element either increases or reduces the income earned by the Trust at a rate of 75% of the tariff price. In 2021/22 income earned by the system for elective recovery was distributed between individual entities by local agreement. Income earned from the fund in 2021/22 was accounted for as variable consideration.

In 2022/23 fixed payments were set at a level assuming the achievement of elective activity targets. These payments were anticipated to be accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services, however this variable element was removed in year so no adjustments to the orignal allocation to ICBs and to the Trust was changed.

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. In 2022/23 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria.

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.

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 probability of not receiving the income, which should be included within the provision for impairment of receivables. For 2022-23 this figure is 24.86%. Therefore, 24.86% of accrued ICR revenue has been included 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 grants is used to fund capital expenditure, it is credited to the consolidated 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 employers, 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 and when 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 meeting the 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.

Depreciation

Items of property, plant and equipment are depreciated 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 has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets 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. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	5	62
Dwellings	30	46
Plant & machinery	2	25
Transport equipment	5	5
Information technology	2	7
Furniture & fittings	2	15

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, on a straight line basis unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

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

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg 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, eg 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 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. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	2	-
Licences & trademarks	2	5
Patents	-	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 receives 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, ie, 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.

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).

Expected credit losses are determined by reference to past experience within separate categories of debt, including 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.

Note 1.15 Leases continued

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 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

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.

Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard has been 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 have only been 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 have not been 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 has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been 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 has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line basis.

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 using HM Treasury's discount rates effective from 31 March 2023:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
	Exceeding 40 years	0.66%	1.99%

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 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95).

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 33 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 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 34, 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 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 the this financial period due to accumulated tax losses.

Deferred taxes are provided for on temporary differences and carryforwards. 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 early adopted in 2022/23.

Note 1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 17 Insurance Contracts - Applies to accouting 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.

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

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.

Note 1.29 Key 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:

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 2023. 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.

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.

The RUH Charitable Funds is managed by, and operates separately from, the main services provided by the Trust, and as such is considered a separate segment. Income for the RUH Charitable Funds is made up of donations mainly from individuals and local organisations, the activities of the Charity are focussed to improve the environment in the hospital for staff and patients and support innovative developments not funded by NHS money.

Whilst the RUH Charitable Fund is managed by, and operates separately from, the main services provided by the Trust. The Trust Board receives quarterly performance reports from the Charity.

The Charitable Fund does not own any Property, Plant and Equipment or Intangible assets. The other assets and liabilities of the group are not reported by segment to the Trust Board, rather aggregated as part of the whole organisation to Management Board and the Board of Directors.

The financial position of the Charity is reported within this set of Financial Statements and has been shown in the segmental analysis below.

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

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**

Income and Expenditure analysis by Segment

2021/22	Trust	Sulis	Charity	Adjustments for intracompany eliminations	Total
	£000s	£000s	£000s	£000s	£000s
Operating income	457,054	24,624	2,927	(1,236)	483,369
Operating expenditure	(450,012)	(24,917)	(1,283)	561	(475,651)
Operating surplus /(deficit	**7,042**	**(293)**	**1,644**	**(675)**	**7,718**
Net finance costs	(6,924)	(19)	156	-	(6,787)
Other	(118)	-	-	-	(118)
Surplus/(deficit) for the period	**-**	**(312)**	**1,800**	**(675)**	**813**
Impairments	836	-	-	-	836
Revaluations	2,882	-	-	-	2,882
Share of comprehensive income from associates and joint ventures	56	-	-	-	56
Fair value gains on financial assets mandated at fair value through OCI	-	-	723	-	723
Total comphrensive Income for the period	**3,774**	**(312)**	**2,523**	**(675)**	**5,310**

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**

Balance Sheet analysis by Segment

2021/22

	Trust	Sulis	Charity	Adjustments for intracompany eliminations	Total
	£000s	£000s	£000s	£000s	£000s
Non-Current Assets	**259,743**	**1,600**	**10,157**	**(2,346)**	**269,154**
Current Assets	62,151	6,172	3,683	(677)	**71,329**
Current Liabilities	(58,745)	(5,059)	(204)	400	**(63,608)**
Total assets less liabilities	**263,149**	**2,713**	**13,636**	**(2,623)**	**276,875**
Non-current liabilities	(8,518)	(757)	-	411	**(8,864)**
Total net assets employed	**254,631**	**1,956**	**13,636**	**(2,212)**	**268,011**

