Royal United Hospitals Bath
NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation Trust Annual Report and Accounts

1 April 2024 to 31 March 2025

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Contents

Statement from the Chair and Chief Executive

Welcome to our Annual Report and Accounts 2024/25, the second year of our You Matter Strategy. We hope you find the information about our achievements in this report interesting and that you can find out a little about the challenges and opportunities we face at the RUH.

Starting with the national picture it has become very clear in the last 12 months that change is needed to make the NHS we know and love sustainable in the current international and UK situation. The national narrative is of a service which is "on its knees" and "bankrupt".

We do not think this narrative is entirely accurate although the pressures are real and immense. Most of our patients receive a reasonably timely and high-quality service – particularly in maternity. This allows us to focus our attention on the long waiters and highly stressed services such as Emergency Admissions where increased demand is largely driven by our demographics – especially here in the Southwest. Feedback from our patients is that they hugely appreciate the care given to them by our staff who deserve the encouragement and support they receive so generously from our community. We also could not do without all of our amazing volunteers.

One of the changes which many hospitals have adopted to become more sustainable is working together with other in their localities. We have been working with Great Western Hospital Swindon (GWH) and Salisbury Foundation Trust (SFT) since 2018, when the three Trusts formed the Acute Hospital Alliance.

In Summer 2024, each Trust's Board formally agreed to form BSW Hospitals Group, to solidify our commitment to work together, learn and improve and invest together for the benefit of the communities we serve. We remain sovereign organisations with separate Boards but with shared leadership and increasingly pooled budgets and operational plans. (This report covers the RUH only).

The People we Care for.

This year we experienced an increase in both the numbers of patients attending our Emergency Department and the seriousness of their conditions; attendance at our emergency department exceeded over 100,000 for the first time. In consequence average ambulance handover time has increased, and our bed occupancy is consistently above the NHS target of 92%. As well as being unfortunate for patients these factors have consequences for the whole hospital, in particular delay as patients cannot be moved to the right place in good time. We aim to improve the timeliness of all parts of Emergency Care in the coming year.

We also focussed on reducing inpatient length of stay, using day surgery whenever possible – because rapid discharge leads to faster and stronger recovery for patients as well as freeing up resource within the hospital. As a result, we maximise our use of the discharge lounge and have worked to significantly reduce length of stay in Cardiology and Trauma & Orthopaedics wards.

Being able to discharge patients however requires our partners in the community to be able to receive them safely. We have been reducing the numbers of people who are waiting for these services through collaboration with our local partners, including Wiltshire and BaNES Councils plus HCRG – the local community provider, and initiatives such as the community wellbeing hub. Sadly, we often still have up to 100 patients who would really be better outside the hospital than in, so we will continue to work with partners to strengthen our support for patients for the whole of their pathways.

We were proud that we exceeded the national target for elective activity by 15%, which significantly reduced our waiting times for planned procedures and made us one of the best performing hospitals in the Southwest. This work takes place at the Combe Park site as well as at Sulis Hospital where the Regional Orthopaedic Centre is being developed. In 2025/26 we will focus on reducing the number of patients who are waiting over 52 weeks to meet the national target of no more than 1% of the total patients waiting in-year.

Hospitals that are research active deliver better outcomes for patients. The RUH undertakes more research than most hospitals of its size and has had several research successes this year. For example, gaining funding to develop and trial, with the University of Bath, the 'BathMat' an inflatable cushion which aims to make care safer for patients with acute respiratory conditions in intensive care.

The People We work with.

We have breakthrough objectives for all parts of our strategy – the things we can do which we believe will turn us into the hospital we want to be. This year one of these was that we wanted to reduce the number of staff reporting that they experience discrimination at work from their manager. We have seen a gradually improving picture here but still have a way to go. Pleasingly, our work on becoming an anti-racist organisation and reducing violence experienced by our staff has achieved regional recognition.

The People in Our Community

We are more than conscious that our community are not only our patients and staff but also, through their taxes, our funders. In 2024/25 we pledged to make the best use of available resources, demonstrated by the delivery of the financial plan. We did this in collaboration with our system and underpinned by a local Improvement programme.

Thanks to the efforts of our amazing staff, we were able to deliver £32.8m of financial efficiencies. Continuing to make savings of this scale – which is necessary for at least the next 12 months, will put considerable strain on all areas of activity. Behind every clinical service is a non-clinical support service and we are striving to produce genuine productivity improvement, not just slashing costs where it seems easiest to do.

We always want to offer our patients the very best care available, but this presents many new costs which are difficult to manage, in particular for high-cost drugs, which have impacted on our finances heavily during the year. Funding does not keep up with these costs or other inflationary pressures within healthcare.

In Bath our community is also affected by our environmental impact – travel to the Combe Park site, carbon emissions and other waste. We have a comprehensive green plan and the beginning in the year of the decarbonisation of the site with a £21million investment in solar panels and heat pumps will go along way to meeting net zero targets.

No review of the year could pass without mention of a delightful day in September 2024 when HM The Queen officially opened the Dyson Cancer Centre. She met some of the 340 patients the centre sees each day, the teams who work with them – united under one roof and in skilfully designed therapeutic surroundings – and many of the supporters whose generosity made the building not only possible but beautiful and well equipped too. We know it will make a difference to our community for many years to come.

Moving forward

Last year was tough and next year will be tougher but RUH has proved once again that it is resilient, that it remains focussed on care and that its values are at the core of everything we do.

2025/26 looks set to be another very challenging financial year for the RUH. This is because the funding available to the NHS is reducing as additional funding added through the Covid pandemic is withdrawn back to sustainable levels. The new Government is demanding further recovery of key performance standards, such as a 5% improvement in elective patients treated within 18weeks, and shorter ambulance handover waiting times and waiting time in ED.

After accounting for the costs of pay awards NHS England Operational Planning guidance set out an expectation of 1% real terms cost reductions and 4% increases in productivity.

As the Trust has been operating at a deficit and is having deficit support funding withdrawn; and is also experiencing higher levels of growth in demand for its services through ED attendances and elective care referrals and cancer diagnoses this translates into a cost reducing savings programme of 4.7% and an overall productivity of 6.7%.

The Trust Savings Plan for 25/26 is £29.7m. Whilst last year much of the success was from maximising income from the Elective Recovery Fund and enhancing controls, particularly reducing pay costs and almost eliminating the use of premium agency expenditure; the challenge for 25/26 will need to be met through improving productivity and maximising use of core capacity and redesigning clinical and corporate services.

There are 3 key pillars to delivery of this challenge:

1. Integration with partners in BSW Integrated Care System, such as benefits of transformed Adult Community Services on demand for RUH care

2. Closer collaboration with BSW Hospitals group partners, such as benefits of new investment & transformed care models such as Sulis Orthopaedic Centre, Community Diagnostic Centres and new Electronic Patient Record and redesigning Corporate Services

3. Internal Trust Transformation and Improvement Plan have been evolved with 5 key Delivery Groups, which are sponsored by Executive Directors and clinician-led where appropriate:
    a. Urgent & Emergency Care
    b. Elective Theatres
    c. Outpatients
    d. Corporate services
    e. Central Delivery Programme

At the time of writing the full £29.7m has not yet been identified and the Trust has entered a financial turnaround period, with the support of a Recovery Director. Controls and limits of discretionary expenditure are being put in place; whilst the BSW Hospitals Group newly established Joint Committee is developing a medium-term Financial Stability and Recovery Plan.

Everyone Matters, and we Work Together to Make a Difference. We are grateful to everyone who shares the work and provides the support we genuinely value.

Thank you for your interest.

Alison Ryan
Chair

Cara Charles-Barks
Chief Executive

About us

Purpose and activities

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

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

In addition to the most deprived 20% of the population within BaNES (CORE20), the following population groups (PLUS groups) have been identified by the BSW Integrated Care Board (ICB) as groups experiencing poorer than average access and outcomes from healthcare:

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

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 also provided at the hospital as well as from several community birth centres, and the Trust runs outpatient centres across the region.

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

Our core business is the provision of NHS services under contracts mainly to the Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB), and to other local commissioners as well as NHS England specialised service commissioners.

The BSW ICB became a legal entity on 1 July 2022 following the enactment of the Health and Care Act 2022, and it is responsible for bringing together and coordinating the work of local NHS organisations, local authorities, and other partners to improve population health and establish shared strategic priorities. The Trust is a key player within this partnership and is working closely with partners to share and embed best practice and improve the quality of care.

The Trust is divided into a number of clinical and non-clinical divisions: medicine, surgery, family and specialist services, estates, and facilities and corporate.

We provide a service for patients needing emergency and unplanned specialist care, 24 hours a day, every day of the year. From that core, we have 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 (from the Dyson Cancer Centre)
- Cardiac and stroke
- Care for older people, particularly those with dementia
- Higher levels of critical care
- Pulmonary hypertension
- Maternity services
- Rheumatology, pain, and fatigue (from the Royal National Hospital for Rheumatic Diseases (RNHRD) and Brownsword Therapies Centre)
- Specialist orthopaedics (surgery on joints and bones)

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

The RUH, in partnership with local universities and colleges, also plays a major role in education and research.

Integrated Care System and Partnership working

The Trust is part of the Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care System (ICS). The BSW ICB is responsible for bringing together and coordinating the work of local NHS organisations, local authorities, and other partners to improve population health and establish shared strategic priorities.

The Trust is a key player within this partnership and is working closely with partners to share and embed best practice and improve the quality of care, both at system level and locally through the Bath and North East Somerset (BaNES) and Wiltshire Integrated Care Alliances.

More about this can be found here: https://bswtogether.org.uk/blog/bswtogether/hospitals-working-together-across-bsw-leading-innovation/

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

Acute Hospitals Alliance and BSW Hospitals Group in 2024/25

The Boards of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury NHS Foundation Trust agreed to work closely; seeking opportunities to collaborate and share resources. This would be known as the BSW Hospitals Group. It would look at shared posts and how to maximise care for patients and look for savings opportunities. This decision followed years of increasingly close working as part of a provider collaborative called the Acute Hospital Alliance, which in 2023 was selected as the only South West representative to join the first wave of NHS England's new Provider Collaborative Innovators Scheme.

We decided to work together as a group because we want to deliver high quality care for our population. Through working as a group we increase our ability to improve patient care and how we use our resources.

Becoming a group gives us an opportunity to build on the successes we had as an Acute Hospital Alliance, including introducing robotic surgery to our system, developing the Sulis orthopaedic hub and community diagnostics centres, a successful joint business case to purchase a shared Electronic Patient Record, and creating a joint procurement function.

In November 2024 Cara Charles-Barks began her role as Chief Executive of each of the three Trusts, and of the BSW Hospitals Group. Cara has worked in the BSW system for eight years, having been Chief Executive of both Salisbury NHS Foundation Trust and the Royal University Hospital Bath.

The three trusts working together, realising our shared ambition and potential to make the care we provide truly exceptional.

The appointment provides an opportunity to take a more strategic approach, plan further into the future, and ensure we make the best decisions for our population.

The Chief Executive is supported at each Trust by a managing director who will be involved in co-creating and designing the vision and strategy, and leading teams to implement it. The managing directors are responsible for the day-to-day leadership at the Trusts. Interviews for these substantive posts took place in April 2025, and a Managing Director has been selected subject to the approval of the Remuneration Committee. One Non-Executive Director has been appointed in Joy Luxford following Paul Fox's retirement from the Board in June 2025.

Our leadership team will be values-based, and they will role model the behaviours we expect everyone to demonstrate – how we do things is just as important as what we do.

To realise the opportunities and make large-scale transformation we need to get the basics right, with our organisational performance being critical. Getting this right will enable us to build the confidence that we can be truly transformative.

In 2025/26 we plan to appoint a Joint Chair to drive forward the strategic vision of a wider group structure. A joint committee terms of reference have been agreed, and the committee will support the development of new ways of working across all of the Trusts in the BSW group.

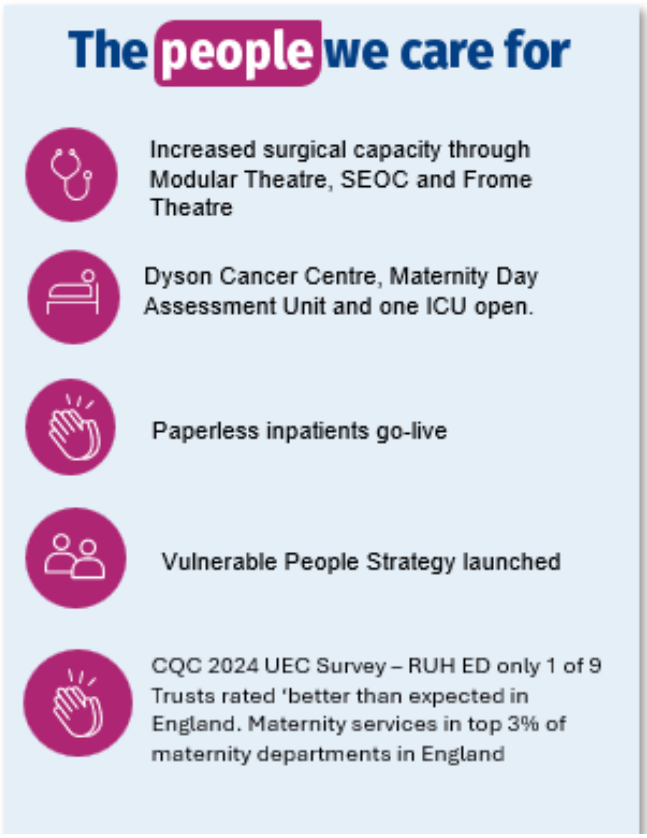
We held our first Board to Board meeting in January 2025, giving Board members from the three Trusts the opportunity to reflect on our collective challenges and opportunities, and agreed to hold further joint development sessions in 2025/26.

We are now focussing on establishing our group operating model and our shared Strategic Planning Framework, which provides clarity on our priorities and is an enabler to transform clinical and corporate services.

Our shared strategic priorities have been agreed under the vision 'Working Together, Learning Together, Improving Together' as:

1. Shared Strategy and Planning
2. Transforming our Model of Care for the population we serve
3. Financial Recovery and Sustainability
4. Group Mobilisation and Development
5. Achieving Digital Maturity

What are we proud of – our achievements



Our strategy

Members of strategy/transformation from across the BSW Hospitals Group meet virtually monthly and for in-person away-days every 4-6 months. At the last away-day, key topics for discussion included: engine room, patient involvement and sustainable QI. The next away-day is planned and will focus on learning and collaboration around breakthrough objectives and corporate projects.

Our Strategy 2023/24 - 2028/29

The strategy is a key document as it sets out the future plans and priorities. In 2023 the Trust launched the "You Matter" strategy, focusing on enhancing patient care, supporting staff, and engaging with the community. This strategy is built on the foundation of our core values: everyone matters, working together, and making a difference.

The strategy outlines several key priorities:

The People we care for: Ensuring that every patient receives timely, high-quality care tailored to their needs.

The People we work with: Creating a supportive and inclusive environment where staff feel valued and empowered.

The People in our community: Strengthening partnerships with local organisations and stakeholders to improve health outcomes for the wider community.

These priorities guide how we work as part of an Integrated Care System. The publication of the strategy was the first step in using these priorities to continuously improve the way the Trust works and focus on the things that are most important to the local community and staff.

As the 'Improving Together' system is embedded across the Trust, work is prioritised through the identification of key short and long-term improvement projects and programmes:

Strategic initiatives

These are Trust-wide, large-scale programmes of work, planned to deliver over 3-5 years. Because they are so crucial to the successful delivery of the strategy, they have dedicated delivery teams working to ensure they are delivered. There are five strategic initiatives:

1. Digitally enabled
2. Delivering our people promise through culture and leadership
3. Clinical transformation
4. Future estates
5. Financial resilience

Breakthrough objectives

These are operational in nature and where improvement efforts are focused for 12-18 months. They are reviewed each year and can evolve when the targets have been achieved for 6+ months.

Breakthrough Objectives 2024/25

In 2024/25 the Trust chose the following four breakthrough objectives:

1. Why not home, why not now? Reducing inpatient non elective length of stay
2. Reducing the number of staff reporting they experience discrimination at work from their manager
3. Making the best use of available resources, demonstrated by the delivery of the financial plan
4. Enabling breakthrough objective, 'we improve together to make a difference' measured by the adoption of the tools, routines and behaviours of Improving Together.

To support delivery of the strategic initiatives and breakthrough objectives the Trust created an 'Engine Room'. The Engine Room is a key component of the Improving Together methodology and is equipped with visual tools, like charts, graphs that display key performance indicators, strategic goals and progress updates.

This visual management helps the Executive and Senior Leadership Team to quickly understand current performance and areas needing attention. The Engine Room ensures;

- Alignment and focus – ensure all levels of the organisation are aligned with the strategic objectives through regular meetings, like Performance Review Meetings, allowing leaders to focus on the most critical priorities.
- Data driven decision making – Decisions in the Engine Room are based on accurate and up to date data.

Trust Priorities 2024/25

NHS
Royal United Hospitals Bath
NHS Foundation Trust

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

Trust goals

- Patient safety incidents (moderate to catastrophic)
- Number of patients over 65 weeks
- Overall patient experience score
- % recommend RUH as a place to work
- % staff say the organisation acts fairly with regard to career progression
- % staff experiencing discrimination at work
- Delivery of breakeven position
- Equity of access to RUH for all
- Carbon emission reduction

Breakthrough goals 24/25

Why not home? Why not now?
Reducing inpatient length of stay top 25% of acute trusts

Discrimination
% of staff reporting they have experienced discrimination at work

Making best use of available resources
Delivery of financial plan

Enabling Breakthrough Goal: We "Improve Together" to make a difference
(measured by the adoption of tools, routines and behaviours of Improving Together via a quarterly maturity assessment)

Trust-wide projects

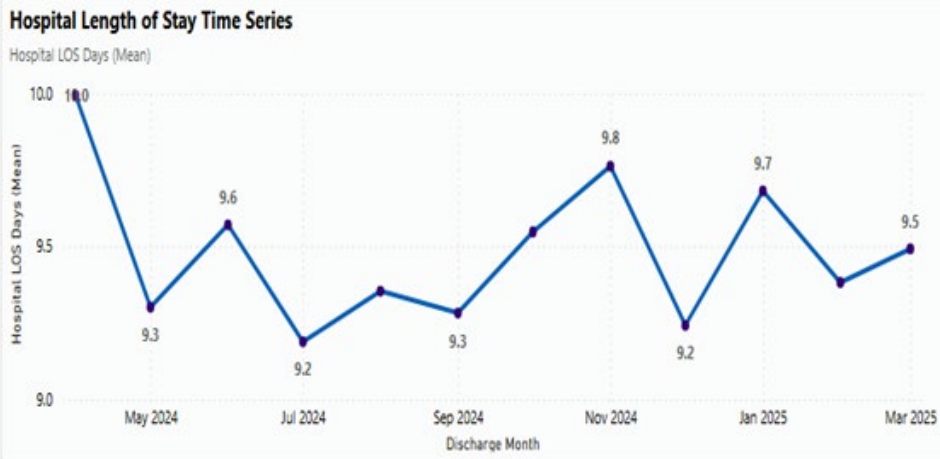
- Atrium Redesign
- Community Diagnostics Centre (Sulis)
- Paperless Inpatients
- Quality Governance
- Sulis Elective Orthopaedic Centre (SEOC)
- Single Intensive Care Unit (ICU)
- Basics Matter
- Compassionate Leadership
- Dignity at Work
- Equality, Diversity & Inclusion (EDI)
- Learning and Development
- Reducing Discrimination
- Staff Engagement and Experience
- Health Inequalities Programme
- Community Services Tender
- Heat Decarbonisation
- Financial Improvement Programme – Clinical productivity, Pay Bill, Income and cost controls
- Single Electronic Patient Record (EPR)

Progress against the 2024/25 breakthrough objectives

Non-Elective Length of Stay - This project focused on improving in-hospital flow and discharge processes to reduce the length of stay (LOS). This included deploying and educating staff on new tools, standard operating procedures (SOPs), and policies.

Intensive one-on-one training was provided across all wards, supported by the UEC improvement team until November 2024. By March 2025, the Trust had restarted the revised UEC Improvement Programme and ensured timely and accurate discharge referrals. Key metrics were manually reported and met, and initiatives like whiteboard standardisation and afternoon huddles were embedded to reduce discharge delays.

The Discharge Lounge saw increased activity, and significant reductions in LOS were achieved in Cardiology and Trauma & Orthopaedics wards. Whilst an overall reduction in non-elective length of stay was not achieved, there have been significant improvements at ward level.



Reducing Discrimination

The organisation continues to see a gradually improving picture of reducing bullying and harassment from managers, colleagues and members of the public. Colleagues saying they have experienced discrimination has remained relatively static, which may be the result of increased awareness of, and reduced tolerance for, discriminatory behaviour as a result of our insights work and the introduction of psychologically safe reporting platforms (such as Report+Support).

Over the last year we have seen a 30% expansion in the membership of our six staff networks and our two specialist support groups, a 150% increase in the number of inclusion champions, and a full, diverse calendar of well-attended recognition events.

Our work on anti-racism and violence prevention / reduction has achieved regional recognition, and ongoing work will focus on consolidating and embedding improvements in practice to achieve more profound impacts. Routes to Success, our positive action programme, has recently launched its second cohort and our Independent Equality Advisors will begin their work on recruitment panels in June 2025.

Our 2024/25 focus was on improving experiences for people with disabilities and long-term conditions, which has included commissioning an internal estates accessibility audit, making significant improvements to our workplace adjustments process, amending our attendance / sickness support infrastructure and designing a new support package and policy for colleagues working with cancer.

Delivery of financial plan

The Trust breakthrough objective was delivery of the financial plan, and this was underpinned by a requirement for a Savings programme of £36m.

The Trust ended the year with a deficit of £4.2m. This deficit was in line with financial forecast agreed with NHS England.

In reaching this position the Trust delivered £32.8m of savings through its Improvement Programme. This was 89.5% of target and a far higher level than achieved in previous years.