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)	2022/23 £000	2021/22 £000
Income from commissioners under API contracts*	392,959	342,666
High cost drugs income from commissioners (excluding pass-through costs)	25,160	1,382
Other NHS clinical income	10,177	24,944
Income from other sources (e.g. local authorities)	1,653	1,350
Private patient income	16,107	12,678
Elective recovery fund	13,186	8,035
Agenda for change pay offer central funding***	10,069	
Additional pension contribution central funding**	12,032	11,253
Other clinical income	4,400	34,065
Total income from activities	**485,743**	**436,373**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2022/23 National tariff payments system documentation.

https://www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/

**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.

**'In March 2023 the government announced an additional pay offer for 2022/23, in addition to the pay award earlier in the year. Additional funding was made available by NHS England for implementing this pay offer for 2022/23 and the income and expenditure has been included in these accounts as guided by the Department of Health and Social Care and NHS England. In May 2023 the government confirmed this offer will be implemented as a further pay award in respect of 2022/23 based on individuals in employment at 31 March 2023.'

Note 3.2 Income from patient care activities (by source)	2022/23 £000	2021/22 £000
Income from patient care activities received from:		
NHS England	104,465	81,517
Clinical commissioning groups	75,067	334,323
Integrated care boards	281,527	-
Other NHS providers	2,570	1,948
NHS other	1,062	640
Local authorities	1,435	1,349
Non-NHS: private patients	16,107	12,678
Non-NHS: overseas patients (chargeable to patient)	142	166
Injury cost recovery scheme	316	44
Non NHS: other	3,052	3,708
Total income from activities	**485,743**	**436,373**
Of which:		
Related to continuing operations	485,743	436,373
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2022/23	2021/22
	£000	£000
Income recognised this year	142	166
Cash payments received in-year	94	101
Amounts added to provision for impairment of receivables	-	111
Amounts written off in-year	1	7

Note 4 Other operating income (Group)

	2022/23			2021/22		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	3,618	-	**3,618**	4,128	-	**4,128**
Education and training	14,913	688	**15,601**	14,487	622	**15,109**
Non-patient care services to other bodies	6,901	-	**6,901**	8,671	-	**8,671**
Reimbursement and top up funding	2,008	-	**2,008**	7,578	-	**7,578**
Income in respect of employee benefits accounted on a gross basis	3,180	-	**3,180**	2,646	-	**2,646**
Receipt of capital grants and donations and peppercorn leases		1,229	**1,229**	-	600	**600**
Charitable and other contributions to expenditure		954	**954**	-	1,677	**1,677**
Revenue from operating leases	-	492	**492**	-	298	**298**
Charitable fund incoming resources	-	1,970	**1,970**	-	2,926	**2,926**
Other income	3,698	(173)	**3,525**	3,363	-	**3,363**
Total other operating income	**34,318**	**5,160**	**39,478**	**40,873**	**6,123**	**46,996**
Of which:						
Related to continuing operations			39,478			46,996
Related to discontinued operations			-			-

Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2022/23	2021/22
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	47	422

Note 4.2 Income from activities arising from commissioner requested services

Under the terms of its provider licence, 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:

	2022/23	2021/22
	£000	£000
Income from services designated as commissioner requested services	485,743	436,373
Income from services not designated as commissioner requested services	44,528	46,996
Total	**530,271**	**483,369**

Note 4.3 Fees and charges (Group)

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from 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.

	2022/23	2021/22
	£000	£000
Income	2,817	2,117
Full cost	(2,317)	(1,766)
Surplus / (deficit)	**500**	**351**

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 Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis. This includes a different maturity analysis of future minimum lease receipts under IAS 17 compared to IFRS 16.

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)

	2022/23	2021/22
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	708	38
Total in-year operating lease income	**708**	**38**

Note 5.2 Future lease receipts (Group)

	31 March 2023
	£000
Future minimum lease receipts due at 31 March 2023:	
- not later than one year	2,348
- later than one year and not later than two years	2,310
- later than two years and not later than three years	2,272
- later than three years and not later than four years	2,204
- later than four years and not later than five years	2,075
- later than five years	2,551
Total	**13,760**

	31 March 2022
	£000
Future minimum lease receipts due at 31 March 2022:	
- not later than one year;	147
- later than one year and not later than five years;	509
- later than five years.	-
Total	**656**

Note 6.1 Operating expenses (Group)

Note 6.1 Operating expenses (Group)