The main contributors were £17.3m pay savings (total workforce numbers decreased by 2.8% across the year, but remain 16% higher than pre-pandemic levels) and £10.9m of Elective income (with a 57% margin of Elective Recovery Fund and Elective income 133% of pre-pandemic levels).

Trust productivity (cost changes compared to activity changes) has increased by 3% compared to last year. The Trust was also able to invest £64.7m in Capital projects. BSW ICS, including RUH, delivered a breakeven financial position:

- RUH - £4.2m adv
- GWH - £1.4m fav
- SFT - £5.5m adv
- ICB - £8.4m fav

However, to achieve this position £45m of NHSE deficit support funding was allocated. In 2024/25, RUH received £10.1m. As well as the shortfall on savings delivery, the key reason the underlying position was off track were overspends on non-pay budgets.

The removal of deficit support funding and also the NHS national efficiency requirement of 2% means that the Trust needs to sustain all of these savings, and also deliver an additional £29.7m savings in 25/26.

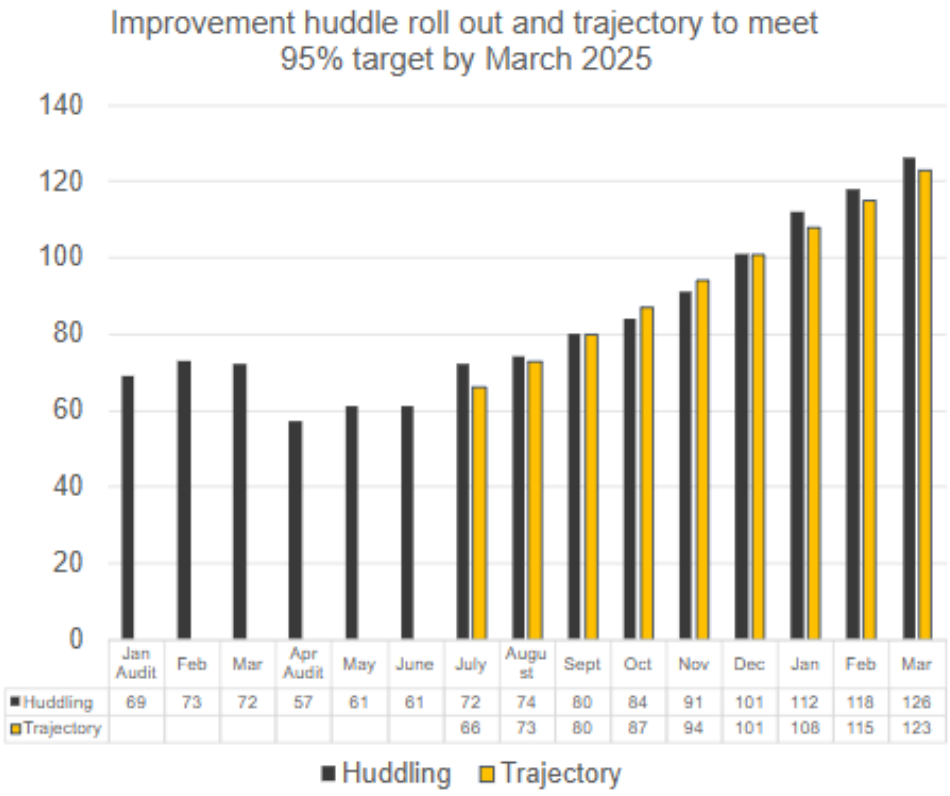
Embedding Improving Together

The Trust achieved its target of 95% of teams running regular improvement huddles, with 72 teams using performance boards and A3 problem-solving. Over 2,500 improvement tickets were implemented, and five teams received Gold ward accreditation. In the 2024 staff survey, the Trust reported several achievements: notably, 75% of staff felt able to make suggestions for departmental improvements, 5% above the national average, and 73% felt they had shared objectives.

Additionally, 6.7/10 staff felt their voice counted, also above the national average. The application of A3 thinking to the 2024/25 breakthrough objectives resulted in £26.4 million in savings, a 1% reduction in staff experiencing discrimination from managers, and a 2.2-day reduction in Cardiology length of stay. Five teams, supported by the Centre for Sustainable Healthcare and the Coach House, identified a £50k reduction in CO2 and £41,000 in cost savings.

The impact of Improvement Huddles:

Achievements – empowering staff to make change in their areas
These tools and routines established at the frontline are having a positive impact on the culture of continuous improvement as detailed in the soft benefits in the following two slides.



"The improvement huddle creates a calmer environment for creating change. Ideas can be written on the tickets, discussed with the team and actioned together"

"I believe Improving Together has added great value to our team since we have gone live with the boards. We have engagement from all staff which is improving week-on-week.

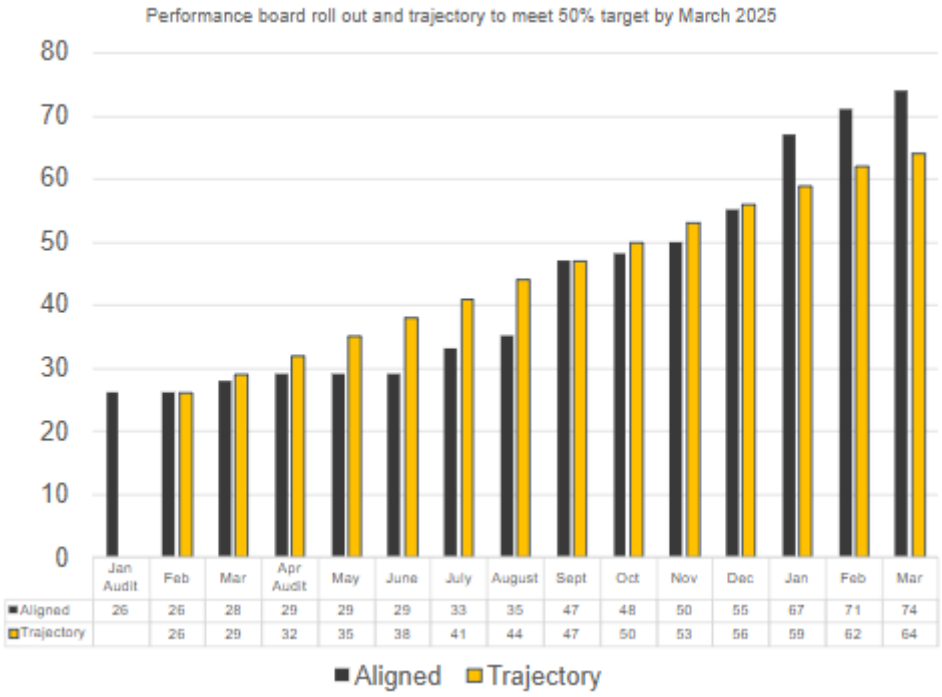
"Improvements to our service are progressing much quicker with the boards in place. The feedback I have had from staff has been positive as they can see that actions are being implemented and their ideas are being listened to"

"Holding the huddles regularly has now given others the confidence to lead the huddles and take on responsibilities or offering their time to find solutions to the problems and raising everyone's awareness"

The impact of Performance Boards:

Achievements – aligning teams to strategic priorities

The visibility of team priorities on the Performance Board helps staff focus their improvementefforts on the areas that are most important.



"Using Improving Together methodology helps us be clear on what our priorities are, how to communicate these with both the team and the wider trust in simple and easy language.

"Using visual tools means it's easy for others to understand our problems and what help we need to support improvements."

"The Directorates in our division are very different, but by using Improving Together techniques to structure meetings and record performance, we can be sure we are all linked to Trust goals and priorities"

Delivery of Trust-wide Projects

In 24/25, a number of Trustwide and/or large scale projects have been progressed or delivered to support overall delivery of our annual priorities and longer term strategy. This includes:

The people we care for

- **Dyson Cancer Centre** which was opened in April 2024
- **Website redevelopment-** working with Salisbury Foundation Trust and Great Wester Hospitals Trust to build a new public-facing website. This project received sign off in Q1 24/25 and has been progressing well over the year with plans to launch the new website in May 25.

- **Quality Governance-** four workstreams established: Governance Architecture, Divisional Governance, Risk Management and Quality Data. Key deliverables in 24/25 include process mapping of our future states and creation of a business case to support changes; updates to risk recording and training; and review of committees' terms of references
- **Vulnerable People Strategy-** signed off and launched in Q4 24/25
- **Paperless Inpatients-** went live in Q2 and continues in benefits realisation phase
- **Atrium redesign-** small improvements completed (e.g. new cafe chairs and information screen); group set up to oversee further development plans
- **One ICU-** opened and fully operational
- **Maternity Day Assessment Unit refurbishment-** opened
- **Community Diagnostics Centre at Sulis-** opened March 2025
- **Sulis Elective Orthopaedic Centre-** works continued through 24/25, due to be opened in May 25
- **Increased surgical capacity-** through modular theatre, SEOC and Frome Theatre
- **Outpatient Transformation**- Key themes identified: demand and referral management, scheduling, specialty-specific plans, AI coding; deep dives for scheduling complete for each specialty
- **UEC Programme-** Relaunched and expanded; 6 workstreams (demand management, non-admitted pathways, admitted pathways, specialty pathways, ward processes, and discharge)

The people we work with

- **Calderdale training-** A systematic approach to workforce review and transformation. 9 additional Calderdale Facilitators trained in May 2024.
- **Stress and burnout pilot -** completed with roll out to support staff health and wellbeing
- **Violence Prevention and Reduction (VPR) Programme-** Policy launched in August 2024, over 125 staff members across 10 wards trained
- **Halo Self-Service Portal-** Launched in February 2025 to deliver more efficient processes for responding to staff queries
- **Staff gym-** market engagement underway to explore option of external provider running the gym
- **Equality, Diversity and Inclusion**
    - New EDI newsletter published
    - Celebrated Spring Inclusion Week in March 2025
    - Executive engagement sessions with Enable network
    - Neurodiversity Support Group launched
- **Corporate Service Review-** Work commenced to review corporate functions to identify potential improved and more efficient ways of working

The people in our community

- **Health Inequalities Programme**- New digital inclusion service for patients, continued funding for Health Inequalities Lead confirmed for 2025/26, smoking cessation team now covering 40% of wards
- **Sustainability Green Team Competition-** Competition complete with five beneficial projects showcased
- **Single Electronic Patient Record (EPR)-** Implementation plan underway
- **RUH Community Day-** Community Day held in September 2024; to continue as an annual event
- **Heat decarbonisation-** project commenced to help achieve Carbon Net Zero by 2030
- **Anchor Plan-** Linked in with Future Ambitions Board subgroups, work underway within Creativity and Innovation and Good Work, continued partnership activities with local academic institutions
- **Community Site Review-** Underway to look at opportunities to maximise use of community sites
- **AI Programme-** working together with Salisbury and Swindon to support safe and effective use of AI across corporate and clinical functions

Performance Analysis 2024/25

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

Introduction

2024/25 has been a challenging year for the organisation, but there have been some real successes. Elective recovery has been a key priority and the RUH has been successful in increasing activity levels to manage ongoing demand and improve on last year's performance. The Trust has also delivered good performance against the core cancer standards, especially for the 28-day Faster Diagnosis Standard which has increased by 4% from 2023/24. In the year ahead, the RUH will continue to focus on improving waiting times for elective care, including cancer and diagnostic care.

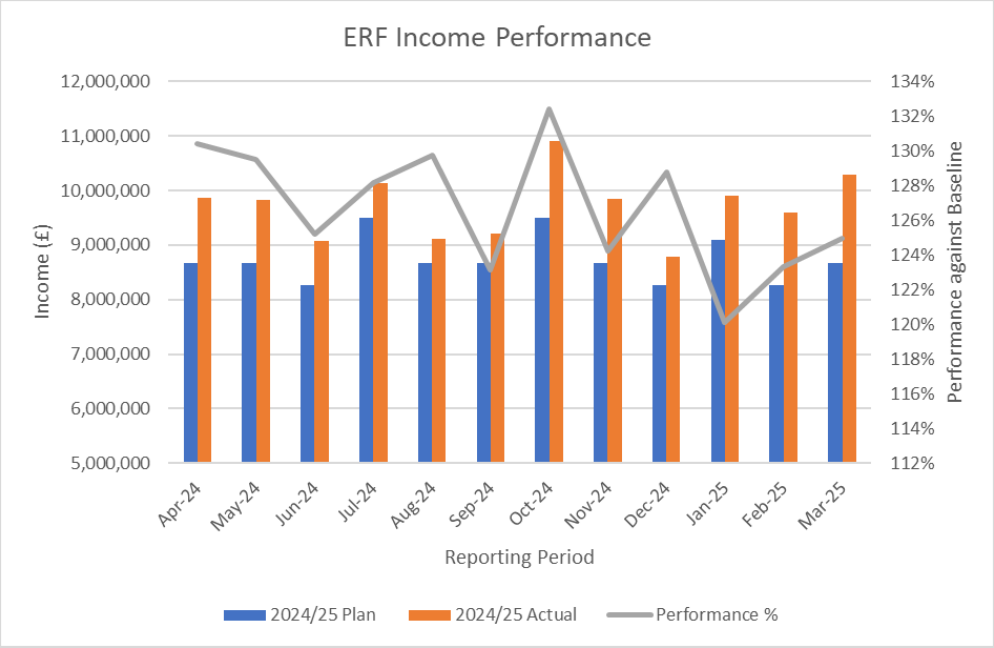
Alongside the rest of the NHS, the RUH has seen significant challenges in delivering the 4-hour Emergency Department (ED) performance target, with the number of patients attending the ED in 2024/25 exceeding 100k for the first time. The average ambulance handover time, (that is the time it takes for a patient at ED who arrived by ambulance at ED to be handed over to the care of ED staff) has increased to an average of 76.3 minutes in 2024/25 (against the national standard of 15 minutes), and bed occupancy is consistently above the NHS target of 92%. Improving handover times and flow out of the ED remains a significant ongoing priority to further resolve in 2025/26.

The main risks facing the Trust throughout the year related to increasing demand for both emergency and planned care, workforce supply, finance and estates (more information on risks can be seen in the Annual Governance Statement). The Trust also noted risks, as identified through its internal audit programme, relating to digital capabilities, industrial action and patient experience. The risks and internal audit responses are monitored by the Board and its Committees to ensure that appropriate and timely action is taken to mitigate the risks occurring and to address any control issues identified.

Elective Care

Elective recovery remains a priority with a focus on improving our operational performance and reducing waiting lists. The RUH has been successful in increasing activity levels to manage ongoing demand and see the patients waiting the longest for treatment. The Trust delivered 128% of 2019/20 income and exceeded the 2024/2025 plan by 11%. This is a significant increase, driven by enhanced productivity in theatres and outpatients, clinical administration booking ax`xnd more accurate clinical coding of patients seen.

The below graph shows the Trust performance over the year to deliver 128% across the whole year against the nationally set baseline during 2024/25, delivering £11.6m additional income over plan.



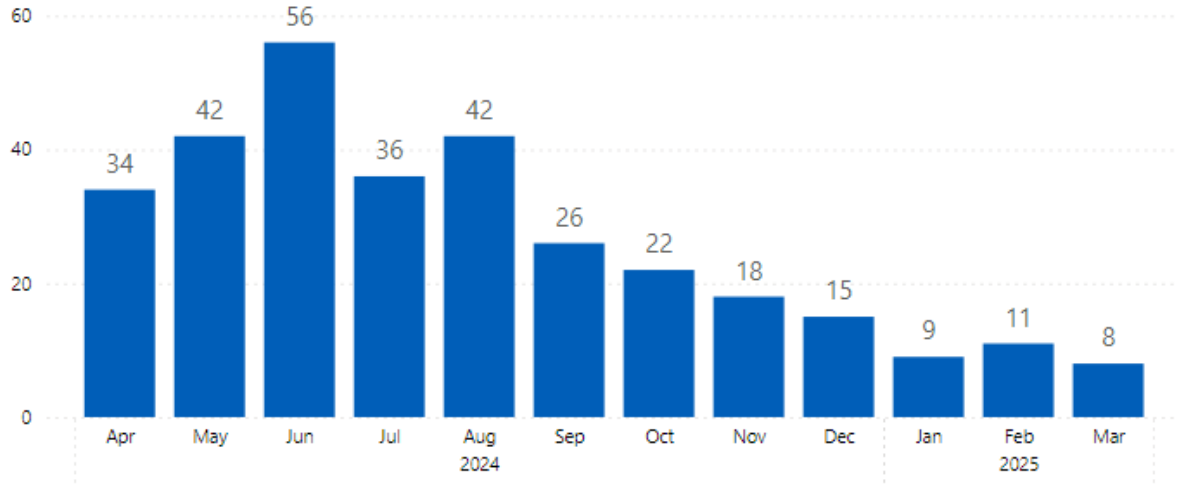
Elective waiting times and activity

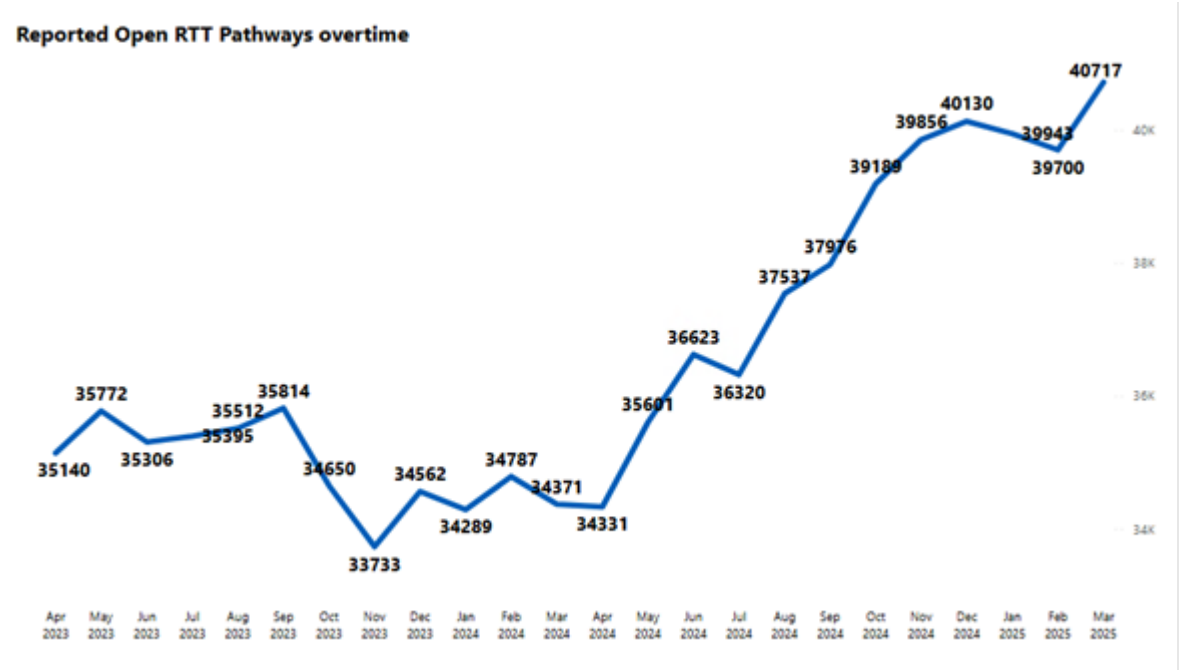
The RUH continues to focus on reducing the length of time patients are waiting for treatment. During 2024/25 the Trust has been successful in treating patients who have been waiting for over 65 weeks for their care except for those patients choosing to delay their treatment and national challenges for patients waiting for Corneal Transplants. Despite growth in our overall waiting list, we have delivered a strong performance in this area.

The Trust is now focused on reducing the number of patients who are waiting over 52 weeks to meet the national target of no more than 1% of the total patients waiting at the end of March 2026. This is together with a 5% increase in referral to treatment (RTT) performance as of November 2024 which gives us a target of 67.7% by the end of March 2026.

The graphs below demonstrate the decrease in patients waiting over 65 weeks but also illustrate that despite delivering more activity than in previous years, the Trust has more patients waiting, further to an increase in referral growth.

RTT Incompletes >65 Weeks - All Ages





Infection, Prevention and Control

There were 103 Trust apportioned cases of C. difficile during 2024/25. This was 28 cases over the threshold set by NHSE. This equates to a 32.1% increase in cases compared to the last year. UKHSA have launched a national incident response to further investigate the rising cases, which appear to have multiple, yet unidentified causes related to both microbiological and epidemiological factors.

The emergence of new strains, especially ribotype 955, underscores the critical need for effective Standard Infection Prevention and Control Precautions. These infections have a significant impact on the Trust and the pressure on side room occupancy.

Cancer

During 2024/25 the RUH demonstrated a significant and sustained improvement in performance against the 28-day Faster Diagnosis Standard (FDS), however, Q1 and Q2 performance was very challenged which resulted in the Trust being placed into NHSE Tier 2 for performance oversight.