	2022/23	2021/22
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	-	104
Purchase of healthcare from non-NHS and non-DHSC bodies	4,514	3,044
Staff and executive directors costs	333,893	300,396
Remuneration of non-executive directors	144	167
Supplies and services - clinical (excluding drugs costs)	47,098	43,531
Supplies and services - general	8,729	4,376
Drug costs (drugs inventory consumed and purchase of non-inventory drug	53,031	51,531
Consultancy costs	-	236
Establishment	7,462	5,655
Premises	19,768	19,090
Transport (including patient travel)	1,611	862
Depreciation on property, plant and equipment, and right of use assets	16,858	13,041
Amortisation on intangible assets	2,409	2,045
Net impairments	(1,297)	1,162
Movement in credit loss allowance: contract receivables / contract assets	44	311
Increase/(decrease) in other provisions	(31)	(637)
audit services- statutory audit	95	135
other auditor remuneration (external auditor only)	76	64
Internal audit costs	-	59
Clinical negligence	13,638	14,002
Legal fees	105	775
Insurance	771	538
Research and development	3,680	4,033
Education and training	2,078	4,658
Expenditure on low value leases (current year only)	105	-
Operating leases expenditure (comparative only)	-	4,125
Hospitality	115	36
Losses, ex gratia & special payments	55	18
Other NHS charitable fund resources expended	569	546
Other	455	1,748
Total	**515,975**	**475,651**
Of which:		
Related to continuing operations	515,975	475,651
Related to discontinued operations	-	-

Note 6.2 Other auditor remuneration (Group)

	2022/23	2021/22
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any subsidiary of the Trust	76	64
Total	**76**	**64**

Note 6.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1 million (2021/22: £1 million).

Note 7 Impairment of assets (Group)

	2022/23	2021/22
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	-	410
Abandonment of assets in course of construction	-	4,947
Changes in market price	(1,297)	(4,195)
Total net impairments charged to operating surplus / deficit	**(1,297)**	**1,162**
Impairments charged to the revaluation reserve	1,810	(836)
Total net impairments	**513**	**326**

Note 8 Employee benefits (Group)

	2022/23 Total £000	2021/22 Total £000
Salaries and wages	257,548	232,764
Social security costs	26,092	22,470
Apprenticeship levy	1,166	1,269
Employer's contributions to NHS pensions	39,640	36,994
Pension cost - other	99	192
Temporary staff (including agency)	14,192	11,888
NHS charitable funds staff	767	663
Total gross staff costs	**339,504**	**306,240**
Recoveries in respect of seconded staff	-	-
Total staff costs	**339,504**	**306,240**
Of which		
Costs capitalised as part of assets	1,153	1,892

Note 8.1 Retirements due to ill-health (Group)

During 2022/23 there were 3 early retirements from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2022). The estimated additional pension liabilities of these ill-health retirements is £35k (0k in 2021/22).

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 two 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 are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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 2023, is based on valuation data as at 31 March 2022, updated to 31 March 2023 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 results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

Note 10 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2022/23	2021/22
	£000	£000
Interest on bank accounts	979	22
Interest income on finance leases	-	5
NHS charitable fund investment income	156	156
Total finance income	**1,135**	**183**

Note 11 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2022/23	2021/22
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	131	157
Interest on lease obligations	636	44
Total interest expense	**767**	**201**
Unwinding of discount on provisions	15	-
Other finance costs	2	-
Total finance costs	**784**	**201**

Note 12 Other gains / (losses) (Group)

	2022/23	2021/22
	£000	£000
Gains on disposal of assets	88	3
Losses on disposal of assets	(19)	(121)
Total gains / (losses) on disposal of assets	**69**	**(118)**
Total other gains / (losses)	**69**	**(118)**

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 £7.0m (2021/22 £0.0m). The Trust's total comprehensive income for the period was £9.9m.

Note 14 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 - brought forward	**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 - brought forward	**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 14.1 Intangible assets - 2021/22

Group	Software licences	Licences & trademarks	Goodwill	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - as previously stated	**1,757**	**14,320**	**-**	**1,753**	**17,830**
Additions	6	1,802	1,384	79	**3,271**
Impairments	-	-	(410)	(145)	**(555)**
Reclassifications	-	937	-	(937)	**-**
Disposals / derecognition	(88)	-	-	(750)	**(838)**
Valuation / gross cost at 31 March 2022	**1,675**	**17,059**	**974**	**-**	**19,708**
Amortisation at 1 April 2021 - as previously stated	**1,634**	**7,531**	**-**	**-**	**9,165**
Provided during the year	88	1,957	-	-	**2,045**
Disposals / derecognition	(88)	-	-	-	**(88)**
Amortisation at 31 March 2022	**1,634**	**9,488**	**-**	**-**	**11,122**
Net book value at 31 March 2022	**41**	**7,571**	**974**	**-**	**8,586**
Net book value at 1 April 2021	**123**	**6,789**	**-**	**1,753**	**8,665**