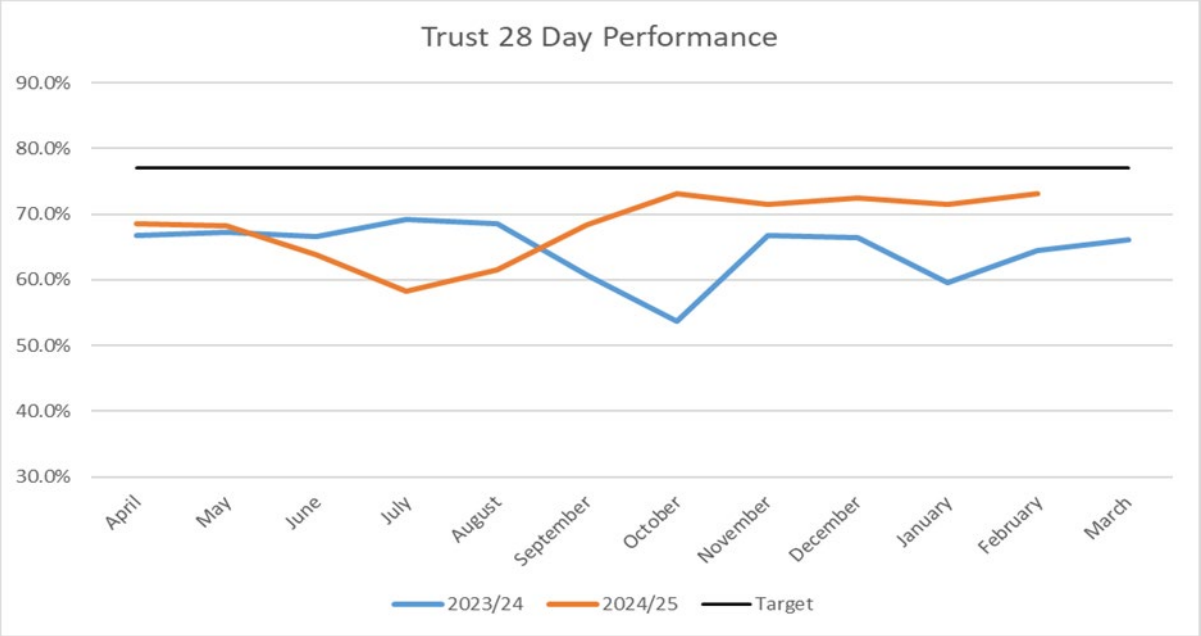
In the key tumour sites of Breast, Colorectal, Skin, Upper GI and Urology performance was impacted by increasing waiting times for outpatient appointments, imaging, endoscopy, prostate biopsies and histology due to a combination of increased demand and reduced capacity due to staff shortages.

There was sustained improvement in performance from September 2024 onwards, with the RUH achieving the Tier 2 exit criteria in Q3, with three consecutive months of performance above 70%. The Tier 2 exit criteria were then increased from January 2025 to 72.5%.

In January the Trust maintained performance above 70%, achieving 71.3%. In February the Trust achieved above the new criteria, with performance of 73.4%. Key improvement initiatives have been implemented including provision of investigations at Sulis, implementation of a new endoscopy reporting system, and the recent implementation of Breast and Haematology one-stop clinics.

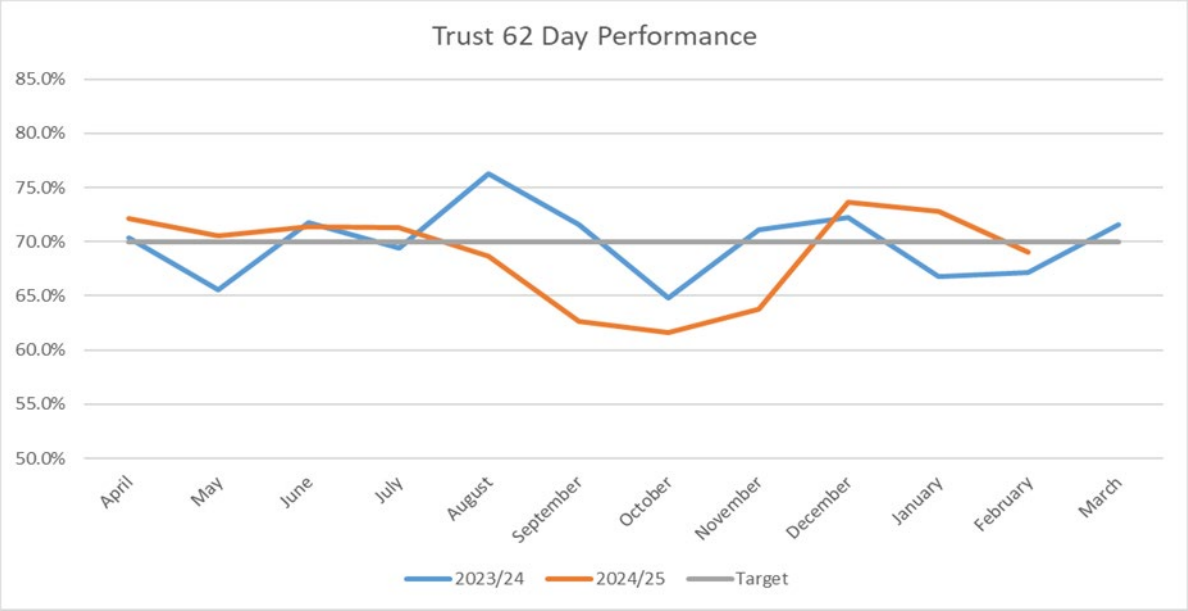
It has also been necessary for the Trust to increase capacity through additional weekend activity, insourcing services and locum consultants to manage the increasing demand and short-term deficits in substantive capacity.

Overall, in 2024/25 68.8% of patients received their diagnosis within 28 days of referral against a target of 77%. This was an increase of 4% from 2023/24.



Against the 62-day combined standard the RUH has delivered good performance in 2024/25, with 69.3% of patients commencing treatment within 62 days of referral, against a target of 70%. This is a slight decrease of 0.4% against 2023/24 as overall demand increased by 18% during this time.

The biggest challenge for the RUH came over the autumn with the Breast, Skin and Urology services coming under most pressure due to staff shortages and increasing demand. Colorectal also remained challenged throughout the year due to waiting times during the diagnostic phase of the pathway, although their cumulative performance improved by 10%.

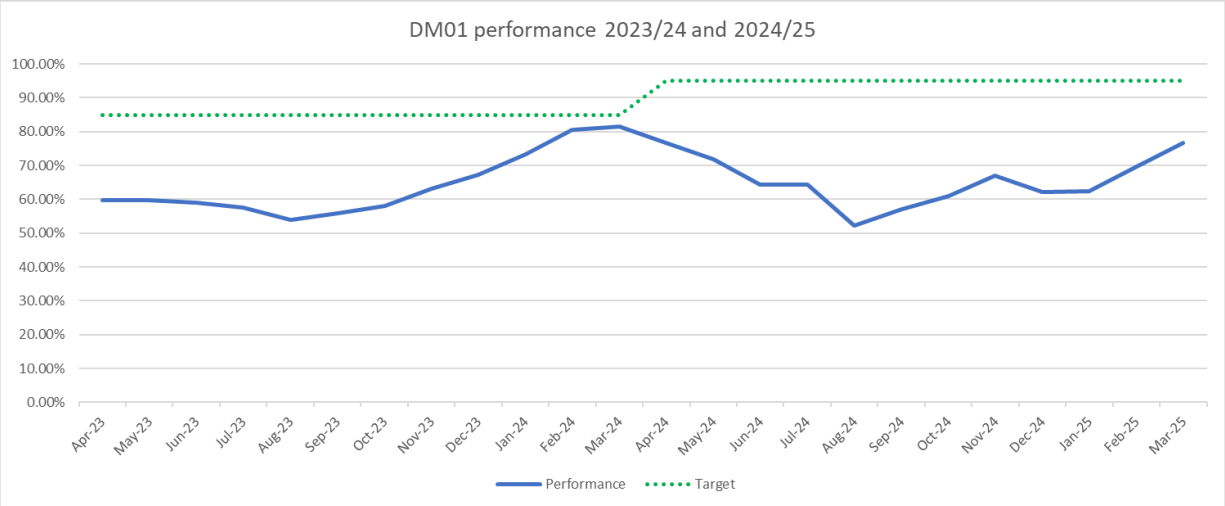


In 2025/26 the national standards are increasing to 80% for 28 Day FDS (previously 77%) and 75% for 62 Day Combined (previously 70%). The Trust expects to improve against the national cancer standards with improvement trajectories in place for all tumour sites to deliver the Trust target.

With an expected average 6% growth in demand across cancer pathways, a combination of pathway transformation and additional Cancer Alliance funded capacity will be required to meet the trajectories. Key areas of pathway transformation for 2025/26 include a new pathway for iron deficient patients referred on the Colorectal and Upper GI pathways, and a tele-dermatology service for Skin cancer patients which is due to go-live in May 2025.

Diagnostics

The national operational standard for diagnostics (DM01) is that 99% of patients should receive their diagnostics test within 6 weeks. This target was adjusted to reflect the challenges with waiting lists/backlogs and was set at 85% compliance by end of 2023/24, and 95% compliance by end of 2024/25.



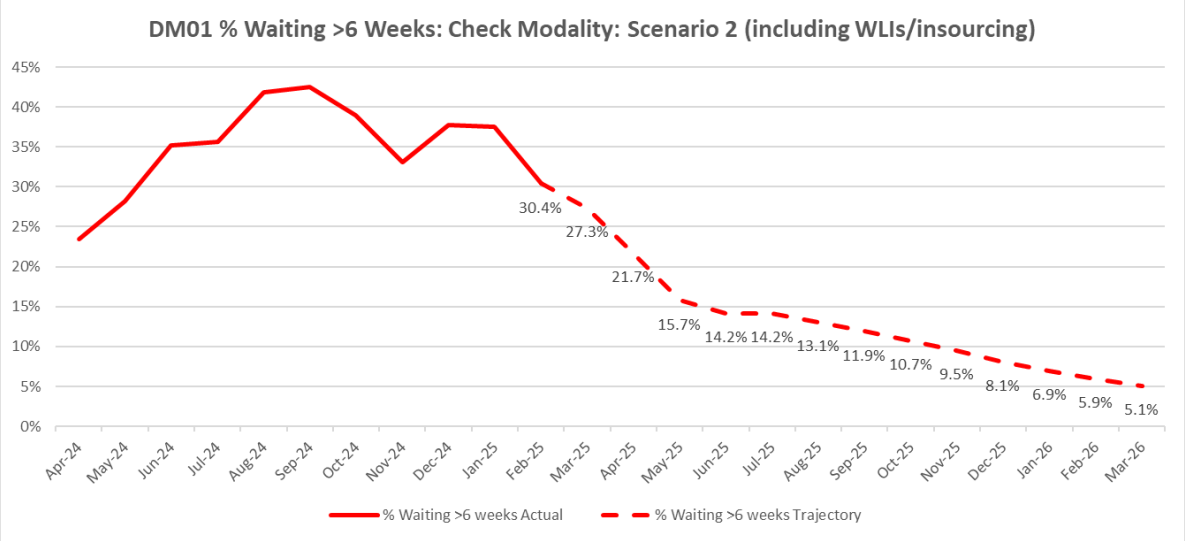
In 2024/25, despite delivering planned activity levels for most modalities, an increased demand for urgent and suspected cancer above original trajectory led to a worsening DM01 performance in the first half of the year. This impacted the routine backlog as more capacity was directed at the more clinically urgent referrals, increasing waiting times for DM01 diagnostics.

Since October 2024, additional recovery actions have been in place to support DM01 performance improvement, which include resuming of waiting list initiatives (WLIs), Ultrasound (USS) insourcing and increased Community Diagnostic Centre (CDC) capacity. This has led to an improvement in trajectory, despite additional staffing and demand challenges in December 2024 and January 2025. Currently, DM01 performance for March 2025 is forecasted to be 76.64% against the 95% target.

Despite the current underperformance, the RUH was able to achieve a significant increase in diagnostic activity delivered (+1000 tests per month in Q4 when compared with Q1), supported through additional activity initiatives, the partnership with Sulis CDC and improved productivity in several areas.

For 2025/26, DM01 performance is expected to continue to improve following the continuation of additional activity schemes from 2024/25 into the new financial year. These include maintaining WLIs for key modalities, insourcing (USS), utilising all CDC capacity made available and productivity improvements, such as the MRI acceleration software.

Overall, DM01 is expected to achieve 94.9% compliance (or 5.1% breaches) against a 95% target by March 26 (see graph below). As per above, activity levels are expected to continue to increase (+14% on 2024/25 levels) to ensure waiting time reduction for routine diagnostics and correspondent reduction in waiting list size.



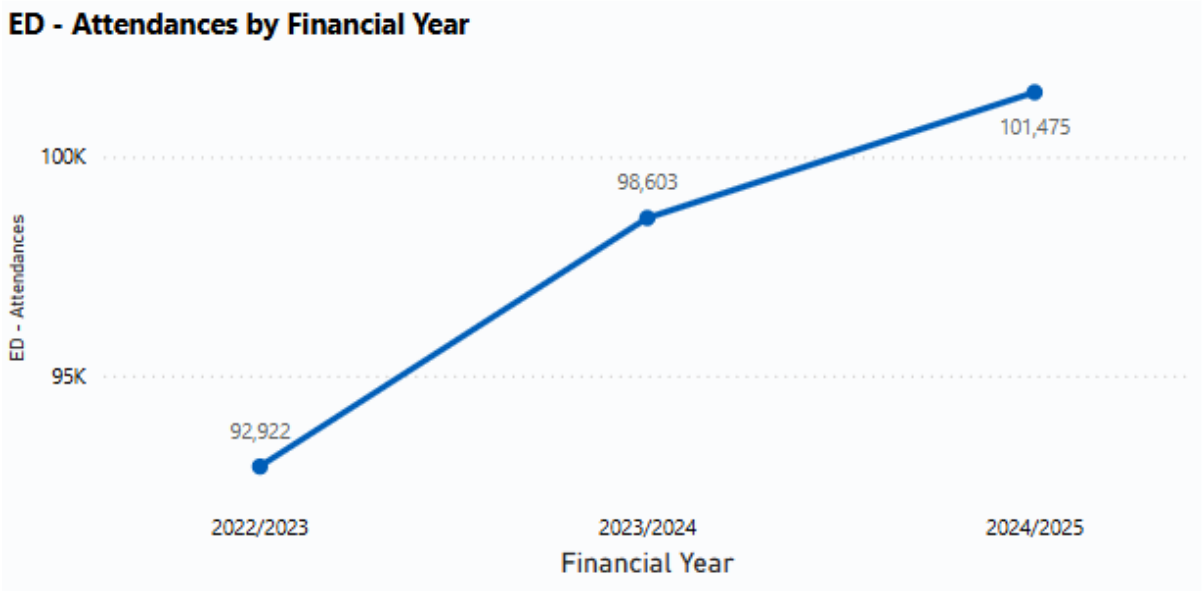
Key challenges for 2025/26 continue to be increased demand (especially for urgent and suspected cancer referrals) and improved productivity within diagnostic modalities.

The expected improvement in RTT performance in year also adds to the routine demand, with an additional 13,000 diagnostic tests required to support RTT targets. The other significant challenge is around staffing levels and ensuring modalities are as supported as possible to reduce sickness levels and staffing gaps.

Emergency Department & Urgent Care

In 2024/25 the number of patients attending the Emergency Department (ED) was 101,475, setting a record and the first time the figures have exceeded 100k. This is the equivalent of 278 patients per day. The ED has also seen a change in the type of patients who are attending, with a growth in the more complex patients and those with a higher acuity.

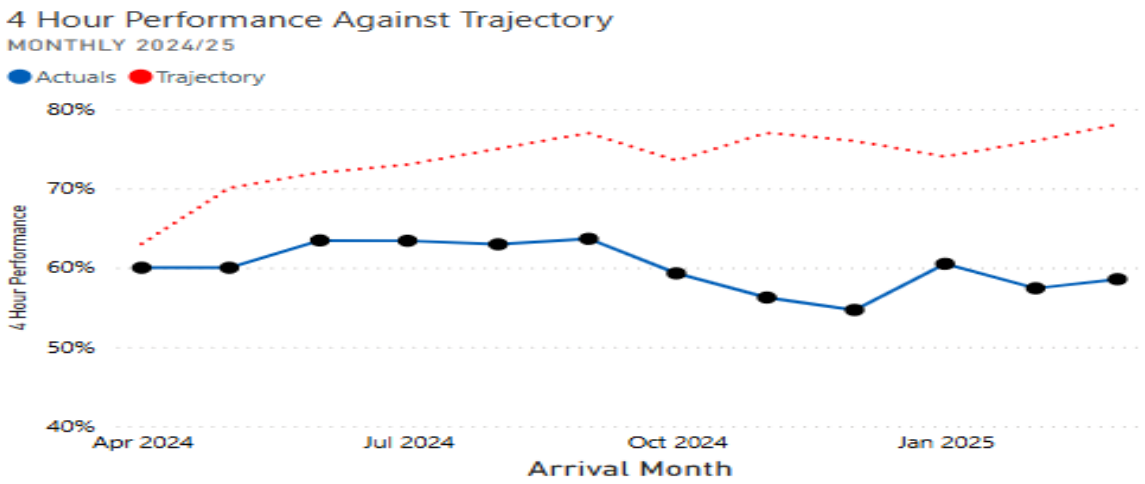
ED attendances have increased by 2.9% in year, alongside an increase of 0.1% in ambulance conveyances. The hospital has increased the GP direct access into Medical Assessment Unit (MAU), the Older Person Assessment Unit, and the Surgical Assessment Units; 34.1% of urgent and emergency care patients now access a same day emergency care (SDEC) service (equivalent to 20.3k patients).



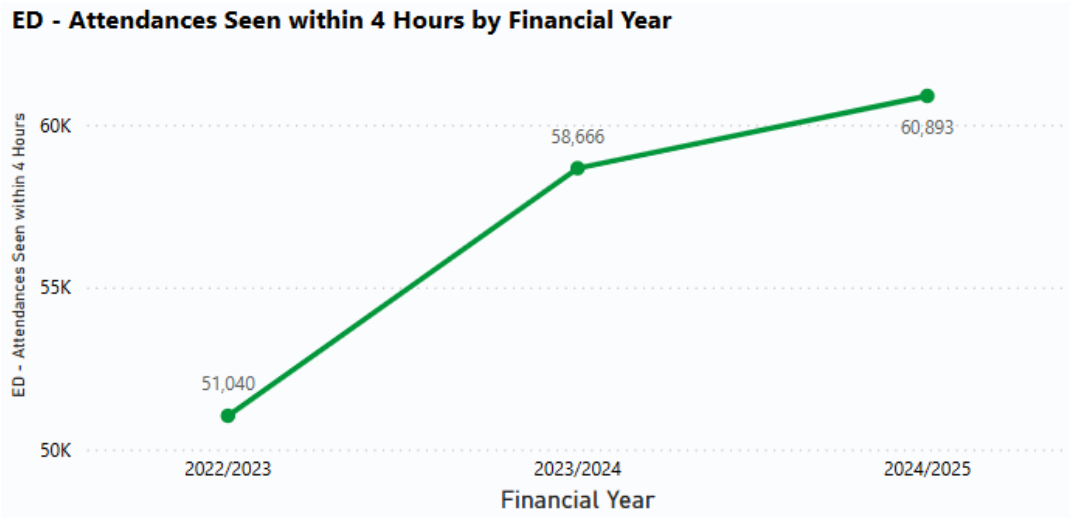
During 2024/25 the Trust continued to be monitored against the national access target of treating 78% of patients attending its Emergency Department within 4 hours of arrival and achieved a combined performance of 68.30% for the year.

Unmapped performance (thereby representing activity on the Combe Park site only), shown below, has improved to 60.01% in 2024/25 (from 59.50% in 2023/24). The RUH has, alongside the rest of the NHS, seen significant challenges in the delivery of the 4-hour performance target.

Flow out of the Emergency Department has also affected performance which is correlated to operating at high bed occupancy rates (adult general & acute occupancy was 95.8% over 2024/2025) and the number of patients with no criteria to reside exceeded the system target of 53, at 92.5 patients per day on average in 2024/25, a very slight increase from 91.9 in 2023/24.



Capacity at the RUH, to see patients within 4-hours, has increased to the highest-level in the last three financial years, 60,893 patient attendances (167 patients per day), as shown in the chart below.

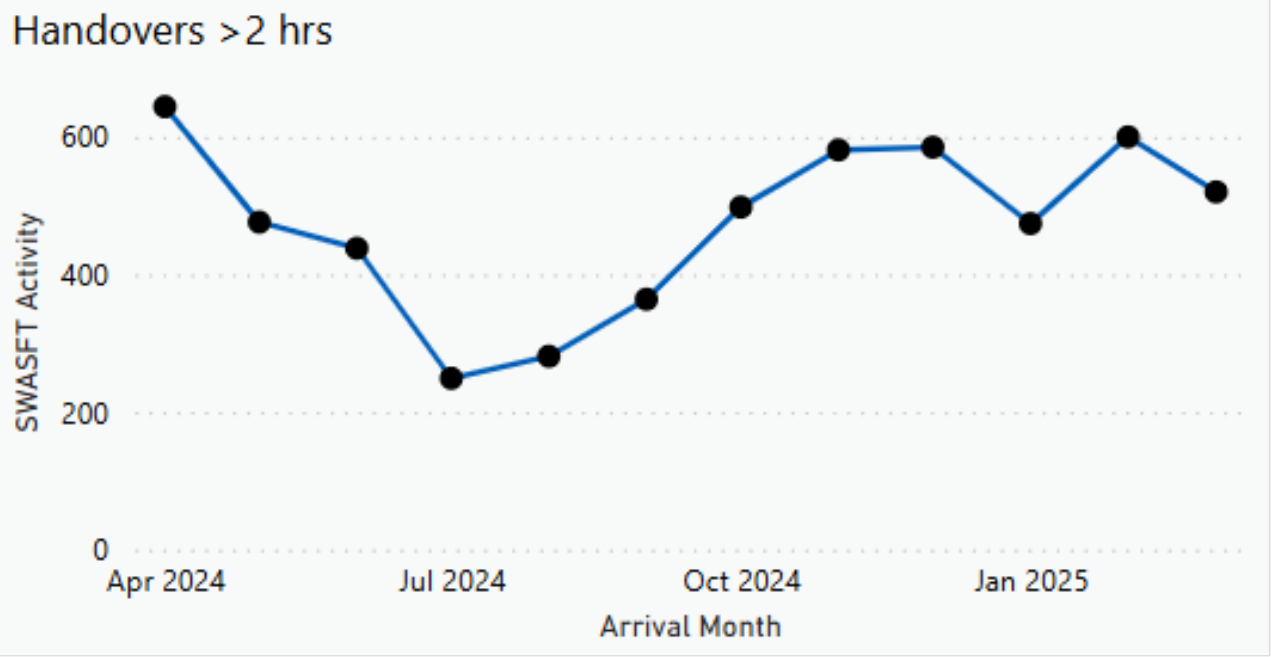


One of the other key urgent care measures is timely ambulance handovers. Performance in year has deteriorated from an average of 57.9 minutes in 2023/24 to 76.3 minutes in 2024/25.