Note 14.2 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 - brought forward	**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 - brought forward	**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**

Note 14.3 Intangible assets - 2021/22

Trust	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - as previously stated	**1,757**	**14,320**	**1,753**	**17,830**
Additions	6	1,802	79	**1,887**
Impairments	-	-	(145)	**(145)**
Reclassifications	-	937	(937)	**-**
Disposals / derecognition	(88)	-	(750)	**(838)**
Valuation / gross cost at 31 March 2022	**1,675**	**17,059**	**-**	**18,734**
Amortisation at 1 April 2021 - as previously stated	**1,634**	**7,531**	**-**	**9,165**
Provided during the year	88	1,957	-	**2,045**
Disposals / derecognition	(88)	-	-	**(88)**
Amortisation at 31 March 2022	**1,634**	**9,488**	**-**	**11,122**
Net book value at 31 March 2022	**41**	**7,571**	**-**	**7,612**
Net book value at 1 April 2021	**123**	**6,789**	**1,753**	**8,665**

Note 15 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, as set out below.

	£'000
Goodwill at purchase date	1,384
Less impairment of goodwill at reporting date	- 410
Goodwill at reporting date	**974**

Note 16 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 - brought forward	**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)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	5,400	(66)	-	-	-	-	-	**5,334**
Reclassifications	-	3,965	180	(5,043)	1,678	-	125	8	**913**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
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 - brought forward	**-**	**549**	**-**	**-**	**38,155**	**10**	**11,346**	**998**	**51,058**
IFRS 16 implementation - reclassification to right of use assets	-	-	-	-	(1,841)	-	-	-	**(1,841)**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
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 16.1 Property, plant and equipment - 2021/22

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 2021 - as previously stated	**11,042**	**157,096**	**4,000**	**16,830**	**64,694**	**34**	**15,317**	**1,930**	**270,943**
Additions	-	2,181	27	23,143	4,627	-	1,920	217	**32,115**
Impairments	-	-	-	(4,802)	-	-	-	-	**(4,802)**
Reversals of impairments	1,457	-	-	-	-	-	-	-	**1,457**
Revaluations	-	1,460	140	-	-	-	-	-	**1,600**
Reclassifications	-	6,784	-	(6,784)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(2,378)	(24)	(57)	(68)	**(2,527)**
Valuation/gross cost at 31 March 2022	**12,499**	**167,521**	**4,167**	**28,387**	**66,943**	**10**	**17,180**	**2,079**	**298,786**
Accumulated depreciation at 1 April 2021 - as previously stated	**-**	**466**	**-**	**-**	**34,604**	**34**	**9,407**	**768**	**45,279**
Provided during the year	-	4,813	126	-	5,809	-	1,996	297	**13,041**
Impairments	-	1,097	-	-	-	-	-	-	**1,097**
Reversals of impairments	-	(4,671)	-	-	-	-	-	-	**(4,671)**
Revaluations	-	(1,156)	(126)	-	-	-	-	-	**(1,282)**
Disposals / derecognition	-	-	-	-	(2,258)	(24)	(57)	(67)	**(2,406)**
Accumulated depreciation at 31 March 2022	**-**	**549**	**-**	**-**	**38,155**	**10**	**11,346**	**998**	**51,058**
Net book value at 31 March 2022	**12,499**	**166,972**	**4,167**	**28,387**	**28,788**	**-**	**5,834**	**1,081**	**247,728**
Net book value at 1 April 2021	**11,042**	**156,630**	**4,000**	**16,830**	**30,090**	**-**	**5,910**	**1,162**	**225,664**

Note 16.2 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 16.3 Property, plant and equipment financing - 31 March 2022

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	12,499	160,547	4,167	26,765	24,660	5,830	1,039	**235,507**
Finance leased	-	-	-	-	1,705	-	-	**1,705**
Owned - donated/granted	-	6,425	-	1,622	2,423	4	42	**10,516**
NBV total at 31 March 2022	**12,499**	**166,972**	**4,167**	**28,387**	**28,788**	**5,834**	**1,081**	**247,728**

Note 16.4 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 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 16.5 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 - brought forward	**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 - brought forward	**-**	**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 16.6 Property, plant and equipment - 2021/22