Whilst mitigation has been put in place to improve handover times, including the cohorting of patients awaiting admission to inpatient beds during periods of peak demand to provide increased space within the Emergency Department to enable handover and offload patients, this standard remains a significant ongoing priority to further resolve in 2025/26.

The number of long waiters (handovers over 2 hours) reduced between April and July 2024 but started increasing over the summer and autumn (see graph below).

Mitigating measures, including the opening of the 6-bedded C16 (medical specialty escalation area) and focus on reducing any patient waiting over 75 minutes, was put in place in November 2024 and led to improvements at the end of December 2024 and January 2025 and prevented the situation from deteriorating further.



Bed occupancy

One of the major factors influencing performance against both the 4-hour ED target and the requirement to reduce ambulance handover delays is the ability to admit patients into the hospital in a timely manner.

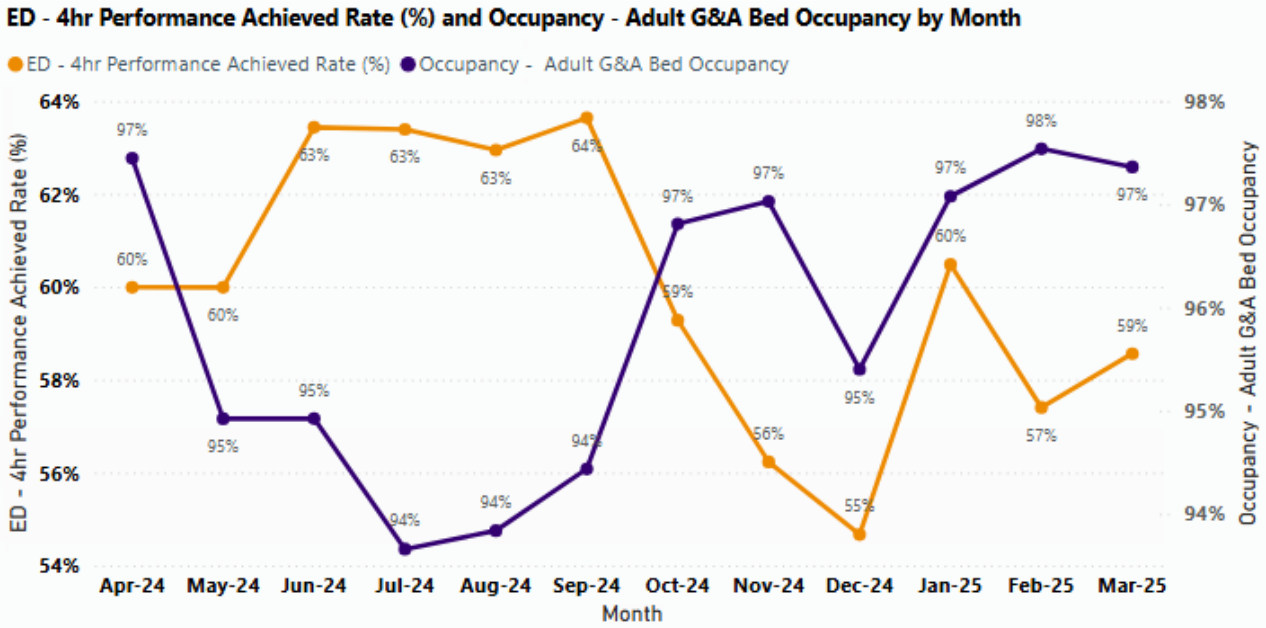
A key driver of this is ensuring there is sufficient bed availability.

In February 2023 NHS England introduced a target for each hospital to get their bed occupancy to below 92%.

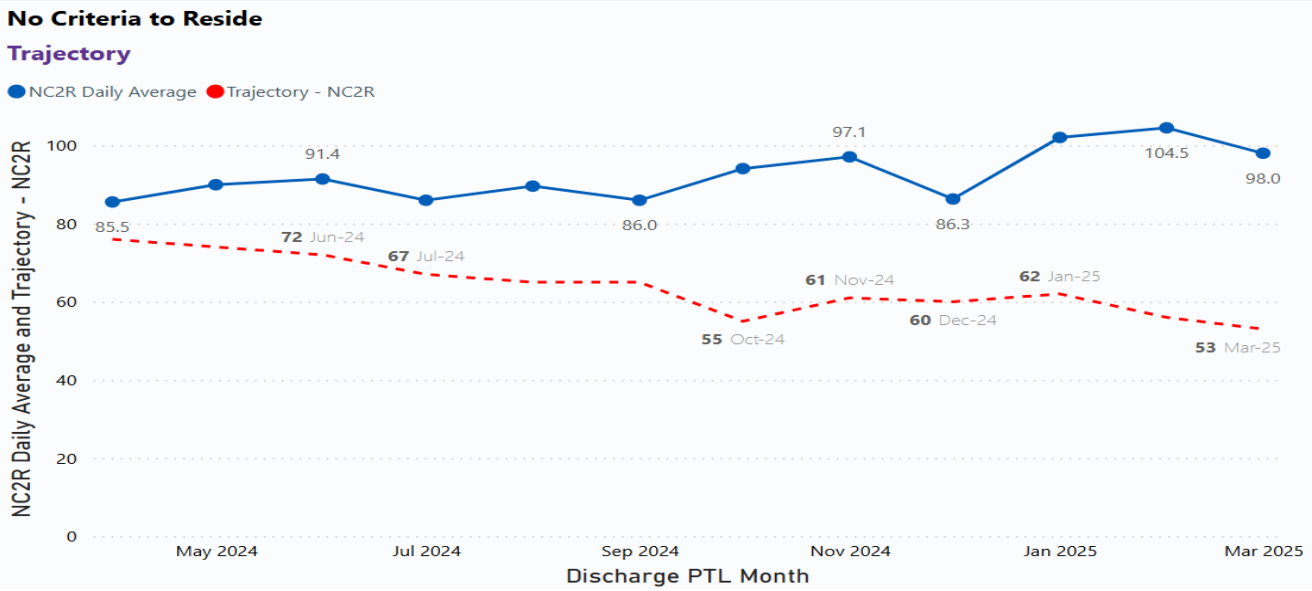
The graph below demonstrates that the RUH bed occupancy is consistently well above this level, averaging 95.8% in 2024/25 for adult acute beds. It is known that bed occupancy above this point increases the operational challenges and increases internal delays, slows down new admissions, and increases infection risks.

Predictably, bed occupancy is higher in the winter period (October to March) when demand for admission is at its highest with an associated high patient acuity and complexity, as seen in December 2024 and January 2025.

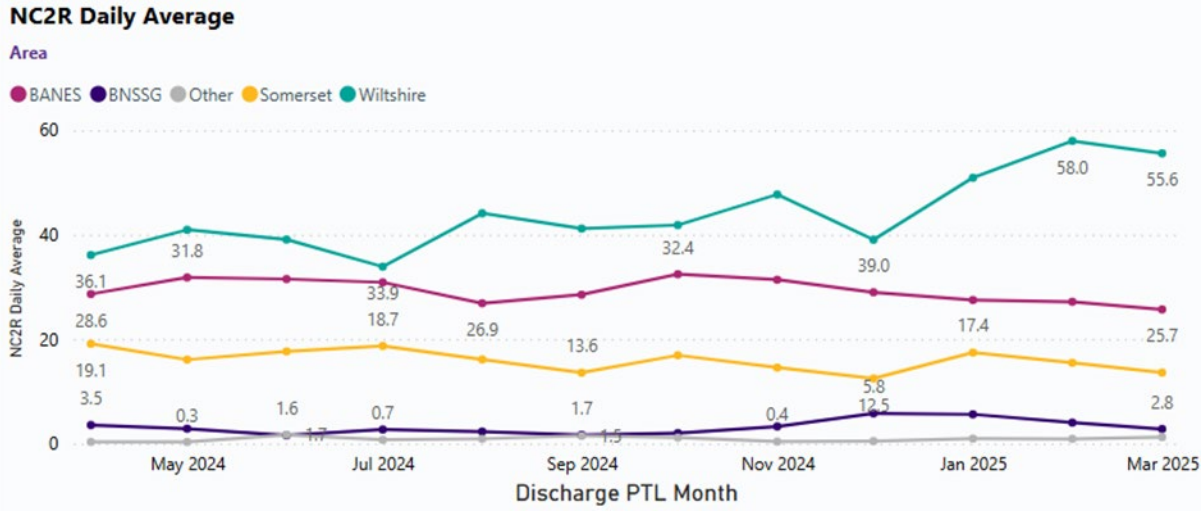
Bed capacity due to infection prevention and control measures also adversely affected occupancy in January and February 2025 with empty bed capacity not accessible for new admissions.



Patients' length of stay and time of discharge also affects bed occupancy. There were 3% more patients discharged before 10am and 5% more patients discharged before midday by March 2025 (24% of all discharges) when comparing April 2024 to March 2025 performance. The Trust has also continued to have a high number of patients who no longer have criteria to reside in an acute hospital and are awaiting community support to discharge. The graph below shows that throughout this financial year, the number of patients who no longer have criteria to reside is increasing, from a daily average of 85.5 patients in April 2024 to 98 patients in March 2025, peaking at 104.5 patients in February 2025. There was significant improvement pre-Christmas 2024, however numbers returned to the higher daily average in the New Year.



The graph below shows the breakdown, by locality, for both hospital and community responsibility, with the top contributor to numbers of patients not meeting criteria to reside being Wiltshire.



Overall, non-criteria to reside volumes have decreased throughout the year for three of the four main locality partners of the RUH: BaNES (HCRG), Somerset and BNSSG. Wiltshire was averaging 36.1 patients at the start of the year however this has now risen to 55.6 patients in March 2025.

The demand for pathway 2 capacity (discharges to a community bed-based setting) was the top contributor to this change in performance. The Trust has been working across all locality partners (Wiltshire, BaNES (HCRG), and Somerset) to deliver improvements within the non-criteria to reside position. The Trust continues to support the following initiatives.

- Internal process improvement for:
    - Complex discharge planning - achieving 0 patients with a plus 50-day length of stay with no criteria to reside.
    - Pathway 0 reduction through multidisciplinary team working and improved daily data monitoring processes to ensure patients are on the right pathway for their clinical needs to reduce delays.
- Introduction of the transfer of care hub with the ambition to reduce bed request and streamline pathways and decision making – work continuing throughout 2025/26.
- The shared 'Home is Best' transformation plan is focused on ensuring patients receive the right care for their needs, removing barriers and delays and integrating work across teams. This has helped to maintain the percentage of patients discharging within 48 hours of non-criteria to reside at 84.7% despite the overall increase in patients.
- The community wellbeing hub in the RUH Atrium, staffed by the BaNES community hub team, continues to support admission avoidance and prevention of emergency attendance for any patient in the BaNES and Wiltshire areas. The work links to the Riviam onward referral form to support early discharge planning with system partners including the third sector such as the charity Bath Mind.
- The Trust will be supporting the new community-based care partnership provided by HCRG for the people in Bath and North East Somerset, Swindon, and Wiltshire from April 2025, seeking opportunities to improve access for our patients who no longer need acute hospital care.

The Trust's Breakthrough Objectives for 2025/26

The Breakthrough Objectives for 2025/26 have been agreed as follows and will be reported on in next year's annual report:

People we care for

- **Valuing Patient & Staff time** – *Achieving ambulance offload times*

People we work with

- **Recognising and valuing colleagues' work** – *Increase percentage of staff feeling valued*

People in our community

- **Productivity** – *Maximising value, eliminating waste*

These will be supported by various corporate projects, including:

- Urgent and Emergency Care
- Corporate Services Redesign
- Theatres Transformation
- Outpatient Transformation
- Financial Improvement

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

Compliance with the Care Quality Commission

The Trust is compliant with the registration requirements of the Care Quality Commission (CQC) and is registered with no conditions applied. Full details on the CQC inspection can be found in the Annual Governance Statement.

Overview of financial performance

In 2024/25 the NHS has continued the drive to regain momentum delivering elective services and address waiting times, however a continued high level of emergency and unplanned care has impacted this. 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.

Payments to the Trust for patient activity continued to operate on the same block basis introduced in 2021/22 covering the majority of the clinical activity undertaken in the organisation.

The incentive funding stream made available to target increasing elective activity and create additional capacity to help reduce waiting lists and minimise very long waits for treatment, also continued into 2024/25.

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 £25.3 million through this scheme. This income was used to cover the costs of providing extended services to treat patients.

In 2024/25 variable income streams for outpatient diagnostics, chemotherapy and high-cost drugs and devices continued for activity and costs above 2023/24 outturn. This additional income helped off-set the higher costs incurred through providing these increases in activity.

£21.6 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 £22.7 million to reallocate the funds that they held in their capacity as Commissioner to each of the Providers as part of a transitional funding agreement.

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

Following the required adjustments for national reporting, the Group reported an adjusted position of £4.2 million deficit. Within this Sulis closed the financial year with a £0.1 million surplus with increases in NHS and private activity.

	2024/25 £000	2023/24 £000
Group surplus for the period from continuing operations as per the Statement of Comprehensive Income	**-3,283**	**-4,918**
Impairments	-2,117	-4,684
Revaluations	2,959	1,086
Other reserve movements	-1	-1
Movement in fair value of charitable funds	80	-226
Total comprehensive income for the period	**-2,362**	**-8,291**

	2024/25 £000	2023/24 £000
Group surplus for the period from continuing operations as per the Statement of Comprehensive Income	**-3,283**	**-4,918**
Remove impact of consolidating NHS Charitable Fund	983	2,348
Remove net impairments not scoring to Departmental expenditure limit	10,339	2,161
Remove impact of capital grants and donations	-12,233	-3,229
Remove net impact of DHSC centrally procured inventories	23	148
Adjusted financial performance for the period	**-4,171**	**-3,490**

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 use of premium operational costs to deliver pre-pandemic levels of activity, many of which reflect the national situation within the NHS.

The cost of bringing waiting lists back down to pre-pandemic levels, while also managing increasing levels of emergency and urgent care, also remains significant. At the same time, income derived from non-patient care related services, such as car parking and catering, did not recover sufficiently enough to cover the Trust's overheads.

Whilst 2024/25 brought about significant financial challenges to deliver a breakeven position there were also significant successes during the year. £32.8 million (89.5% of the target) savings were delivered during the year with new models of care developed to support patients with enhanced needs as well as reducing the reliance of patients using an inpatient ward, instead being cared for in the community through virtual wards.

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. Increased focus on referral to treatment times will drive operational plans for the coming financial year.

Efficiency Programme

The Improvement Programme Management Office, overviewed by three Programme Boards, supported the delivery of £32.8m of financial efficiencies in the year, which equated to £36.6m of full year savings across several initiatives. These included:

- £5.5m saving in use of temporary staffing and overtime
- £10.5m in additional income from increase in productivity, reducing non-attendance and improved theatre efficiency and improved data capture within the ERF programme
- £2.0m through procurement efficiencies
- £1.0m from medicine management opportunities and bio-similar
- Through service improvement and redesign, £4.1m in savings was achieved. Initiatives included - enhanced care models and improved rostering.

Capital investment

The Group invested £64.7 million in infrastructure, equipment, information technology and projects during 2024/25, (£38.1million in 2023/24). This includes £3.7 million related to leases which are now capitalised in line with accounting standards, £28.5 million from national capital funding, donated and grant funded capital of £13.3 million and £22.9 million respectively.

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

External support was also made available for projects to support additional elective capacity, community diagnostics, digital diagnostics and endoscopy scopes. The Trust also received PDC funding for the System-wide electronic patient record system.

The capital programme has continued to seek to achieve a balance between maintaining and replenishing the asset infrastructure, reducing risk, and improving patient experience. However, the Group and in particular the Trust are working within the context of significantly constrained capital funding and increased demand, several risks relating to capital have been recorded on the Trust risk register.

Significant in-year programmes included expenditure of:

- £5.8 million on the digital programme, including additional investment in hardware to support changes in working practices, clinical systems, and infrastructure support as well as investment in cyber security. This included investment towards the BSW single electronic patient record system of £3.6 million.
- £9.3 million on medical equipment. Within this, £1.9 million related to the purchase of a new robot, and £3.7 million for endoscopy equipment. £2.3 million was funded through charitable donations including a new Linac.

- £13.4 million on estates significant projects include the completion of the single ITU for £4.3 million, £1.0 million on same day emergency capacity, £2.2 million on fire risk reduction schemes and £0.9 million on backlog maintenance.
- £0.5 million related to capital investment in Sulis Hospital and £0.2 million for a lease relating to office space.
- £3.7 million on leases for pathology managed equipment, vehicles, and various medical equipment. Spend includes a charge for the yearly indexation increase relating to the lease held by the Trust for Sulis Hospital.
- £10.9 million grant spent on decarbonisation of our heat infrastructure.

Significant multi-year capital projects:

- £3.2 million to support Community Diagnostics Centre at Sulis Hospital was completed this year, with an in year spend of £2.2 million.
- £24.8 million relating to Sulis Orthopaedic Elective Centre (SEOC), the total spend in year was £18.1 million.

These are capitalised costs only.

Capital Impairments

The Trust had capital impairments totalling £10.4 million, of which £10.1 million related to an impairment resulting from the valuation on 31st March 2025 and £0.3 million capital asset impairments (£0.3 million in 2023/24).

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

Living more sustainably can have a huge impact, both at work and at home. At the RUH, we aim to embed sustainable development in everything we do. To achieve this, our aim is 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 non-renewable resources such as fossil fuels and heavy metals;
- reducing our dependence on substances that persist in nature; and
- reducing our destruction of nature.

In 2020, the Trust published its 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, an NHS England programme, have since introduced an updated format to the Sustainability Strategy, known as the Green Plan and we will be developing a new five year plan covering 2025-2030 in line with this guidance.

There are three new categories that have been mapped and incorporated into our existing areas of focus as follows: Medicines and Digital Transformation are covered within 'Designing sustainable care models'; and Food and Nutrition is covered within 'Using resources sustainably'.

Targets

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

Net zero carbon means balancing the scope 1, 2 and 3 greenhouse gas emissions released into our atmosphere with the amount removed:

- 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; and
  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:

- To be net zero in Scope 1 and 2 emissions by 2030;
- All Scope 3 emissions will be measured and monitored as accurately as possible, covering 2026< at the latest, and a target set for reduction of Scope 3 by 2030; and
- To be net zero by 2045 across all three scopes.

Progress to date

Highlights of this year's progress against our targets include:

Managing our carbon & greenhouse gases:

- Main contractor appointed for £21.6million project to decarbonise heating onsite – see 'Showcase project' for more information.
- We secured £498k in funding towards energy saving projects; £22k for additional energy sub-metering, £123k for Building Management System (BMS) controls upgrades and £353k for LED lighting upgrades.

Adapting to climate change:

- A Climate Change Risk Assessment and Adaptation Plan has been drafted and shared, and is currently going through the governance process. This will assess the Trust's adaptation capability against the Climate Adaptation Framework and an action plan created to build capability. Engagement with stakeholders across the Integrated Care System (ICS) was sought through workshops and interviews. The final report is due to be published in April 2025.

Designing sustainable care models:

- Clinical teams are continuing to explore and implement reusable rather than single-use products to reduce waste, including theatre hats, sterile drapes and gowns, forced air warming and pulse lavage systems.
- Paperless Inpatient Project went live in August 2024, to improve patient safety, clinical outcomes, efficiency, job satisfaction, auditing and to support virtual working.

Enabling sustainable travel & logistics:

- 1 more electric vehicle added to RUH fleet.
- 45 members of staff have used or are on the waiting list for the e-Bike loan scheme- free for staff to use to encourage active and sustainable travel.
- 34 electric vehicles were delivered to staff, with a further 7 on order via the electric vehicle salary sacrifice scheme.

Embedding sustainability:

- A ‘Green Team Competition’ was held to support staff with sustainability QI projects and drive momentum for similar projects around the Trust. Projected savings of over £41k, 50 tCO_2e and improved patient and social outcomes.
- Staff are encouraged to complete eLearning training modules on ‘Building a Net Zero NHS’ and ‘Environmental sustainability in quality improvement’.
- Sustainability Champions network reinstated with 114 colleagues joining the network.
- RUH staff members continue to have access to a behaviour change platform, logging over 7,000 environmental sustainability actions in 2024/25.

Managing our assets & utilities:

- Ran another winter TLC campaign – encouraging **T**urning off of equipment, turning **L**ights out and **C**losing doors where safe and suitable to do so.

Creating a sustainable built environment:

- The Wellbeing Garden opened last summer with further planting planned and is being well used by patients, staff and visitors.

Empowering our people:

- First RUH Sustainability Day was held in April 2024 to align with Earth Day and raise awareness and drive further engagement amongst staff. A second event is planned for April 2025.
- Sustainability added as an awards category in our You Matter staff awards to recognise contributions.

Enhancing greenspace:

- We have had 120 native trees secured via NHS Forest and planted on the Combe Park site.
- We worked with Bath Urban Treescape to create guided tree walks around the Combe Park site to encourage site awareness and wellness for staff, patients and visitors.

Showcase project

The Trust has appointed a main contractor as part of the multi-year heat decarbonisation works, of which £21.6M of funding was received from the Salix Public Sector Decarbonisation scheme (3c). This energy infrastructure investment project will target a 19% reduction in scope 1 and 2 carbon emissions with a further 6% by 2030.

Project scope includes:

- removal of 1 steam gas fired boiler and replacement with air and water source cascade heat pump system;
- new low temperature hot water distribution system will replace ageing steam network across site;
- installation of over 2000 new LED lights;
- installation of solar panels covering 3 buildings;
- new high voltage connection to power heat pumps; and
- installation of smart Building Management System controls to optimise new heating system for maximum efficiency.

Plans are already underway for future phases of heat decarbonisation to build on this major milestone for our net zero target for scopes 1 and 2 by 2030.