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 2021 - as previously stated	**11,042**	**157,096**	**4,000**	**16,830**	**64,694**	**34**	**15,317**	**1,930**	**270,943**
Additions	-	2,159	27	23,143	3,004	-	1,765	111	**30,209**
Impairments	-	-	-	(4,802)	-	-	-	-	**(4,802)**
Reversals of impairments	1,457	-	-	-	-	-	-	-	**1,457**
Revaluations	-	1,460	140	-	-	-	-	-	**1,600**
Reclassifications	-	6,784	-	(6,784)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(2,378)	(24)	(57)	(68)	**(2,527)**
Valuation/gross cost at 31 March 2022	**12,499**	**167,499**	**4,167**	**28,387**	**65,320**	**10**	**17,025**	**1,973**	**296,880**
Accumulated depreciation at 1 April 2021 - as previously stated	**-**	**466**	**-**	**-**	**34,604**	**34**	**9,407**	**768**	**45,279**
Provided during the year	-	4,811	126	-	5,563	-	1,972	262	**12,734**
Impairments	-	1,097	-	-	-	-	-	-	**1,097**
Reversals of impairments	-	(4,671)	-	-	-	-	-	-	**(4,671)**
Revaluations	-	(1,156)	(126)	-	-	-	-	-	**(1,282)**
Disposals / derecognition	-	-	-	-	(2,258)	(24)	(57)	(67)	**(2,406)**
Accumulated depreciation at 31 March 2022	**-**	**547**	**-**	**-**	**37,909**	**10**	**11,322**	**963**	**50,751**
Net book value at 31 March 2022	**12,499**	**166,952**	**4,167**	**28,387**	**27,411**	**-**	**5,703**	**1,010**	**246,129**
Net book value at 1 April 2021	**11,042**	**156,630**	**4,000**	**16,830**	**30,090**	**-**	**5,910**	**1,162**	**225,664**

Note 16.7 Property, plant and equipment financing - 31 March 2023

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
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 16.8 Property, plant and equipment financing - 31 March 2022

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
Owned - purchased	12,499	160,527	4,167	26,765	23,283	-	5,699	968	**233,908**
Finance leased	-	-	-	-	1,705	-	-	-	**1,705**
Owned - donated / granted	-	6,425	-	1,622	2,423	-	4	42	**10,516**
Total net book value at 31 March 2022	**12,499**	**166,952**	**4,167**	**28,387**	**27,411**	**-**	**5,703**	**1,010**	**246,129**

Note 17 Donations of property, plant and equipment

The Trust received donations from which assets were purchased to the value of £4.5m (£1.3m 2021/22).

The donations were made up as follows:

- £2.8m cash donation from Royal United Hospital Bath Charitable Funds towards the costs of the new Cancer Centre which is under construction, the donation was restricted to the Cancer Centre.
- £1.1m cash donation from MacMillan towards the costs of the WISH centre the donation is restircted to the new Cancer Centre.
- £0.5m from Royal United Hospital Bath Charitable Fund to fund various medical equipment and works to the Breast Unit Ultrasound room.
- £0.1m cash grant from an external organisations towards the purchase of a new medical equipment

Note 18 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 2023. 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 £1.3m, this is a result of the desktop valuation of land, buildings and dwellings as at 31 March 2023 following a valuation carried out by Gerald Eve in line with Trust’s policy.

Note 19 Hertiage 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 20 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
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
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**
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	-	1,841	-	**1,841**	-
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 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 20.1 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
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**
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)**	-
Disposals / derecognition	-	-	-	**-**	-
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 of right of use assets leased from non NHS providers	48,876
Net book value of right of use assets leased from other DHSC group bodies	1,456

Note 20.2 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 .

	Group	Trust
	2022/23	2022/23
	£000	£000
Carrying value at 31 March 2022	**2,086**	**1,680**
IFRS 16 implementation - adjustments for existing operating leases	24,903	1,836
Lease additions	28,916	49,703
Interest charge arising in year	636	462
Early terminations	(903)	(903)
Lease payments (cash outflows)	(4,493)	(2,022)
Carrying value at 31 March 2023	**51,145**	**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 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Income generated from subleasing right of use assets is £464k and is included within revenue from operating leases in note 4.

Note 20.3 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 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 20.4 Maturity analysis of finance lease liabilities at 31 March 2022 (IAS 17 basis)

The following table details the maturity of obligations under leases the Trust previously determined to be finance leases under IAS 17 at 31 March 2022.

	Group	Trust
	31 March 2022	31 March 2022
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	586	513
- later than one year and not later than five years;	1,585	1,206
- later than five years.	-	-
Total gross future lease payments	**2,171**	**1,719**
Finance charges allocated to future periods	(85)	(39)
Net finance lease liabilities at 31 March 2022	**2,086**	**1,680**
of which payable:		
- not later than one year;	554	495
- later than one year and not later than five years;	1,532	1,185
- later than five years.	-	-

Note 20.5 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the Trust previously determined to be operating leases under IAS 17.