Key areas of focus

Taking responsibility for our carbon footprint

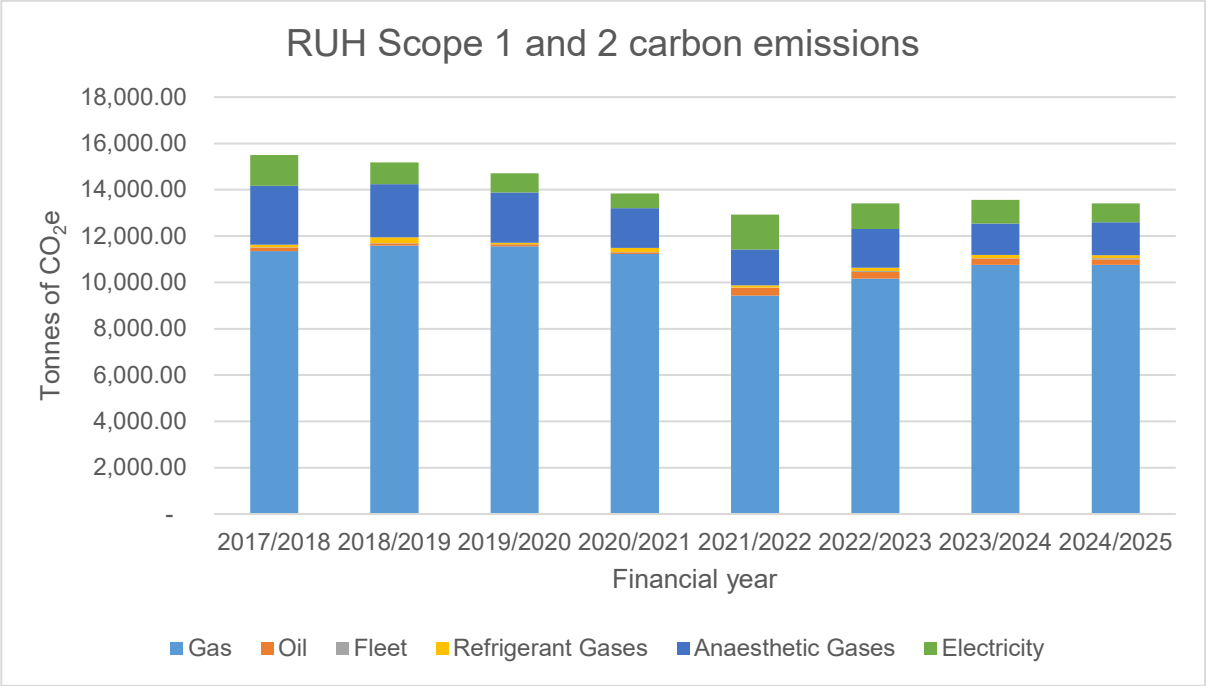


Figure 1: The Trust's carbon footprint for scope 1 and 2 emissions over the last 8 years.

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

- Gas: consumption onsite has remained constant, however as part of the heat decarbonisation project, work is underway to de-steam the heating system on site and support the RUH in shifting away from fossil fuel reliance.
- Electricity: improvements in CHP performance and on-site solar generation have resulted in reduction in purchased electricity and related carbon emissions.
- Anaesthetic gases: the overall carbon emissions of anaesthetic gases has decreased due to the decommissioning of the Nitrous Oxide manifolds as well as ceasing the use of Desflurane, one of the more potent gases.
- Oil: consumption has reduced slightly this year. The RUH are targeting a complete phase out of oil boilers for heating by 2028 aligned to NHS wider targets.
- Fleet: emissions remain fairly static; however, the Trust continues to systematically transfer the fleet vehicles to electric when operationally possible.
- Refrigerant gases: remain fairly static, however this is dependent on leakages to the systems.

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

Improving air quality through sustainable travel

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

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

The Trust monitors the nitrogen dioxide (NO2) levels – one of the most harmful pollutants. Diffusion tubes are placed across the site and are analysed monthly. In the UK, the law on nitrogen dioxide (NO2) pollution says annual average concentrations cannot exceed 40 µg/m3 (micrograms per cubic metre of air). The latest figures show the annual site average for 2024/2025 is 18.5 ug/m3, substantially below this figure.

The Trust are exploring live air quality monitoring and measurement of $PM_{2.5}$ and PM_{10} particulate emissions to give a wider and more accurate picture of air quality on our Combe Park site.

During 2024/25, the Sustainability Team continued to run initiatives to reduce air pollution on site including:

- a ‘switch off when you drop off’ campaign in the Estate’s contractor’s car park and across the main drop off points across the site;
- procurement of further electric vehicles as we transition our fleet; and
- the E-bike loan scheme has had continued success, with all bikes out on loan.

Task force on climate-related financial disclosures (TCFD)

NHS England’s NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for 2024/25. The governance and metrics and targets disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

The disclosure requirements for risk management have not been provided as we are currently focussing on finalising our Climate Change Risk Assessment and Adaptation Plan. Disclosure requirements have been drafted and at the rime of writing are going through the correct governance route for approval and publication, which is expected in July 2026.

Board oversight of climate-related issues

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

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

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

One of our vision metrics on the RUH Integrated Performance Scorecard is our percentage reduction in scope 1 and 2 carbon emissions (for electricity and gas) against a 2020/21 carbon footprint.

Progress in delivering this priority is reported at Estates & Facilities Board, Trust Management Executive Board and Board of Directors meetings. The metric that is monitored to measure success is a reduction in our carbon emissions.

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

The Trust employs the following members of staff:

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

The staff members listed above have specific climate-related managerial responsibilities. One of their key roles is to engage the rest of the organisation and make sustainable working practices everyone's responsibility and embed them into business as usual.

To support this, we are re-launching the Sustainability Steering Committee which will have the role of co-ordinating the work of the working groups including:

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

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

Our Sustainability Champions network was relaunched in summer 2024, with champions joining to drive forward this agenda across the Trust.

Risk management, metrics and targets

A Climate Change Risk Assessment and Adaptation Plan is currently being developed and the draft and is going through the correct governance route for approval and publication, which is expected in July 2026. Steps to manage climate-related risks, including metrics and targets are to be developed along with governance around awareness and response to climate change risk and adaptation following publication.

The Trust currently have Emergency Preparedness, Resilience & Response policies in place for a wide range of incidents, including those which are related to climate change; extreme weather. Further work will be done to align these with the forthcoming Climate Change Adaptation Plan.

Tackling Health Inequalities

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

In addition to the most deprived 20% of the population within BaNES (CORE20), the following population groups (PLUS groups) have been identified by the BSW Integrated Care Board (ICB) as groups experiencing poorer than average access and outcomes from healthcare:

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

The key focuses for the Trust Health Inequalities Programme in 2024/25 were:

1. **Ensuring datasets are timely and complete and utilised to inform targeted interventions**: there continues to be greater focus and efforts to improve the recording and use of ethnicity data and other protected characteristics i.e. disability to inform strategy and action.

2. **Accelerate Preventative Programmes and Promotion of Wellbeing**: Smoking continues to be identified as the single largest driver of health disparities between the most and least affluent quintiles. The Trust has had a well-established programme to treat tobacco dependency amongst expectant parents and staff for a number of years, and it launched a programme for inpatients in September 24, providing holistic care and addressing broader lifestyle behaviours i.e. diet, exercise, alcohol consumption and conditions such as hypertension.

3. **Restore Services Inclusively**: The Trust launched a new pilot to improve access and restore services inclusively and equitably. The project involves the collection and analysis of qualitative data for patients who miss their appointments, in order to understand, and help the Trust address the barriers patients face accessing healthcare.

4. **Awareness raising and training**: This is part of the Trust's ongoing commitment to take positive action to reduce health inequalities. Acknowledging that raising awareness requires constant and coordinated efforts, the Health Inequalities Lead works closely with the Communication team to provide frequent updates and plan joint Trust-wide action.

5. **Anchor institution**: the Trust has a key domain in its strategy directly relating to our role as an anchor institution called the "People in our Community". The Trust is utilising its position as an "anchor" organisation to address some of the broader causes of health inequality, including:

- Prioritising some of the more deprived local communities for employment and apprenticeship opportunities
- Encouraging local businesses to become suppliers to the RUH, thereby increasing economic activity locally
- Reducing environmental impact through more sustainable practices
- Working with BaNES Council to help reduce vehicular traffic to and from the RUH sites, thereby improving air quality for local people and reducing respiratory illnesses
- Support our staff health & wellbeing through a series of opportunities and programmes such as our Employee Assistance Programme, Health Checks onsite and our staff networks

6. **Mitigating against digital exclusion**: a new project to reduce digital exclusion was launched in October 2024. A team of digital inclusion navigators are available to support patients with their digital needs, in response to the increased digitalisation of healthcare. Staff are available to help patients with access to free data, use of the NHS app, manage accessibility features on their phone, read electronic letters and promote patients' self-care and self-management of long-term conditions through apps and online forums.

7. **Leadership and Accountability:** A Health Inequalities Steering Group has been established, and clear governance and accountability has been described to support and deliver against the identified priorities for improvement related to Health Inequalities. The Trust has also completed the Health Inequalities self-assessment maturity tool, designed by NHS Providers, in June 2024 with the following results:

Theme	Score	% complete	Maturity level
Building public health capacity and capability	4	50	Maturing
Data insight, evidence and evaluation	5	36	Developing
Strategic Leadership	14	78	Thriving
System partnerships	8	80	Thriving

The RUH has been a key partner in establishing the BaNES Health Inequalities Group which has been established to promote collaboration between healthcare, local authority and voluntary sector organisations to identify and deliver opportunities for improvement in Health Inequalities for our populations aligned with the CORE20PLUS5 framework.

We have deepened links between clinical teams in secondary care and Public Health colleagues to break down barriers and begin to co-own, design and deliver Health Inequalities improvement for our population.

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

1. Smoking Cessation

Proportion of adult acute inpatient settings offering smoking cessation services: The Trust launched its inpatient smoking cessation service in August 2024.

Proportion of maternity inpatient settings offering smoking cessation services: The Trust has a well-established smoking cessation service for expectant parents.

2. Urgent and emergency care

Emergency admissions for under 18s broken down by ethnicity and index of multiple deprivation (IMD), where 1 represents most deprived and 5 least deprived. The Index of Multiple Deprivation (IMD) datasets are small area measures of relative deprivation across each of the constituent nations of the United Kingdom.

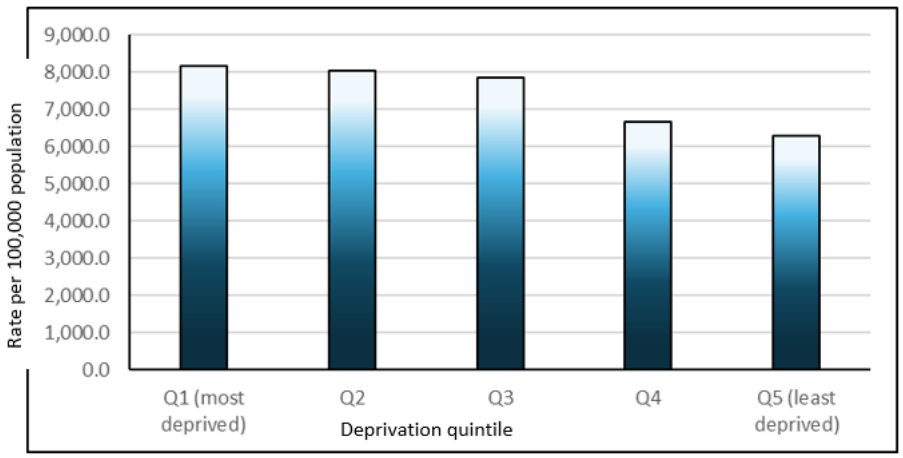


Table 1: Emergency admission rates (per 100k of population) for under 18s, broken down by IMD. This is BaNES patients only. Source: BSW ICB Business Intelligence Unit.

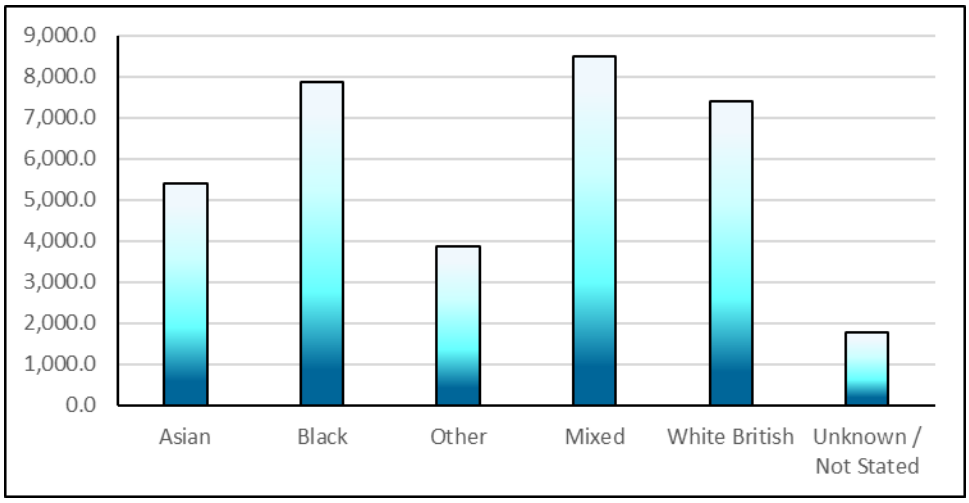


Table 2: Emergency admission rates (per 100k of population) for under 18s, broken down by ethnicity. This is BaNES patients only. Source: BSW ICB Business Intelligence Unit.

Elective Recovery

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

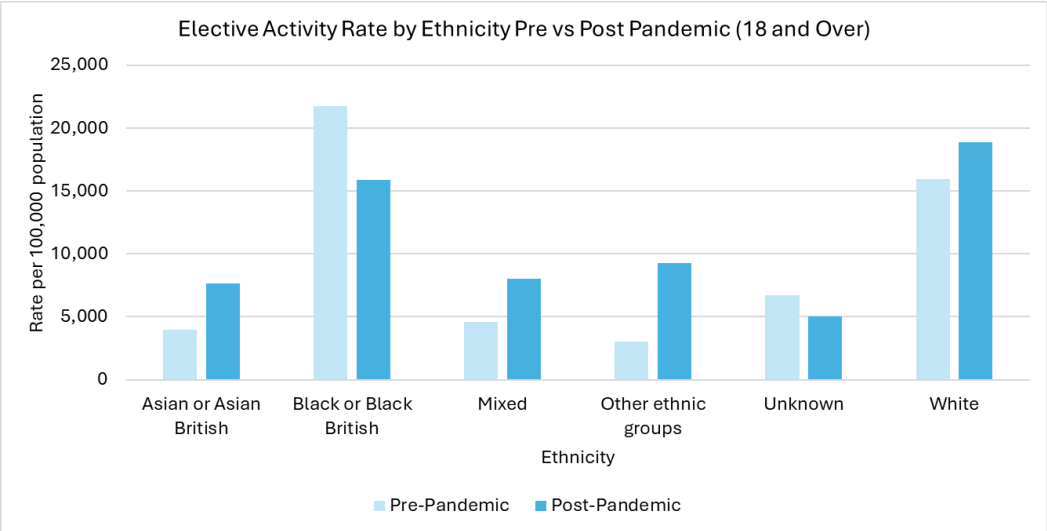


Table 3: Elective activity broken down by Ethnicity, 18 and over. This is BaNES patients only. Source: BSW ICB Business Intelligence Unit.

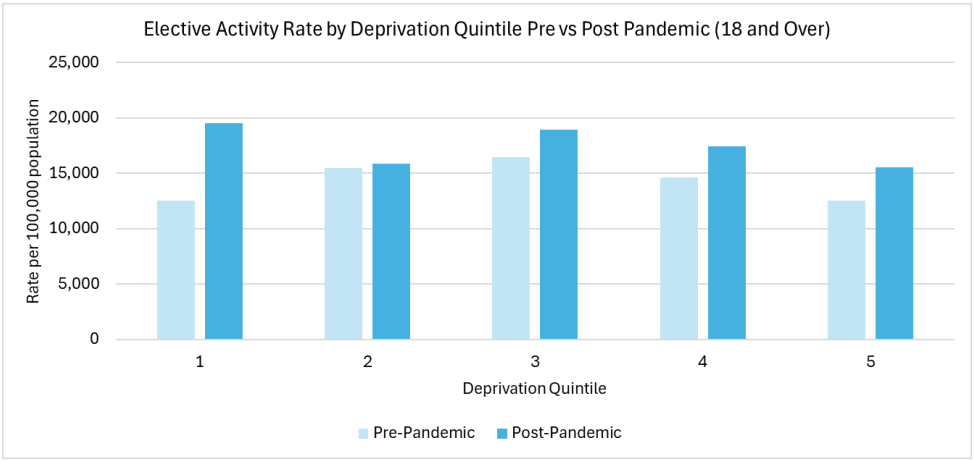


Table 4: Elective activity broken down by IMD, 18 and over. This is BaNES patients only. Source: BSW ICB Business Intelligence Unit.

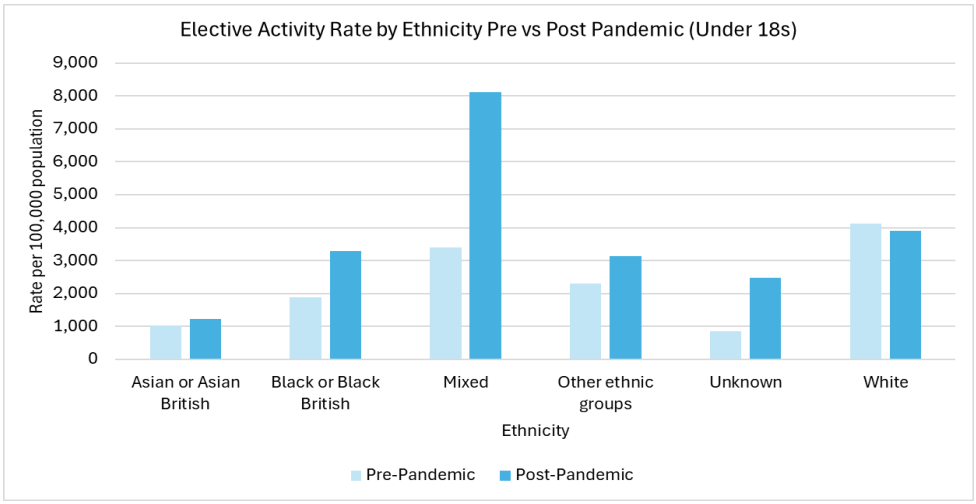


Table 5: Elective activity broken down by Ethnicity, under 18. This is BaNES patients only. Source: BSW ICB Business Intelligence Unit.

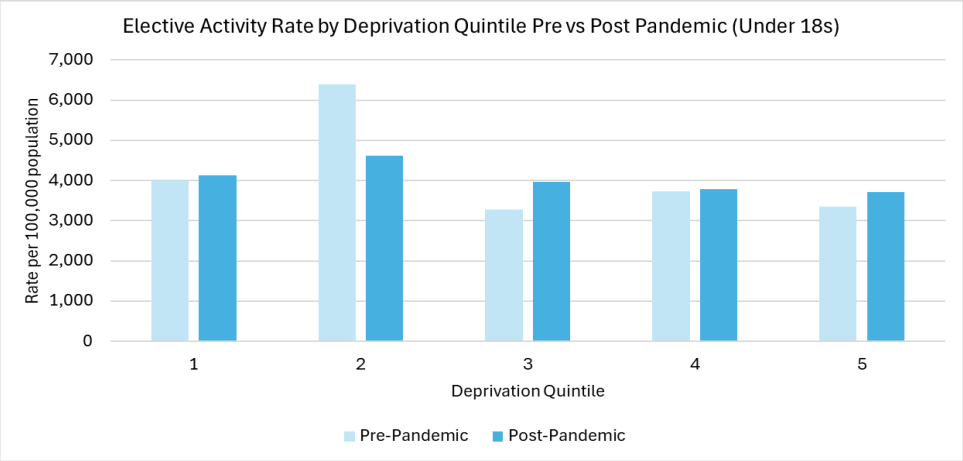


Table 6: Elective activity broken down by IMD, Under 18. This is BaNES patients only. Source: BSW ICB Business Intelligence Unit**.**

3. Oral health

Tooth extractions due to decay for children. The graph shows the number of children admitted to hospital as in patients, not the number of teeth removed. Children are aged 10 and under and the admissions are based on deprivation with the first column (1) the most deprived.

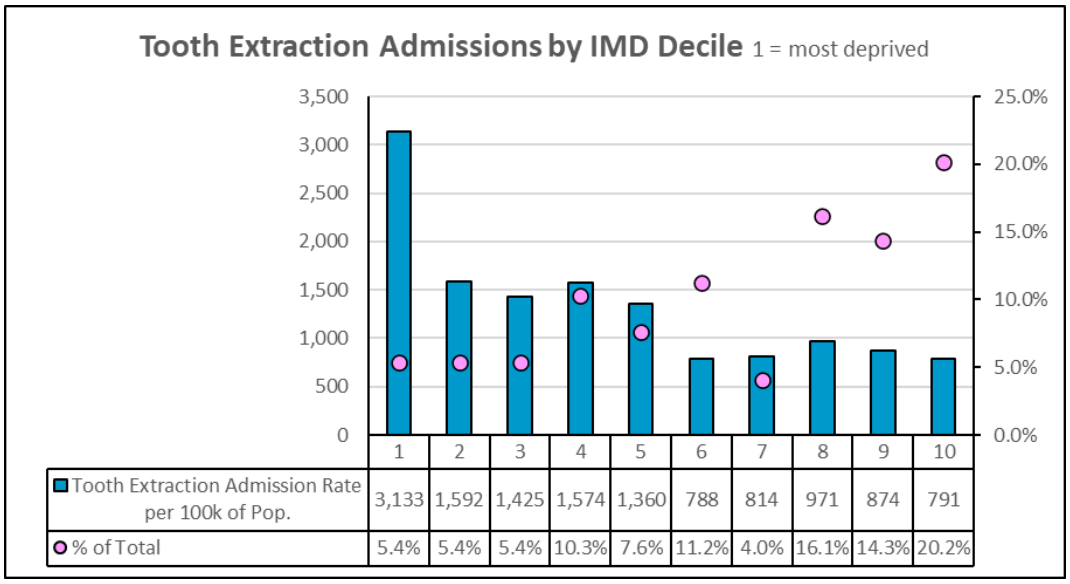


Table 7: Tooth Extractions broken down by IMD deciles. Source: BSW ICB Business Intelligence Unit.

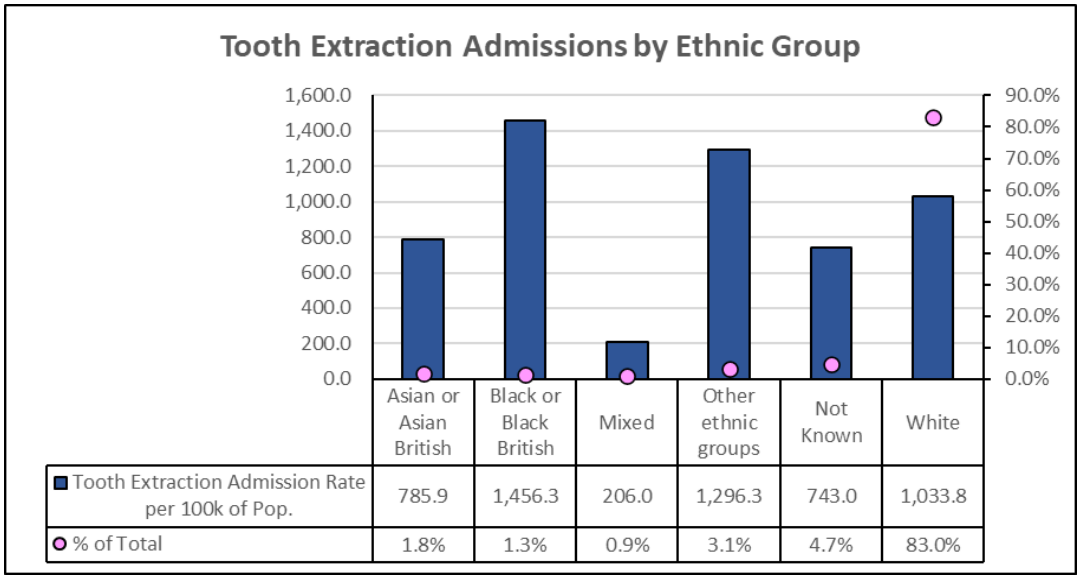


Table 8: Tooth Extractions broken down by Ethnicity. Source: BSW ICB Business Intelligence Unit.

Social, community, antibribery and human rights

All Group policies and procedures are based on national employment legislation, are in line with NHS constitutional commitments and include an equality and diversity impact assessment.

The Trust's implementation of the Equality Delivery System 2, the Workplace Race and Disability Equality Standards, and reporting on the Gender Pay Gap, ensures that the organisation has a transparent approach to ensuring that the rights, interests and needs of all sections of the community are considered in terms of service delivery and development, and employment practices.

In June 2022, the RUH Board approved a revised People Plan to cover the period from 2022 to 2025. This focuses on three strategic themes:

- Culture
- Capability
- Capacity,

It is underpinned by two key foundations:

- user friendly people processes (including recruitment, onboarding, and appraisals)
- creating an environment where everyone is respected and treated kindly.

Reporting on the gender pay gap at the RUH can be found within the Equality, Diversity and Human Rights section of the Trust website as below, and is reported within the Staff Report of this report: https://www.ruh.nhs.uk/about/equality_diversity/gender_pay_gap.asp

This information may also be found on the Cabinet Office website (https://gender-paygap.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 2024/25, the Group had no social, community or human rights violation issues.

Cara Charles-Barks
Chief Executive
26 June 2025

Accountability Report

Directors' report

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

In 2024/25:

- The Chair was Alison Ryan
- The Chief Executive was Cara Charles-Barks
- The Senior Independent Director and Vice Chair was Nigel Stevens
- 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. This did not apply to any Director in 2024/25.

Directors of the Royal United Hospitals Bath NHS Foundation Trust during 2024/25:

Executive Directors	
Cara Charles-Barks	Chief Executive (BSW Group Chief Executive from November 2024)
Andrew Hollowood	Chief Medical Officer (until November 2024) Deputy Chief Executive (until November 2024)** Interim Managing Director (from November 2024)
Sarah Richards	Acting Chief Medical Officer (from November 2024 – February 2025)
Kheelna Bavalia	Interim Chief Medical Officer (from February 2025)
Libby Walters	Chief Finance Officer (until April 2024)
Jon Lund	Interim Chief Finance Officer (from May 2024 – March 2025)
Simon Truelove	Interim Chief Finance Officer (from March 2025)
Antonia Lynch	Chief Nursing Officer***
Paran Govender	Chief Operating Officer
Alfredo Thompson	Chief People Officer
Jocelyn Foster	Chief Strategic Officer
Christopher Brooks-Daw *	Chief of Staff

Non-Executive Directors		Appointed
Alison Ryan	Chair	1 April 2019
Nigel Stevens	Non-Executive Director	1 April 2018
Sumita Hutchison	Non-Executive Director	1 September 2019
Ian Orpen	Non-Executive Director	7 September 2020 (ceased 31 August 2024)
Antony Durbacz	Non-Executive Director	1 November 2020
Paul Fairhurst	Non-Executive Director	1 October 2022
Hannah Morley	Non-Executive Director	1 April 2023
Paul Fox	Non-Executive Director	1 April 2023
Simon Harrod	Non-Executive Director	1 October 2024

Notes

*Christopher Brooks-Daw is a non-voting member of the Board.
**The Deputy Chief Executive role was superseded by the Interim Managing Director role following the formation of the BSW Group model.
***Following the departure of the Director of Estates and Facilities in February 2024 it was agreed that the role would be undertaken by the Chief Operating Officer (estates) and the Chief Nursing Officer (facilities). In January 2025 Chief Nursing Officer also took executive responsibility for estates.

The Board of Directors

Non-Executive Directors

Alison Ryan, Chair

Alison was previously a Non-Executive Director at the University Hospitals Bristol NHS Foundation Trust and has also held Non-Executive Director positions on the Boards of Somerset Partnership NHS Foundation Trust, NHS South West, and NHS South of England Strategic Health Authorities. Alison has had 30 years' strategic and executive experience in the health and social care sector as CEO of several national and local voluntary sector bodies working in health and social care. She has a MA (Oxon) in Philosophy, Politics and Economics and is a member of the Chartered Institute of Management. Alison Chairs the Board of Directors, the Board of Directors' Nominations and Remuneration Committee and the Council of Governors. She also sits on the Charities Committee. By way of interests, Alison continues in her role as South West Regional Chair for Organ Donation following her reappointment in March 2022 and she is also mentor to the CEO of Julian House.

Nigel Stevens, Non-Executive Director

Vice-Chair and Senior Independent Director from 1 April 2023

Nigel was previously Chair of the Quality Assurance Committee and remains Chair of the Subsidiary Oversight Committee. He is also a member of the Board of Directors' Nominations and Remuneration and Finance and Performance Committees and is the Non-Executive Director champion for patient and families' experience. Nigel has a BA (Hons) in Politics and Geography and an MA in Defence Studies. After 20 years as a logistics officer in the Royal Air Force, Nigel moved into the commercial sector. Following eight years as Chief Executive Officer for the UK and Ireland Division of a major, global public transport group, he worked as Chief Operating Officer for Keolis UK, a role he combined with wider work in the commercial and public sectors on future transport solutions. He is the owner and sole trader of Raybarrow Consulting, a management consultancy business and was appointed as Chair of Transport Focus, a public funded watchdog in June 2022.

Sumita Hutchison, Non-Executive Director

Sumita is Chair of the Non-Clinical Governance Committee and Charities Committee and sits on the People and Audit and Risk Committees, as well as the Board of Directors' Nomination and Remuneration Committee. She is the Board lead for equality, diversity and inclusion and health and wellbeing. Sumita has an LLB (Hons) and has practised as a solicitor specialising in employment law. She has also worked as Engagement Development Manager at the Avon and Somerset Constabulary, leading on diversity and inclusion initiatives across the organisation. Sumita has been heavily involved in promoting race, disability, and gender equality in the Bristol area, serving as Commissioner for Adult Social Care at both South Gloucestershire and Bristol City Councils and as a member of the Women's and Race Equality Commissions in Bristol. In addition to her role at the RUH, she also currently serves as a Non-Executive Director of the Gloucestershire Health and Care NHS Foundation Trust, is Chair of West of England Nature Partnership, a Trustee of Avon Wildlife Trust, a Governor of Bristol Grammar School, and volunteers for the Save the Soil Movement.

Ian Orpen, Non-Executive Director

Ian joined the Board in September 2020 as the Trust's first clinically qualified Non-Executive Director. He previously worked as a General Practitioner in the Bath area and served as Clinical Chair at the Bath and North East Somerset Clinical Commissioning Group from 2013 to 2020. In that capacity, Ian held the role of Stakeholder Governor on the RUH's Council of Governors right from the Trust's authorisation as a Foundation Trust in 2014. Ian chaired the Quality Assurance Committee, and sat on the People, Non-Clinical Governance and Subsidiary Oversight Committees. He was the Board's Maternity Safety Champion, and he led on Children and Young People. In terms of declared interests, Ian was an investor in tem.energy which operates a platform to connect suppliers of renewable energy with business consumers. Ian left the Trust in August 2024.

Antony Durbacz, Non-Executive Director

Antony is a chartered accountant by background and an experienced Non-Executive Director. Before he joined the RUH Board in September 2020, he had previously served as a Non-Executive Director and Chair of the Audit Committee at Taunton and Somerset NHS Foundation Trust. He is also Chair of the Audit Committee at LiveWest, one of the largest housing associations in the South West. Antony has held a number of senior finance roles, mainly in the manufacturing sector. On the RUH Board, he has been Chair of the Finance and Performance Committee since October 2023 and sits on the Subsidiary Oversight Committee and Board of Directors Nomination and Remuneration Committee. He was Chair of the Audit and Risk Committee until September 2023 and a member of the Non-Clinical Governance Committee until October 2023. In addition to his membership of the LiveWest Board, Antony is also a Governor at Bath Spa University and is a Trustee at Wessex Learning Trust. His daughter is on rotation as a registrar in Obstetrics and Gynaecology at the RUH.

Paul Fairhurst, Non-Executive Director

Paul has professional backgrounds in corporate law and strategic business development. He started his career at the international law firm, Simmons & Simmons, working on mergers and acquisitions, and subsequently took on a variety of senior roles in a range of international organisations such as Intercontinental Hotels Group PLC and Diageo PLC. His more recent full-time role was as Strategy, Planning and Policy Director and Operations Director at UK charity the Jubilee Sailing Trust. Paul Chairs the People Committee and was a member of the Finance and Performance and Quality Assurance Committees until February 2024. He sits on the Vulnerable Persons Assurance Committee, and he is the Non-Executive lead on safeguarding, security, staff inequalities and Improving Together. By way of declared interests, Paul acts of a Trustee for two charities: Designability, a Bath-based national charity that creates products with and for disabled people, and Back Up Trust, which is dedicated to supporting and inspiring people affected by spinal cord injury.

Hannah Morley, Non-Executive Director

Hannah has a Clinical background, having gained her undergraduate degree from the University of Cardiff in 2010, before completing her Masters in 2018. She started her career at the Aneurin Bevan University Health Board in 2010 before progressing to the Fraser Health Authority in 2013. Hannah spent time overseas before coming back to the UK in 2015. Hannah has taken on a variety of roles in the healthcare sector since returning to the UK and is currently a Senior Planning and Service Development Manager at Aneurin Bevan University Health Board. She is a member of the Non-Clinical Governance and People Committees and became Chair of the Quality Assurance Committee in August 2024 but temporarily stepped back in January 2025. In terms of declared interests, Hannah is a member of the Chartered Society of Physiotherapists, the Canadian Alliance Physiotherapy, the College of Physiotherapy British Columbia, and the Health and Care Professions Council.

Paul Fox, Non-Executive Director

Paul has a financial background. He has an MA in Modern History and Economics from Oxford University and has since worked as Finance Director / Chief Operating Officer in a range of complex organisations, including Bath & NE Somerset Council, the Natural Environment Research Council and Bath Spa University. He was awarded an OBE in 2022 for services to scientific research. On the RUH Board, he has been Chair of the Audit and Risk Committee since October 2023 and sits on the Finance and Performance, Non-Clinical Governance, and Subsidiary Oversight Committees. In terms of declared interests, Paul is a member of UKRI Financial Sustainability Research Committee and the Chartered Institute of Public Finance and Accountancy. He is also Treasurer of the Liberal Democrat History Group, and his wife works at University Hospitals Bristol NHS Foundation Trust.

Simon Harrod, Non-Executive Director

Simon has a Bachelor of Medicine and Bachelor of Surgery (MBBS) from the University of London. He trained as an Anaesthetist in London, gaining a FcAnaes in 1992, and becoming a Consultant at St Bartholomew's Hospital in 1996. After several medical management roles, he was appointed as the Medical Director for the Royal London Hospital in 2015 and remained in the role until his retirement in 2022. Simon has witnessed and led on many changes during the course of his career and is interested in patient safety and improving the quality of healthcare for all patients. He is passionate about using his experience to ensure that the Trust maintains its high reputation and that the needs of the local community are reflected in the Trust's strategy. Simon became interim Chair of the Quality Assurance Committee in January 2025 and is a member of the Audit and Risk and Subsidiary Oversight Committees, as well as the Board of Directors Nomination and Remuneration Committee. He is the Board's Maternity Safety Champion, and he leads on Children and Young People. In terms of declared interests, Simon is a Trustee of Amesbury History Society.

Cara Charles-Barks, Chief Executive

Cara has worked at board level within the NHS since 2008, including as Chief Operating Officer and Deputy CEO at Hinchingbrooke Healthcare NHS Trust, and more latterly as CEO at Salisbury Foundation Trust between 2017 and 2020. Before that, Cara held senior healthcare management roles in her native Australia, including as Nursing Director at the Queen Elizabeth Hospital in Adelaide, South Australia. She holds Bachelor's and Master's Degrees in Nursing as well as an MBA from the University of Adelaide. In November 2024, having worked within the Bath and North East Somerset, Swindon, and Wiltshire system for 8 years, Cara was appointed as the new Joint Chief Executive Officer at Great Western Hospitals, Royal United Hospitals Bath, and Salisbury Foundation Trust. In terms of other declared interests, Cara is a Visiting Professor of the Faculty of Health and Applied Sciences at the University of the West of England, Chair of NHS Quest, a leadership and development service provider, and Honorary Colonel of 243 Multi-Role Medical Regiment, part of the Army Reserve Medical Services.

Andrew (Andy) Hollowood, Chief Medical Officer (until November 2024), Interim Managing Director (from November 2024).

Andy joined the RUH as Chief Medical Officer on 15th September 2022. He is a cancer surgeon by background, specialising in gastric cancer, and he previously worked as Deputy Medical Director at the University Hospitals Bristol and Weston NHS Foundation Trust, covering the Weston site. Andy is passionate about taking positive action to reduce the impact of health inequalities, and he is committed to creating a listening culture to support staff in problem solving and creating solutions. Andy was Deputy Chief Executive from November 2023 until November 2024, when he became Interim Managing Director following the appointment of the Joint Chief Executive Officer. In terms of declared interests, Andy is a director of Sulis Hospital Bath Ltd., and his wife is a general practitioner at Hartcliffe Surgery in Bristol.

Sarah Richards, Acting Chief Medical Officer (November 2024 – February 2025).

Sarah is a Consultant Surgeon with a sub-specialist interest in Upper Gastro-Intestinal and Emergency Surgery. She was appointed as the first female Consultant General Surgeon at the RUH in 2013 and led the development of emergency surgical services in the hospital. She was appointed as Deputy Chief Medical Officer alongside her clinical role in 2023. She has a strong background in surgical training, quality improvement and medical leadership. She is National Clinical Lead for Surgical Same Day Emergency Care at NHS England and an advisor to the Royal College of Surgeons. Sarah temporarily joined the Board of Directors as Acting Chief Medical Officer between November 2024 and February 2025. In terms of declared interests, she is Director of Minerva Surgery Ltd, a company through which she undertakes private practice. She is a mother of two and a military (RAF) wife.

Kheelna Bavalia, Interim Chief Medical Officer (from February 2025).

Kheelna qualified as a doctor in 1997 from King's College London and completed her GP in London in 2001. She has a Masters' degree and has held different general practitioner roles across South London, the longest as a GP Principle serving a diverse and largely deprived population in inner city London. Kheelna is a keen educator and learner, committed to professional development and continuous improvement. She worked as Deputy Post-Graduate Dean and Deputy Medical Director in the London region before taking up the role of Medical Director for System Improvement and Professional Standards, and Responsible Officer for the South West Region in 2021. Kheelna is interested in healthcare systems and strives to improve health services in ways that make sense for patients, service users and populations. She is committed to better working across organisational boundaries and maintaining a strong focus on quality improvement and equity. In terms of declared interests, Kheelna is a Health Foundation Generation Q Fellow, and is on the Board of Trustees of Shooting Star Children's Hospices

Libby Walters, Chief Finance Officer (until April 2024).

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. By way of declared interests, Libby holds a voluntary role as a Trustee of the charity, and her daughter is a student midwife, undertaking clinical placements at the Trust. Libby stepped back from her role as Chief Finance Officer in April 2024.

Jon Lund, Interim Chief Finance Officer (May 2024 – March 2025).

Jon joined the Trust from Bristol, North Somerset, and South Gloucestershire Integrated Care Board where he was Deputy Chief Finance Officer for 5 years. He has spent his career in NHS finance in the South West working in senior finance and business planning roles in acute hospitals and integrated care boards. Jon believes that robust and effective financial and IT systems and controls are an essential enabler of the delivery of sustainable and effective healthcare. He is a passionate believer in the power of data and insights to support clinical teams to improve patient care and outcomes. By way of declared interests, Jon is a Trustee of Windmill Hill City Farm in Bristol.

Simon Truelove, Interim Chief Finance Officer (from March 2025).

Simon joined the Trust in March 2025 on temporary secondment from Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). Simon joined AWP in September 2016, having previously worked as the Chief Financial Officer and Deputy Accountable Officer at Wiltshire Clinical Commissioning Group. He has spent the whole of his career in the NHS and has worked in a range of organisations including ambulance Trusts, integrated health and social care providers, and commissioning organisations. He is passionate about the NHS and empowering his teams to transform the services that they support. In terms of declared interests, Simon's wife is the Chief Finance Officer and Deputy Chief Executive of Bristol, North Somerset, and South Gloucestershire Integrated Care Board.

Antonia (Toni) Lynch, Chief Nursing Officer

Toni joined the RUH in April 2021 from Guy's and St Thomas' NHS Foundation Trust, where she was the Deputy Chief Nurse and acting Chief Nurse providing leadership to 7000 nurses and midwives through the first two waves of the COVID-19 pandemic. She previously held senior roles both in clinical and operational management. Toni holds a Masters' degree in Advanced Nursing Practice and has completed the Nye Bevan Executive Leadership programme. Toni took executive responsibility for facilities alongside her Chief Nursing Officer role in February 2024. She also has executive responsibility for estates as of January 2025. In terms of declared interests, her spouse is a Matron at the Great Western Hospitals NHS Foundation Trust.

Paran Govender, Chief Operating Officer

Paran joined the Trust in October 2023 from Guy's and St Thomas' NHS Foundation Trust. She has worked in a number of NHS organisations, including King's College NHS Foundation Trust where she held a number of clinical and operational roles. She has extensive clinical and leadership experience as an Occupational Therapist, Chief Therapist and Director of Operations and Partnerships in South East London. Paran grew up in South Africa and was influenced by the political and economic challenges and disproportionate socio-economic climate. She is committed to supporting those in need and works tirelessly to champion basic rights including health and care. Paran has no declared interests.

Jocelyn Foster, Chief Strategic Officer

Joss was previously Director of Business Strategy for Kent County Council, Strategy Director at (Parcelforce) Royal Mail, Strategic and Corporate Development Director at Leicestershire Partnership NHS Trust and has previous public and private sector experience in business strategy, planning, transformation, and new business development. Joss has an MBA, DPhil, and BSc (Hons) in Biological Sciences. Her declared interests include a financial interest in Veloscient Ltd, a company dedicated to facilitating structured data capture for a range of markets, including healthcare, and work as a complaint's panellist for the Dental Complaints Service.

Alfredo Thompson, Chief People Officer

Alfredo joined the Trust at the end of January 2022 from North Middlesex University Hospital NHS Trust where he had led the culture change and leadership programmes. He has held a number of senior roles both within the NHS and in other sectors and is passionate about organisational culture, staff experience and inclusion. In terms of declared interests, Alfredo attends Locum's Nest Special Interest Group Meetings, but has not attended any meetings since January 2025. This is a private organisation that the Trust uses to book medical locums.

Christopher Brooks-Daw, Director of Governance & Chief of Staff

Christopher became the Director of Governance & Chief of Staff in January 2024, having worked in many roles in healthcare for over 30 years beforehand. He has had a varied career spanning clinical and corporate roles in both the NHS, overseas and the independent healthcare sector. His previous roles have included senior positions in nursing, governance and risk, leadership, and organisational change. Christopher's motivation centres on continuous learning, bringing simplicity and clarity, fostering a positive organisational culture, and advocating for both staff and patients. He enjoys working with colleagues to find creative ways to solve problems and design better ways of working. He has no declarations of interest.

Contact with the Directors

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

Register of interests

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

Cost Allocation and Charging Requirements

The Royal United Hospitals Bath NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Political and Charitable Donations

The Royal United Hospitals Bath NHS Foundation Trust has not made any political or charitable donations in 2024/25. This is the same as the 2023/24 year.

Oversea

The Royal United Hospitals Bath NHS Foundation Trust has not had any overseas operations in 2024/25. This is the same as the 2023/24 year.

External Consultancy

The Royal United Hospitals Bath NHS Foundation Trust has not engaged any external consultants.

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 national standard is 95% for both number and £'000. The table below includes the position for both the Trust and Sulis Hospital. Over the 12 months to 31 March 2025, the Group achieved the following performance:

Total interest paid to suppliers under the Late Payment of Commercial Debts Act 1998 was £0k (£0k in 2023/24).