	Group	Trust
	2021/22	2021/22
	£000	£000
Operating lease expense		
Minimum lease payments	4,125	1,559
Total	**4,125**	**1,559**

	31 March 2022	31 March 2022
	£000	£000
Future minimum lease payments due:		
- not later than one year;	4,057	1,559
- later than one year and not later than five years;	10,301	458
- later than five years.	4,918	-
Total	**19,276**	**2,017**
Future minimum sublease payments to be received	-	-

Note 20.6 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 1.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	Group 1 April 2022 £000	Trust 1 April 2022 £000
Operating lease commitments under IAS 17 at 31 March 2022	**19,276**	**1,933**
Impact of discounting at the incremental borrowing rate		
IAS 17 operating lease commitment discounted at incremental borrowing rate	**18,312**	**1,836**
Variable lease payments based on an index or rate	6,033	-
Finance lease liabilities under IAS 17 as at 31 March 2022	2,086	1,680
Other adjustments	558	-
Total lease liabilities under IFRS 16 as at 1 April 2022	**26,989**	**3,516**

Note 21 Investments in associates and joint ventures

	Group		Trust	
	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**56**	**-**	**-**	**-**
Share of Other Comprehensive Income	-	56	-	-
Carrying value at 31 March	**56**	**56**	**-**	**-**

Note 22 Other investments / financial assets (non-current)

	Group		Trust	
	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**10,157**	**9,330**	**3,241**	**-**
Transfers by absorption	-	-		
Acquisitions in year	60	104	700	3,241
Movement in fair value through OCI	(350)	723	-	-
Disposals	(3,384)	-	-	-
Carrying value at 31 March	**6,483**	**10,157**	**3,941**	**3,241**

Note 23 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.

The financial risks of the LLP to the Members are limited to nil as per the signed members' agreement, and are accounted for in the Trust's accounts using the equity method.

Note 24 Analysis of charitable fund reserves

	31 March 2023 £000	31 March 2022 £000
Unrestricted funds:		
Unrestricted income funds	2,627	2,548
Restricted funds:		
Other restricted income funds	7,988	11,088
	10,615	**13,636**

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 25 Inventories

	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
Drugs	2,070	722	1,992	660
Consumables	4,842	4,937	3,740	3,789
Energy	91	132	91	132
Total inventories	**7,003**	**5,791**	**5,823**	**4,581**
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £79,314k (2021/22: £60,117k). Write-down of inventories recognised as expenses for the year were £0k (2021/22: £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 2022/23 the Trust received £954k of items purchased by DHSC (2021/22: £1,677k).

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 26 Receivables

	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
Current				
Contract receivables	22,157	9,854	19,638	7,170
Capital receivables	-	-	849	69
Allowance for impaired contract receivables / assets	(1,208)	(1,183)	(1,074)	(1,024)
Deposits and advances	25	23	28	28
Prepayments (non-PFI)	6,909	2,845	5,547	2,368
Finance lease receivables	-	-	113	109
PDC dividend receivable	-	95	-	95
VAT receivable	371	-	371	(4)
Other receivables	249	232	252	217
NHS charitable funds receivables	281	521	-	-
Total current receivables	**28,784**	**12,387**	**25,724**	**9,028**
Non-current				
Contract assets	1,391	1,962	1,392	1,655
Allowance for impaired contract receivables / assets	(285)	(369)	(285)	(369)
Finance lease receivables	-	-	330	442
Other receivables	890	1,034	890	1,034
NHS charitable funds receivables	-	-	-	-
Total non-current receivables	**1,996**	**2,627**	**2,327**	**2,762**
Of which receivable from NHS and DHSC group bodies:				
Current	15,954	6,118	5,327	4,913
Non-current	890	1,034	1,107	1,034

Note 26.1 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 - brought forward	**1,552**	**1,393**
New allowances arising	-	306
Changes in existing allowances	-	(273)
Reversals of allowances	317	(30)
Utilisation of allowances (write offs)	(273)	-
Changes arising following modification of contractual cash flows	(103)	(37)
Allowances as at 31 Mar 2023	**1,493**	**1,359**

Note 26.2 Allowances for credit losses - 2021/22

	Group	Trust
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 Apr 2021 - as previously stated	**1,284**	**1,284**
Changes in existing allowances	503	272
Reversals of allowances	6	6
Utilisation of allowances (write offs)	(198)	(126)
Changes arising following modification of contractual cash flows	(43)	(43)
Allowances as at 31 Mar 2022	**1,552**	**1,393**