	2024/25			2023/24	
Better payment practice code	**Actual Foundation Trust Number**	**Actual Foundation Trust £'000**		**Actual Foundation Trust Number**	**Actual Foundation Trust £'000**
Non-NHS					
Total bills paid in the year	83,456	377,287		88,907	352,808
Total bills paid within target	78,381	341,612		82,816	322,555
Percentage of bills paid within target	**93.9%**	**90.5%**		**93.1%**	**91.4%**
NHS					
Total bills paid in the year	1,739	29,114		1,451	25,860
Total bills paid within target	1,326	17,742		1,131	18,673
Percentage of bills paid within target	**76.3%**	**60.9%**		**77.9%**	**72.2%**
Total					
Total bills paid in the year	85,195	406,401		90,358	378,668
Total bills paid within target	79,707	359,354		83,947	341,228
Percentage of bills paid within target	**93.6%**	**88.4%**		**92.9%**	**90.1%**

The percentage of NHS bills paid within target has declined, but the overall total has remained consistent. Finance have been working closely with divisions to improve reporting and processes surrounding this, there is an update to the Audit Committee quarterly giving details on aged creditors.

NHS Improvement's Well Led Framework

This information is subject to audit.

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

An external well-led review was commissioned to start in July 2023 for a period of 3 months but was rearranged due to other emerging priorities. The review began in May 2024 and concluded in the summer of 2024.

This developmental review has the key aim to understand our strengths and also areas that require improvement from a well-led perspective.

The Annual Governance Statement describes in further detail the Trust's approach to ensuring services are well-led and quality governance. The Quality Account describes quality improvements in more detail which is published on the Trust's website in June 2025.

Well-Led Improvement Plan:

Aqua were commissioned to carry out Well-Led Developmental Reviews in each of the three organisations of Royal United Hospitals NHS Foundation Trust, Salisbury NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust. The review began in May 2024 and concluded in the summer of 2024.

The final report describes the findings of the review. Key areas include:

- Maintaining alignment as individual strategies evolve with the Clinical Strategy and the People Plan within the context of the financial challenges.
- Embedding governance and wider risk changes that are in the process of being reviewed and developed.
- Developing the maturity of the divisions in terms of accountability, autonomy, visibility with the board, increased awareness of wider corporate issues etc.
- As the community bid progresses, assessment of community leadership expertise and giving a voice to all partners.

A single well-led improvement programme (WLIP) will be developed. Oversight of the programme will be through the Executive Team/Trust Management Executive, linking into existing workstreams.

Key responses include:

- Aligning/mapping existing work to development recommendations. For example, significant work has been ongoing across quality to ensure a robust quality oversight and assurance framework.
- Additionally, strengthening of the core architecture that supports Trust Board and sub-committee effectiveness is well underway.
- Engagement and inclusion of Divisional (clinical and corporate) to develop and oversee actions.
- Implementation of changes/improvements.
- Establishing the oversight mechanism through the Executive Team/TME with the WLIP.

Modern Slavery Act 2023/24 annual statement

The Group is committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain.

We are fully aware of the responsibilities we hold towards our service users, employees, and local communities.

We are guided by a strict set of ethical values in all our business dealings and expect our suppliers (i.e., all companies that we do business with) to adhere to these same principles.

We have zero tolerance for slavery and human trafficking.

Enhanced quality governance reporting

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The accuracy of the Trust's Quality Account and an assessment of whether this presents a balanced view of controls in place is provided through internal review, stakeholder engagement and consultation. The report for 2024/25 will be published on the Trust's website in June 2024.

Quality is embedded in the Trust's overall strategy – *The people we care for.* Quality targets are linked to clinical divisions and the Trust's performance against the quality priorities and targets is included in the Trust-wide Integrated Performance Report (IPR) which is reviewed monthly by various committees and ultimately by the Board of Directors. During 2024/25 the Board continued to receive regular performance information on key quality indicators including patient safety, patient experience, and clinical effectiveness.

Quality Indicators Performance 2024/25

We made successful progress in delivering our quality priorities in 2024/25, which were:

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

These will be reported in full in the 2024/25 Quality Account which is published on the Trust's website in June 2025.

Quality Priorities 2025/26

We have set the following quality priorities for 2025/26:

- Improving Patient Safety & Quality
- Developing our framework for Carers
- Communicating with you in a clear and understandable way at the right time

Improving Patient and Carer Experience

Following a review of Governance at the Royal United Hospitals Bath, the Patient Experience Committee was set up in February 2024 as a subgroup of the Quality Assurance Committee. The Patient Experience Committee is responsible for providing strategic leadership for patient experience and raising the profile and visibility of patient experience in the Trust as well as providing assurance to the Quality Assurance Committee.

It is chaired by the Deputy Chief Nursing Officer and has representation from each of the Clinical Divisions. Operational delivery of improvements to patient and family experience is the responsibility of the Operational Improving Patient Experience group chaired by the Head of Patient Experience.

In 2024/25 we have continued our focus on improving peoples experience of care and in the section below we have listed some of the highlights from the last year.

Adult Inpatient Survey results

The RUH was rated ninth in the country for overall patient experience, based on results from the national Adult Inpatient Survey that the Care Quality Commission carries out each year. Our results showed that patients felt they were treated with respect and dignity and said that staff took time to consider their individual needs.

Responding to what patients tell us

Patients and their families tell us how important **communication and information** is to them; at the right time, in the right format and adapted to meet their needs. In the section below we have included improvements in response to patients' feedback.

Waiting Well website pages

The Patient Experience team and members of the patient readers panel worked together to produce information for patients who are waiting for an appointment or procedure, including waiting times, how to stay well and how to prepare and get the most from their appointment. This information is now available on the hospital website.

Support for staff to ensure better communication with patients and families/carers

The Patient Experience team developed a suite of resources to help staff communicate with patients who need extra support with communicating or understanding. This includes information on interpreters and supporting people who are visually impaired or have hearing loss.

Improving communication access with patients, their carers and families

We have a duty to provide information to our patients in a format that meets their needs. It ensures people with a disability or sensory loss can access and understand the information we provide. This helps improve access to services, promotes inclusion and enables people to make more informed choices about their care and treatment.

For staff, the provision of accessible information and support with communication helps improve communication with patients, supports effective engagement, and supports choice, personalisation and empowerment.

An audit was undertaken this year to understand whether we are meeting patients' information and communication needs. As a result of the findings, we have updated the Trust guidelines to help staff provide easy read information, information in Braille, Electronic Audio files, information in large font, British Sign Language (BSL) interpreters, advocates as required and other communication support.

Communication Access eLearning

This year, the Trust signed up to the Communications Access Standards and as a result has included a short eLearning module accessible for all staff on the 'Learn Together' platform with simple advice as to how they can improve communication with patients and families.

Small, simple changes can make a big difference ensuring people are given time to communicate, for staff to ask the patient/family what helps with better communication, focusing on listening and then remembering that communication is a 2-way process.

Communication Access training helps staff to recognise that a person might have communication support needs and to consider the best way to communicate to help them as an individual.

Improving Deaf Awareness: Deaf Awareness Champions Network

This year, the hospital set up a network of staff and volunteers to raise awareness of best practice and standards to meet the needs of deaf and hard of hearing people. This includes promoting accessibility, inclusion and equality, enhancing patient experience and improving communication with deaf and hard of hearing people.

The vision is for the RUH to be an inclusive and supportive environment for deaf and hard of hearing people. There are currently 66 staff from a range of disciplines championing deaf awareness and identifying areas for improvement.

Improving Deaf Awareness: Deaf Awareness eLearning

We have worked with Unseen Aware, a social enterprise organisation and staff from across the hospital attended training in unseen disability awareness. We recognise that this doesn't make them experts in all unseen disabilities or conditions, but it helps them have greater understanding and empathy.

The training is designed to embed behaviour change over time and introduces the principles of how to engage with someone who has an unseen disability, in particular for this year focusing on being more deaf aware.

Readers Panel

All new written patient and carer information produced by the Trust is reviewed by members of the public who make up our 'Readers Panel.' We are fortunate to have over 140 active members that review patient information. They assess the quality of the written patient and carer information to ensure that it meets Trust standards and is clear and easy to understand for patients and lay people. The Readers Panel reviewed 96 new patient information leaflets in 2024/25.

Improving access to interpreters

We use an external provider for foreign language interpreters, and along with Action Deafness can provide foreign language interpreters and British for Sign Language (BSL) interpreters, to support conversations with patients whose first language is not English or who are deaf and use BSL to communicate.

We are aware that it is increasingly difficult to book interpreters to come to the hospital for planned appointments or for planned conversations with inpatients and so we are reviewing the ability to use interpreters via telephone and video. This is to ensure there is no delay in patient care and treatment due to difficulties in booking interpreters and to reduce the cost of interpreters for the Trust.

The Patient Experience team conducted an audit of 38 departments across the hospital to understand what the challenges and benefits are for staff when booking and using interpreters, whether that is face-to-face, by telephone or by video.

We will be taking the results of the audit to the Patient Experience Committee in May 2025, as well as a proposal to support teams to use telephone and virtual interpreters to reduce any delay in the care and treatment of patients whose first language is not English or who are deaf and use BSL to communicate.

Improving Patient Experience Awards 2024/25

The hospital's Improving Patient Experience awards recognizes teams and individuals who have shown initiative and a commitment to improving patient experience.

The Maternity Triage team were awarded first place for the successful improvements they made to the maternity triage pathway. Maternity Triage provides individualized care for those with maternity concerns during their pregnancy or following birth.

The team engaged with service users to understand their experience of attending Maternity Triage and, as a result, introduced a single point of access for all enquiries, leading to an immediate urgent care review if required. Feedback from women, families and birthing people describes a responsive and supportive team and positive experiences of the new system and department facilities.

The first runner up was the Pain Clinic nursing team for developing a dedicated pain information session for patients. The new session provides patients who have been referred to the service with additional information and support about what to expect from their treatment and help them to make informed decisions about their treatment plan.

Joint second place runners up were Art at the Heart - RUH's in-house art and design team - for their work on children and older patients' wards. To improve patient experience, Art at the Heart introduced a musician in residence and artists in residence along with other ward-based art activities.

These combined efforts create a therapeutic environment where patients can find comfort, joy, and healing through music and art, greatly improving their overall experience during their hospital stay.

The Listening Service was another joint runner up. Introduced by the Patient Support and Complaints team, the Listening Service provides patients, families and carers with an opportunity to reflect on their or their loved one's care and share their thoughts and feedback on the service they received.

This also provides an opportunity for the organisation to learn from experiences and help to facilitate change and improvements in care.

The other joint runner up award went to the Critical Care Outreach team for the development of the 'Call for Concern' service. The team have implemented call for concern following the introduction of Martha's Law. Patient and families are able to contact the team 24/7 if they are concerned that a patient is deteriorating and are not being responded to.

Hearing patient and family stories

A Patient Story is presented to each public meeting of the Board of Directors. The patient story aims to set a patient focussed context to the meeting. The story is either filmed, voice-recorded or the patient/family member shares their experience in person.

Listening to patient and family stories provides a unique insight into their experience of the hospital and helps staff to acknowledge and celebrate what we do well and recognise where we need to improve care. Patient or family and staff stories are shared on the Trust internal web pages and used for training and education.

We try to ensure a wide range of topics are covered, sometimes these link to health inequalities or quality priorities; others can focus on seldom heard or some of the services we see less about.

Topics at the Board have included:

- Working with Bath Ethic Minority Senior Citizen Association (BEMSCA) to co-produce a **'See it my way film' called 'me, my care and my culture**.' The film was created to raise awareness in the hospital of different cultures and how we can best care for people from different ethnic backgrounds

- A film about a mum and her 9 year old son who has profound learning disabilities and cognitively is about 18 months old and their experience of coming to the hospital in an emergency and getting a diagnosis and treatment.
- A young girl with severe weight loss and her mum who stayed with her during her time in hospital. During this time, they felt that there was a lack of joined-up care with other service providers. A lack of privacy on the ward was also highlighted.

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:

- Through social media
- Sharing stories and case studies for learning
- Feedback from complaints, compliments and friends and family tests
- Hospital questionnaires, telephone interviews, focus groups and surveys
- Patients, governors and Board feedback on ward accreditation schemes.

Friends and Family Test (FFT)

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

To support us to understand patient experience the FFT question is now asked by text message. The text is sent to patients who have provided us with their mobile phone number. Feedback via a text messaging service was introduced on 1st October 2023.

The FFT question was sent to 222,442 patients, and of those, 68,632 rated their experience between 1 (very good) and 5 (very poor) of the hospital. This is a response rate of 21.3 %, which is just above the average of 20% nationally.

94% of our patients rated their experience as a positive one, 3.4% felt that they had a negative experience, with the other 2.6% being neutral.

Of those patients that rated their experience, 50,610 also gave comments explaining why they gave the rating that they did.

Those comments are then themed by AI, using the sentiment behind the comment. The top three themes for the positive comments were:

- Staff Attitude
- Care
- Treatment and Communication.

The top three negative themes were:

- Staff Attitude
- Wait Time
- Communication

Complaint handling

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

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

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

This approach is in line with the NHS Complaints Standards. This highlights the importance of welcoming complaints in a positive way ensuring that the process is ‘responsive to the needs of each individual’.

Prompt engagement by Matrons or other senior staff to listen and resolve complaints at the earliest opportunity has also supported the Trust commitment to promote a learning culture and welcome complaints in a positive way.

In 2024/25 the trust received 361 formal complaints which is a 35% increase from 2023/24 (267).

Clinical care concerns accounted for the majority of formal complaints followed by staff attitude and behaviour and Communication.

The trust received 3,596 Patient Support and Complaints team (PSCT) issues for resolution, feedback, compliments and requests for information, which is a decrease from 4,551 in 2023/24.

The Trust received 448 compliments via PSCT; this is a decrease from 657 in 2023/24.

Full details of the number, type and resolution of complaints received at Sulis Hospital during 2024/25 will be reported within their Quality Account.

Stakeholder relations

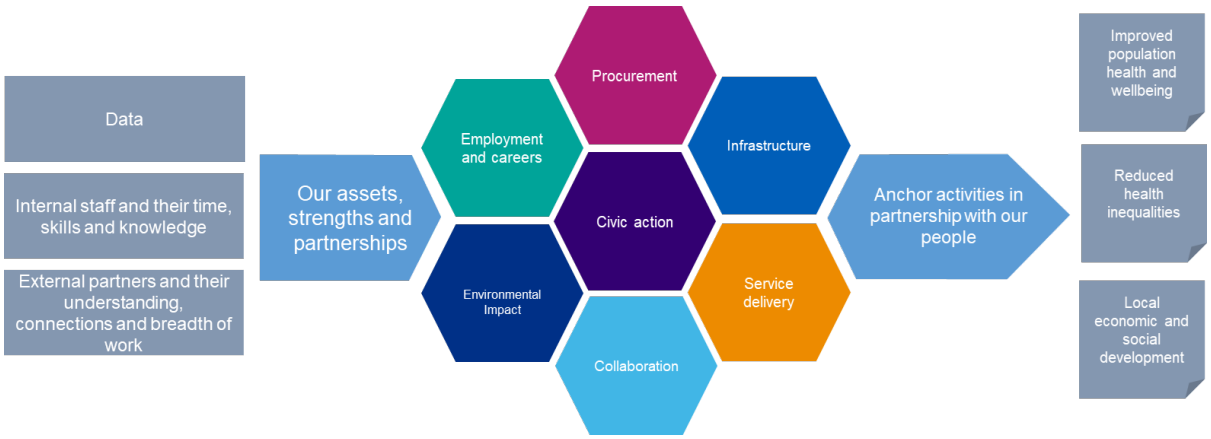
Anchor organisations

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

This year, we have set our anchor aims as an organisation:

1. Work with partners to develop and deliver a shared mission for greater health and wellbeing of our population and communities
2. Fulfil our role in delivering the BANES and Wiltshire economic strategies; establishing the RUH as an integral part of the communities we directly serve
3. Enable delivery of the Health Inequalities Programme
4. Increase our visibility as an anchor organisation and increase understanding of the RUH's role in our community's health and wellbeing

We are delivering these aims through our anchor framework. This demonstrates the different areas where we can proactively look after people's wellbeing and promote economic and social growth. Many of the activities we are delivering are in partnership with our civic partners; BANES Council, Bath Spa University and University of Bath.



Some key highlights from our anchor work in 24/25 are detailed below:

- In our role as a **sustainable community asset**, we aim to reduce our negative environmental impact and use our infrastructure to contribute to a greener community. This has included planning opportunities to deliver social value through our heat decarbonisation project, promoting sustainable travel, and enhancing the green space on our Combe Park site for example through tree planting.
- As an **employer,** we continue to deliver our careers engagement work and grow our partnerships with local educational institutions. We have been working with BANES Council to develop plans for the Good Work subgroup as part of the delivery of the BANES Economic Strategy. This sets the foundations for future opportunities to work together to improve the working lives of our populations.
- As a **purchaser,** we continue to support local supply chains, for example through our Foodie Fayre where local establishments come onsite to offer lunch options for staff.
- As a **civic partner,** we have focused on community engagement, such as running our first Community Day in September 2024. We also continue to work in partnership with local universities, particularly around shared research and innovation.
- As a **service provider,** we continue to deliver our health inequalities programme to work towards our services being accessible to all. We are also exploring options to move care closer to home, and this year have increased provision of some outpatient services at Frome Medical Practice.

Strategic Partnerships

We have continued to build our strategic partnerships, particularly with BANES Council, the University of Bath and Bath Spa University. We have regular steering group meetings to advance joint initiatives and identify where our respective strengths can be combined to make improvements and transformations for our patients, students, staff and shared community.

Third Sector

The RUH works closely with a variety of third sector partners for the benefit of current patients and research for the future. These include partners resident on its site: ReMind, 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.

Training and development

Undergraduate medical students: The RUH hosts Bath Academy as a teaching hub for Bristol University Medical School, supporting the education and training of nearly 400 medical students, equating to 9,000 student weeks, per year.

Around 25 Consultants act as Coordinators and Tutors providing and organising the teaching of medical students. They work alongside eight Clinical Teaching Fellows (Junior Doctors) as the keystone to providing the teaching both on the wards and in the classroom.

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

At the RUH we continue to explore non-medical workforce options, including medical nurse practitioners, Advanced Clinical Practitioners and Physician associates. The Trust Education Group has continued to help facilitate successful multi-professional skills days to further integrate training and development across the various professional groups.

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

Our work experience programme received a gold award under the Work Experience Quality Standard, a national accreditation run by NHS England.

The RUH has a new Clinical Skills programme of work and a new clinical practice facilitator role supporting all learners in clinical practice and in the delivery of high quality skills training and practical competency assessment.

Primary care services

In 24/25 we took over the lease for 9 consulting rooms and 1 minor ops theatre at Frome Medical Practice, with the aim to maximise the volume and diversity of outpatient services delivered there. There were 14 RUH services already running under the previous rental agreement.

As well as expanding some of these services, we have added 3 services, plus work has started to deliver chemotherapy from 2 of the rooms. We will continue to maximise use of this site as part of our plans to move care closer to home.

We have also been working with Frome and Mendip Primary Care Networks to deliver improvements to the primary/secondary care interface as part of the national PCN Test Site Pilot Scheme led by Dr Claire Fuller and Professor Tim Briggs. This partnership working will continue in 25/26 to test innovative ways of enhancing joined up working across primary and secondary care to see what is effective and can be scaled up nationally.

Learning from best practice networks

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

Health Innovation West of England

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

The RUH hosts and continues to work in partnership with Health Innovation West of England to explore new opportunities for collaboration and innovation, further improve patient safety and quality of care, and share best practice across the South West.

A number of our clinical teams have been participating in specific work streams to support the rapid implementation of innovation and service improvement and share best practice across the NHS, including roll out of the Supporting High impact users in Emergency Departments (SHarED) programme, recognised at the 2023 HSJ Patient Safety Awards, at the RUH.

Our work as part of the Maternity and Neonatal Patient Safety Network to improve safety and outcomes of maternal and neonatal care by reducing unwarranted variation and providing high quality healthcare experience to all women, babies and families was also noted by the CQC during their 2023 inspection of RUH Maternity services.

Consultation with local groups and organisations

New approaches to engagement through virtual platforms developed during the COVID-19 pandemic have informed much of our engagement work this year, for example the use of online patient engagement workshops to develop our thinking for a new Vulnerable Persons strategy.

We have also reinstated many of our previous activities, for example the face-to-face Annual General Meeting and Annual Members' Meeting in September 2024, which saw over 100 members of the public, Trust members and governors and local organisations come together to hear updates on key RUH projects and ask questions of our Board of Directors.

Our You Matter strategy puts the voice of our people at the heart of everything that we do.

Our work with local partners plays a key role in this. For example, our maternity matrons run a quarterly forum with the BSW Maternity & Neonatal Voices Partnership and local birth doula's, antenatal teachers, hypnobirthing teachers and yoga teachers to provide communication within the wider birthing community, with a shared vision of personalised care and support for women and birthing people.

Within BSW Integrated Care System, we have sought feedback from patients and families who have recently been discharged from hospital on their experience, as part of a wider programme to improve the process of leaving hospital.

Statement to disclose to the auditor

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

So far as the Director is aware, there is no relevant audit information of which the Trust's auditor is unaware and,

The Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust auditor is aware of that information.

Income Disclosures

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

Joint ventures

In July 2016, Wiltshire Health and Care (a limited liability partnership (LLP) and joint venture created between Great Western Hospitals Foundation Trust, Salisbury Foundation Trust and the RUH) commenced its £40 million a year contract to deliver seamless and improved community services across Wiltshire.

The RUH, along with Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust, are working with local third sector, end of life, primary care, community services and mental health services to consider how we can work together to support transformation of community services in future.

The Wiltshire Health and Care contract was moved and ceased trading on the 1st April 2025.

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. The Chief Medical Officer from RUH Bath has a seat on the Board for Sulis Hospital Bath Ltd. This is part of the portfolio responsibilities of the post. All 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.