Note 27 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	
	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000
At 1 April (restated)	**53,151**	**30,297**	**48,542**	**28,275**
Net change in year	(6,045)	22,854	(7,440)	20,267
At 31 March	**47,106**	**53,151**	**41,102**	**48,542**
Broken down into:				
Cash at commercial banks and in hand	4,480	1,649	4	4
Cash with the Government Banking Service	42,626	51,502	41,098	48,538
Total cash and cash equivalents as in SoFP	**47,106**	**53,151**	**41,102**	**48,542**
Total cash and cash equivalents as in SoCF	**47,106**	**53,151**	**41,102**	**48,542**

Note 27.1 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 2023	31 March 2022
	£000	£000
Bank balances	8	8
Total third party assets	**8**	**8**

Note 28 Trade and other payables

	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
Current				
Trade payables	1,203	2,104	610	1,432
Capital payables	2,908	3,929	2,908	3,929
Accruals	47,206	36,328	45,156	34,918
Social security costs	7,196	5,873	6,987	5,873
VAT payables	-	35	-	91
PDC dividend payable	74	-	74	-
Pension contributions payable	4,002	-	-	-
Other payables	7,748	7,412	10,425	6,266
NHS charitable funds: trade and other payables	327	135	-	-
Total current trade and other payables	**70,664**	**55,816**	**66,160**	**52,509**
Of which payables from NHS and DHSC group bodies:				
Current	3,349	4,858	15,032	5,525
Non-current	-	-	-	-

Note 28.1 Early retirements in NHS payables above

There are no early retirement in the payables stated above

Note 29 Other liabilities

	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
Current				
Deferred income: contract liabilities	2,407	6,717	810	5,221
Total other current liabilities	**2,407**	**6,717**	**810**	**5,221**

Note 30 Borrowings

	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
Current				
Loans from DHSC	349	351	349	351
Lease liabilities*	1,806	554	1,604	495
Total current borrowings	**2,155**	**905**	**1,953**	**846**
Non-current				
Loans from DHSC	5,163	5,476	5,163	5,476
Lease liabilities*	49,339	1,532	49,152	1,185
Total non-current borrowings	**54,502**	**7,008**	**54,315**	**6,661**

* The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 1.15, 20.

Note 31 Reconciliation of liabilities arising from financing activities (Group)

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**

Group - 2021/22	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2021	**8,805**	**2,168**	**10,973**
Prior period adjustment	-	-	**-**
Carrying value at 1 April 2021 - restated	**8,805**	**2,168**	**10,973**
Cash movements:			
Financing cash flows - payments and receipts of principal	(2,967)	(456)	**(3,423)**
Financing cash flows - payments of interest	(168)	(44)	**(212)**
Non-cash movements:			
Additions	-	406	**406**
Application of effective interest rate	157	44	**201**
Other changes	-	(32)	**(32)**
Carrying value at 31 March 2022	**5,827**	**2,086**	**7,913**

Note 31.1 Reconciliation of liabilities arising from lease liabilities

Trust - 2022/23	Loans from DHSC	Finance leases	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	-	49,703	**49,703**
Application of effective interest rate	131	463	**594**
Early terminations	-	(903)	**(903)**
Carrying value at 31 March 2023	**5,511**	**50,757**	**56,268**

Trust - 2021/22	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2021	**8,805**	**2,168**	**10,973**
Cash movements:			
Financing cash flows - payments and receipts of principal	(2,967)	(456)	**(3,423)**
Financing cash flows - payments of interest	(169)	(25)	**(194)**
Non-cash movements:			
Change in effective interest rate	157	25	**182**
Other changes		(32)	**(32)**
Carrying value at 31 March 2022	**5,826**	**1,680**	**7,506**

Note 32 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2022	**904**	**27**	**1,095**	**2,026**
Change in the discount rate	-	-	(783)	**(783)**
Arising during the year	196	73	696	**965**
Utilised during the year	(83)	(53)	(2)	**(138)**
Reversed unused	(315)	-	-	**(315)**
Unwinding of discount	15	-	18	**33**
At 31 March 2023	**717**	**47**	**1,024**	**1,788**
Expected timing of cash flows:				
- not later than one year;	190	-	73	**263**
- later than one year and not later than five years;	-	-	39	**39**
- later than five years.	527	47	912	**1,486**
Total	**717**	**47**	**1,024**	**1,788**

Note 32.1 Provisions for liabilities and charges analysis (Trust)

Trust	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2022	**904**	**27**	**1,095**	**2,026**
IFRS 16 implementation - adjustments for onerous lease provisions	-	-	(783)	**(783)**
Change in the discount rate	196	73	623	**892**
Arising during the year	(83)	(53)	(2)	**(138)**
Utilised during the year	-	-	-	**-**
Reclassified to liabilities held in disposal groups	(315)	-	-	**(315)**
Reversed unused	15	-	18	**33**
Unwinding of discount	-	-	-	**-**
At 31 March 2023	**717**	**47**	**951**	**1,715**
Expected timing of cash flows:				
- not later than one year;	190	-	-	**190**
- later than one year and not later than five years;	-	-	39	**39**
- later than five years.	527	47	912	**1,486**
Total	**717**	**47**	**951**	**1,715**

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.

Note 33 Clinical negligence liabilities

At 31 March 2023, £222,132k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal United Hospitals Bath NHS Foundation Trust (31 March 2022: £318,056k).

Note 34 Contingent assets and liabilities

	Group		Trust	
	31 March 2023	31 March 2022	31 March 2023	31 March 2022
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	11	23	11	23
Gross value of contingent liabilities	**11**	**23**	**11**	**23**
Amounts recoverable against liabilities	-	-		
Net value of contingent liabilities	**11**	**23**	**11**	**23**
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 2022/23 (nil in 2021/22).

Note 35 Contractual capital commitments

	Group		Trust	
	31 March 2023	31 March 2022	31 March 2023	31 March 2022
	£000	£000	£000	£000
Property, plant and equipment	7,849	30,975	7,849	30,975
Intangible assets	23	153	23	153
Total	**7,872**	**31,128**	**7,872**	**31,128**

Note 36 Financial instruments

Note 36.1 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 36.2 Carrying values of financial assets (Group)

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**

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	11,530	-	**11,530**
Cash and cash equivalents	49,989	-	**49,989**
Consolidated NHS Charitable fund financial assets	3,683	10,157	**13,840**
Total at 31 March 2022	**65,202**	**10,157**	**75,359**

Note 36.3 Carrying values of financial assets (Trust)

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**

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	9,234	-	**9,234**
Cash and cash equivalents	48,542	-	**48,542**
Total at 31 March 2022	**57,776**	**-**	**57,776**

Note 36.4 Carrying values of financial liabilities (Group)

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**

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	5,827	**5,827**
Obligations under finance leases	2,086	**2,086**
Trade and other payables excluding non financial liabilities	49,773	**49,773**
Provisions under contract	2,026	**2,026**
Total at 31 March 2022	**59,712**	**59,712**

Note 36.5 Carrying values of financial liabilities (Trust)

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**

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	8,805	**8,805**
Obligations under finance leases	2,168	**2,168**
Trade and other payables excluding non financial liabilities	35,852	**35,852**
Total at 31 March 2022	**46,825**	**46,825**

Note 36.6 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 2023	31 March 2022	31 March 2023	31 March 2022
	£000	£000	£000	£000
In one year or less	69,012	52,978	56,670	49,405
In more than one year but not more than five years	14,708	3,303	1,689	3,303
In more than five years	64,680	4,927	4,515	4,927
Total	**148,400**	**61,208**	**62,874**	**57,635**

Note 37 Losses and special payments

	2022/23		2021/22	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Bad debts and claims abandoned	138	30	3	7
Stores losses and damage to property	-	-	1	-
Total losses	**138**	**30**	**4**	**7**
Special payments				
Compensation under court order or legally binding arbitration award	1	-	-	-
Ex-gratia payments	43	25	25	637
Total special payments	**44**	**25**	**25**	**637**
Total losses and special payments	**182**	**55**	**29**	**644**
Compensation payments received				

Note 38 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 2023, 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

CCGs – all demised on 01/07/2022
NHS Bath and North East Somerset, Swindon and Wiltshire CCG
NHS Somerset CCG
NHS Bristol, North Somerset and South Gloucestershire CCG
NHS Gloucestershire CCG

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 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)

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 2022-23 the Trust received £2.8m from the Charity for the costs of the new Cancer Centre and £0.4m towards the Breast Unit expansion. The audited accounts of the Charitable Funds are available at www.ruh.nhs.uk.

The Trust is an equal partner in Wiltshire Health and Care LLP, the Trust received payment of £0.1m in respect to the provision of Financial Services to the partnership for 2022-23.

On 1st June 2021 the Royal United Hospitals Bath NHS FT acquired Sulis Hospital Bath Ltd. Sulis Hospital is a Private Limited Company offering healthcare and is based at Peasedown St John, just outside of Bath. As part of the Trust's final accounts process Sulis Hospital financial information is consolidated into the Trust's accounts and intracompany transactions are removed.

Note 39 Events after the reporting date

No events after the reporting date have been identified.