Sulis Hospital Bath Ltd and the RUH charity have been included the group accounts.

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.

Cara Charles-Barks
Chief Executive
26 June 2025

Remuneration Report

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

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

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 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 Committee reviewed the salaries of the Executive Directors for 2024/25 and recognised the annual pay increase for Very Senior Managers as laid out in guidance shared from NHS England.

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

The Trust recognises the need to be competitive with remuneration packages for the executive directors, reflecting the level of skills and experience the Trust needs to recruit and retain talent. However, it also needs to be sensitive to the political and financial environment.

The work of the committee covered:

- The proposal and approval of plans to appoint into the interim roles of Chief Finance Officer and Chief Medical Officer.
- The proposal, planning and appointment of a Group Chief Executive Officer.
- Pay review for all Executive Directors in line with NHS England mandate.
- Pay review of new Group Chief Executive role.
- Additional allowance for extra portfolios undertaken by the Chief Nurse and the Chief Operating Officer.

Senior managers' remuneration policy

With the exception of the Chief Executive and Executive Directors, all non-medical employees of the Trust are remunerated in accordance with the national NHS Agenda for Change pay structure.

Medical staff are remunerated in accordance with national terms and conditions of service for doctors and dentists.

The pay and terms and conditions for the Chief Medical Officer are determined by the national Consultant Contract and the associated Medical Terms and Conditions. An additional payment is made which reflects the additional responsibilities for the role of Chief Medical Officer.

The remuneration of the Chief Executive and Executive Directors is determined by the Board of Directors' Nominations and Remuneration Committee considering market levels, key skills, performance, and responsibilities.

This section details the remuneration package and any changes made to it for Executive Directors.

Element	Rationale	Notes
Salary	The Board approved the Trust Strategy. This is delivered by the Executive Directors and the success measurement is one of the ways in which the Director's performance is monitored. All executive director remuneration is subject to satisfactory performance of duties in line with their employment and monitored through regular 1:1 with the Chief Executive and annual appraisal. The Chief Executive performance review is led by the Trust Chairman.	There is no performance related pay and Directors receive 100% of their salary subject to the relevant deductions. Salary is benchmarked and there are no automatic rises for executive directors. No maximum is specified but market rates are considered.
Taxable benefits	Any taxable benefit is agreed by the Remuneration Committee. This forms part of the recruitment and retention of executive directors by ensuring that the Trust remains competitive.	There is no maximum amount payable.
Bonus	No bonus scheme operates at the Trust.	Therefore, the maximum that could be paid is £0.
Pension	Standard pension arrangements are in place.	There is no maximum amount payable.

Executive Terms and conditions

- Annual leave is determined by NHS length of service, up to a maximum of 33 days per annum plus eight bank holidays.
- Sick pay is provided at NHS rates of six months full pay and six months half pay.
- The Trust's normal policies and procedures apply to the directors including disciplinary and redundancy, in line with NHS terms for all staff.
- There is no compensation for early termination of contracts, other than the standard term of all staff which is payment in lieu of notice.
- All other employees' remuneration is based on the national terms and conditions appropriate to their contract of employment.

Disclosures:

- Cara Charles-Banks moved into the Group Chief Executive position on 1 November 2024
- Andrew Hollowood was the Chief Medical Officer and Deputy Chief Executive until 1November 2024 when he became the Interim Managing Director
- Sarah Richards was the Acting Chief Medical Officer from 1 November 2024 – 1 February 2025
- Kheelna Bavalia became the Interim Chief Medical Officer from 1 February 2025.
- Libby Walters was the Chief Finance Officer until 20 April 2024
- Jon Lund was the interim Chief Finance Officer from 1 May 2024 – 1 March 2025
- Simon Truelove is the Interim Chief Finance Officer from 1 March 2025

- There have been no new components of the remuneration package introduced.
- There were no payments made to past senior managers.
- There are no provisions for the recovery of sums paid to directors nor have we withheld any payment to a director.
- All executive directors are employees of the Trust and their contracts of employment are open-ended.
- However, the Trust has not directly consulted with the wider employee body in setting the remuneration policy for senior managers.

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

Following guidance from the Secretary of State for Health, the Trust noted the requirement to seek approval from the Chief Secretary to the Treasury for appointments above the Prime Minister's salary of £150,000.

In 2024/25, the Trust has not made any appointment beyond this level. The Trust does however provide the following staff with a total remuneration package that is higher than £150,000:

- Cara Charles-Barks
- Libby Walters
- Paran Govender
- Andrew Hollowood
- Antonia Lynch

This has been robustly reviewed by the Remuneration Committee and based on the skills and experience required and the complexity of the Trust, the Committee is assured that the total remuneration package for this role is necessary and justifiable.

Non-Executive role	Remuneration
Chair of Trust Board and Council of Governors payment	£49,950
Non-Executive Directors payment	£13,000
Additional Senior Independent Director payment	£1,500
Additional Chair of Audit Payment	£1,500
Additional Committee Chair payment (max one payment)	£1,000

Appraisal arrangements

The Remuneration Committee shall approve nomination, remuneration, and terms and conditions for executives and senior managers. The Council of Governors are responsible for the same arrangements with the Non-Executive Directors.

All executive and non-executive directors have an annual appraisal. The chief executive leads the appraisal arrangements for the executive directors. The chair leads on the non-executive director's appraisals and the chief executive officer's appraisal.

The Senior Independent Director leads on the appraisal of the chairman.

No director or governor have any company directorships or other significant interests which may conflict with their management responsibilities.

Remuneration Committee

Pay levels are informed by executive salary surveys conducted by independent management consultants and NHS Providers which are then thoroughly reviewed by the Remuneration Committee.

Remuneration for the Trust's executive directors, who are members of the Board of Directors, is determined by the Remuneration Committee. This is a statutory committee of the Board of Directors and chaired by the Trust Chairman. It is a Non-Executive Director committee who approve nomination, remuneration, and terms and conditions for executives.

The Committee also considers opportunities for the development of the Executive Directors. Non-executive director remuneration is set and reviewed in accordance with the Trust Constitution and is the role of the Council of Governors Remuneration and Recommendation Panel.

There were nine meetings of the Remuneration Committee, the attendance is below.

Membership:

Name	Attended	Name	Attended
Alison Ryan	8/9	Nigel Stevens	6/9
Antony Durbacz	6/9	Ian Orpen	1/2
Hannah Morley	5/9	Simon Harrod	6/6
Paul Fairhurst	8/9	Paul Fox	9/9

Supported by the following employees:

Name	Attended	Name	Attended
Alfredo Thompson	5	Cara Charles-Bark	4
Christopher Brooks-Daw	1	Andrew Hollowood	2

Expenses

These figures are the expenses that have been paid in year. The disclosed expenses are non-taxable expenses claimed by governors and directors

	Number in Office		Number who claimed		£ claimed	
	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24
Governors	23	26	9	13	1,637.00	1,374.53
Directors	21	19	14	13	9,742.36	£7,674.31

Senior Managers' Remuneration (subject to audit)

Remuneration for Senior Managers for 2023/24:	Salary and Fees (bands of £5,000)	All taxable benefits (total to the nearest £100)	annual performance-related bonuses (in bands of £5,000)	long-term performance-related bonuses (in bands of £5,000)	all pension-related benefits (in bands of £2,500)	Total (bands of £5,000)
Cara Charles-Barks	230 - 235	-	-	-	0 - 2.5	230 - 235
Libby Walters	170 - 175	-	-	-	0 - 2.5	170 - 175
Andrew Hollowood	195 - 200	-	-	-	0 - 2.5	195 - 200
Jocelyn Foster	140 - 145	-	-	-	0 - 2.5	140 - 145
Antonia Lynch	145 - 150	-	-	-	0 - 2.5	145 - 150
Alfredo Thompson	135 - 140	-	-	-	7.5 - 10	145 - 150
Brian Johnson	120 - 125	-	-	-	30 - 32.5	150 - 155
Simon Sethi (until May 2023)	15 – 20	-	-	-	0 - 2.5	15 – 20
Niall Prosser (from May – Oct 23)	45 - 50	-	-	-	75 - 77.5	120 - 125
Paran Govender (from 2 October 23)	75 - 80	-	-	-	57.5 - 60	135 - 140
Christopher Brooks-Daw (from 5 Jan 24)	25 - 30	-	-	-	5.0 – 7.5	30 - 35
Alison Ryan	45 - 50	-	-	-	-	45 - 50
Nigel Stevens	15 – 20	-	-	-	-	15 – 20
Sumita Hutchinson	10 - 15	-	-	-	-	10 - 15
Ian Orpen	10 - 15	-	-	-	-	10 - 15
Antony Durbacz	10 - 15	-	-	-	-	10 - 15
Paul Fairhurst	10 - 15	-	-	-	-	10 - 15
Hannah Morley	10 - 15	-	-	-	-	10 - 15
Paul Fox	10 - 15	-	-	-	-	10 - 15

Senior Managers' Remuneration (subject to audit)

Remuneration for Senior Managers for 2024/25	Salary and Fees (bands of £5,000)	All taxable benefits (total to the nearest £100)	annual performance-related bonuses (in bands of £5,000)	long-term performance-related bonuses (in bands of £5,000)	all pension-related benefits (in bands of £2,500)	Total (bands of £5,000)
Cara Charles-Barks	180 - 185	100	-	-	142.5 – 145.0	325 -330
Libby Walters	175 - 180	-	-	-	180.0 - 182.5	360 - 365
Andrew Hollowood	235 - 240	-	-	-	260.0 - 262.5	495 - 500
Jocelyn Foster	145 - 150	-	-	-	25.0 - 27.5	175 - 180
Antonia Lynch	165 - 170	-	-	-	15.0 - 17.5	180 - 185
Alfredo Thompson	140 - 145	-	-	-	25.0 - 27.5	170 - 175
Paran Govender	170 - 175	-	-	-	102.5 - 105.0	275 -280
Christopher Brooks-Daw	125 - 130	-	-	-	32.5 - 35.0	160 -165
Sarah Richards	50 - 55	-	-	-	17.5 - 20	70 -75
Jon Lund	140 - 145	-	-	-	292.5 – 295.0	435 - 440
Simon Truelove	5 - 10	-	-	-	0 - 2.5	5 -10
Kheelna Bavalia	35-40	-	-	-	5 – 7.5	40 - 45
Alison Ryan	45 -50	-	-	-	-	45 -50
Nigel Stevens	15 - 20	-	-	-	-	15 -20
Sumita Hutchinson	10 - 15	-	-	-	-	10 -15
Ian Orpen	5 - 10	-	-	-	-	5 - 10
Antony Durbacz	10 - 15	-	-	-	-	10 - 15
Paul Fairhurst	10 - 15	-	-	-	-	10 - 15
Hannah Morley	10 - 15	-	-	-	-	10-15
Paul Fox	10 - 15	-	-	-	-	10-15
Simon Harrod	5 - 10	-	-	-	-	5-10

Senior Managers' Remuneration (subject to audit)

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

Senior Managers' Remuneration (subject to audit)

Pension for Senior Managers for 2024/25	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 2025 (bands of £5,000)	Lump sum at pension age, related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real increase in Cash Equivalent Value Transfer	Cash Equivalent Transfer Value at 31 March 2025	Employer's Contribution to Stakeholder Pension
Cara Charles-Barks	7.5 – 10	10 -12.5	55 – 60	125 – 130	1,048	140	1,219	35
Libby Walters	7.5 - 10	15 - 17.5	70 - 75	185 - 190	1,380	186	1,586	26
Andrew Hollowood	12.5 - 15	25 - 27.5	105 - 110	280 - 285	2,210	293	2,532	34
Jocelyn Foster	0 - 2.5	0 - 2.5	25 - 30	55 - 60	594	27	638	20
Antonia Lynch	0 - 2.5	0 - 2.5	50 - 55	135 - 140	1,246	25	1,290	22
Alfredo Thompson	0 - 2.5	0 - 2.5	40 - 45	0 - 5	580	21	619	21
Paran Govender	5 - 7.5	7.5 - 10	50 - 55	125 - 130	961	100	1,082	25
Christopher Brooks-Daw	2.5 - 5	0 - 2.5	25 - 30	35 - 40	476	30	522	18
Sarah Richards	0 - 2.5	0 - 2.5	60 - 65	155 - 160	1,255	18	1,346	6
Jon Lund	15 - 17.5	0 - 2.5	55 - 60	0 - 5	554	215	808	21
Simon Truelove	0 - 2.5	0 - 2.5	50 - 55	125 - 130	1,192	0	1,203	1
Kheelna Bavalia	0 - 2.5	0 - 2.5	25 – 30	55 - 60	519	4	573	5

Value of pensions

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

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

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

Cash Equivalent Transfer Values

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

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Statement of consideration of employment conditions elsewhere in the Trust

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

Fair Pay Multiple – this information is subject to audit

NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce. The calculation is based solely on Trust data, excluding Sulis and Charity staff.

The banded remuneration for the highest paid Director in the Royal United Hospitals Bath NHS Foundation Trust for the financial year 2024/25 was £230,000 - £235,000 (2023/24 £230,000 - £235,000). This is a change between years of 0.91% (2023/24 5.00%).

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 2024/25 was from £255 to £425,338 (2023/24 £27 to £462,564). 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 5.08%. 8 employees received remuneration in excess of the highest-paid director in 2024/25 (2023/24 12).

There has been no:

- Adjustment to the number or composition of the general workforce.
- Pay freeze in place for 2024-25
- Change to the highest paid individual, the renumeration of the most highly paid individual has decreased from 2023/24.

The Group believe that the median pay ratio for 2024-25 is consistent with the pay, reward and progression policies for the Trust's employees taken as a whole.

	2023 - 2024	**2024 - 2025**	**% age difference**
Salary of the highest paid Director	£231,369.96	£233,474.58	0.91
Bonus of the highest paid Director	-	-	0.00
Total of annualised pay – the highest paid Director / FTE employees	£52,621.87	£55,294.39	5.08
Total of performance pay and bonus – highest paid Director / FTE employees	-	-	0.00

Highest Paid Director Bonus

No Director bonus payments were made in 2024/25.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below.

The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

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

2024/25	25th percentile	Median	75th percentile
Salary component of pay	£23,615.00	£29,970.00	£41,219.57
Total Pay and Benefits excluding pension benefits	£28,850.84	£40,313.53	£52,809.00
Pay and Benefits excluding pension: pay ratio for highest paid director	8.09	5.79	4.42

Payments for loss of office

There have been no payments made to any senior manager during 2023/24 or 2024/25 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 2024/25.

Directors responsibilities

The directors understand their responsibility for preparing the annual report and accounts, and after review they consider the annual report and accounts, taken as a whole, is fair, balanced, and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.

Cara Charles-Barks
Chief Executive (Accounting Officer)
26 June 2025

Staff report

Analysis of staff numbers

An analysis of average 2023/24 and 2024/25 staff numbers for the group is outlined below:

This information is subject to audit:

Group						
	Permanent number	Other number	2024/25 total number	Permanent Number	Other Number	2023/24 total number
Medical and dental	774	17	**791**	732	8	**740**
Ambulance staff	4	1	**5**	4	1	**5**
Administration and estates	963	76	**1,039**	916	114	**1,030**
Healthcare assistants & other support staff	1,566	129	**1,695**	1,577	133	**1,710**
Nursing, midwifery & health visiting staff	1,803	125	**1,928**	1,788	166	**1,954**
Scientific, therapeutic, and technical staff	514	12	**526**	522	12	**534**
Healthcare science staff	165	2	**167**	159	2	**161**
Total average numbers	**5,789**	**362**	**6,151**	**5,698**	**436**	**6,134**
Of which: Number of employees (WTE) engaged on capital projects	18	-	**18**	14	3	17

Analysis of staff costs for 2023/24 and 2024/25

	Permanent £000	Other £000	2024/25 total £000	Permanent £000	Other £000	2023/24 total £000
Salaries and wages	298,852	1,308	300,160	276,738	679	277,417
Social security costs	31,307	-	31,307	28,950	-	28,950
Apprenticeship levy	1,413	-	1,413	1,363	-	1,363
Employer's contributions to NHS pension scheme	54,548	-	54,548	44,408	-	44,408
Pension cost - other	408	-	408	71	-	71
Other post-employment benefits	-	-	-	-	-	-
Other employment benefits	-	-	-	-	-	-
Termination benefits	-	-	-	-	-	-
Temporary staff	-	5,073	5,073	-	10,113	10,113
NHS charitable funds staff	777	-	777	892	-	892
Total gross staff costs	**387,305**	**6,381**	**393,686**	**352,422**	**10,792**	**363,214**
Recoveries in respect of seconded staff	-	-	**-**	-	-	**-**
Total staff costs	**387,305**	**6,381**	**393,686**	**352,422**	**10,792**	**363,214**
Of which: Costs capitalised as part of assets	2,111	-	**2,111**	940	832	**1,772**

Sickness absence data

Figures Converted by DH to Best Estimates of Required Data Items				Statistics Published by NHS Digital from ESR Data Warehouse	
Months	Average FTE	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
2024/25	5,918	61,888	10.5	2,160,120	100,395
2023/24	5,654	55,944	9.9	2,063,658	90,754

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

The People Plan

The People Plan was agreed by the RUH Board in July 2022 and outlined the people strategy and agenda for three to five years, with refreshes as required.

Within the People Plan there are three main themes: Culture, Capability and Capacity. Each theme has three associated programmes of work, with two further foundational programmes of work supporting these:

- Restorative, Just and Learning Culture and Civility and Kindness
- Basics Matter and user-friendly processes

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

The majority of the People Plan has been delivered, therefore, an interim People Plan refresh has been drafted for approval in Q1 2025/2026. The plan will be interim due to the evolution of the group model.

People Plan Portfolio

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

The eleven People Plan programmes are:

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

Programme governance is managed through the People Committee.

The people we work with

In this financial year, turnover and staff vacancies have remained low.

Agency and overtime spend have reduced considerably through the Temporary Workforce and Workforce Systems Programmes. In July 2024, we implemented a Preferred Supplier List for Nursing, which increased compliance with NHS price caps.

Our employee value proposition was launched in 2024/25 to promote the employee offer to current and future people. New hire attrition reduced and sustained an improved position throughout 2024/25 in comparison to previous years.

We launched the Indefinite Leave to Remain (ILR) hardship fund and ILR Application workshops to support our international colleagues to stay and make the UK their home.

The Occupational Health Service has been very busy in all aspects this year, culminating at year end with an agreement in principle to work more collaboratively with our other two group OH services.

Safe, Effective, Quality Occupational Health Service (SEQOHS) was achieved in February 2025 with no restrictions. This is accredited by the Society of Occupational Health, Faculty of Occupational Health Medicine and is the industry standard for accreditation.

HALO is the service management platform that has been implemented by IT and the People Directorate during 2024/25. In the People Directorate we have implemented it to manage, track and report on our employee relation cases including disciplinaries, grievances, capability and long-term sickness.

HALO is also used to manage workforce approvals (change of conditions and vacancy authorisation forms) and automate some of our People forms including parental leave, unpaid leave and temporary staffing requests.

We manage all our emails into the People Hub team using HALO which provides our customers with a more efficient, streamlined service enabling us to track our volumes, performance and response times.

A self-service portal and chat bot facility for staff and managers to contact us and answer queries has been in the development phase during 2024/25 and will be implemented in Q2 2025.

Our Dignity at Work programme has resulted in a Violence Prevention and Reduction policy, with an accompanying programme of work to support colleagues (especially frontline staff) to professionally challenge and respond to offensive behaviour from members of the public. Our current focus is on supporting nursing, AHP, support workforce and other patient safety colleagues to make full use of the policy provisions.

The second cohort of our positive action programme called Routes to Success is now active, and proving even more popular than last year (we have a full cohort of 21 candidates, all with sponsors). We continue to see a gradual increase in career progression for colleagues from the global majority, and those with other protected characteristics, although data is slightly skewed by the significant downturn in recruitment activity due to the organisation's sustainability priorities.

Our Anti-Racism programme continues to embed, which is bolstered by the work of the REACH Network and our ongoing Board-level commitment to challenge racism across the full spectrum of organisational activities. RUH has been proactive in promoting this workstream beyond its own boundaries (e.g. with the other organisations in BSW Hospitals Group, and at the NHS South West HRDs Network).

We have 5 staff networks, with variable activity across each of them. Our focus is becoming increasingly intersectional - we now have 4 seasonal inclusion weeks, which are focused, topical events aimed to educate, energise and 'make real' the broader impact of our inclusion programmes.

All leadership and team development activity is being aligned to the Trust's change management priorities, which sit alongside the importance of creating safe, healthy and inclusive working environments. We will be embedding the TED (Team Engagement and Development) platform in Q1 to provide teams and leaders with tools and resources to develop their people to maximise team effectiveness.

Our EAP service has been remodelled into a Wellbeing Hub, with significantly greater focus on proactive and preventative in-reach to teams.

People working groups to support new policy, procedure and culture programme development have been established and working well. These aim to improve specific areas such as workplace adjustments, supporting colleagues with long-term conditions and sexual safety.

We have also overhauled our clinical skills work based system, introducing a central recording and reporting for core clinical competencies. New Clinical Practice Facilitators support all learners in practice (ward based), monitoring clinical skills quality and assessments, delivering core clinical skills education. Therefore, supporting students and bridging the gap between training and practice.

Gender Analysis

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

- Directors
- Other Senior Managers
- Employees

Position as at 31 March 2025

	Female	Male	Total
Directors	5	4	**9**
Other Senior Managers (band 8A+)	84	46	**130**
Employees	4706	1,602	**6,308**
Total	**4,795**	**1,652**	**6,447**

Staff Survey

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

As an organisation, we have a target to be in the top 3 nationally for "recommended as a place to work" as there is a direct link between this metric and high patient safety and care quality outcomes. However, we recognise that our concerted efforts to achieve financial sustainability and to be effective as part of the BSW Hospitals Group may adversely impact staff experience. An interim People Plan for 2025/26 is therefore being finalised to help ensure we maintain an engaged and productive workforce, where people feel valued for the work they do.

NHS Staff Survey 2024 – 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 2024 and we saw a slightly reduced response rate from last year of 54%.

64% of respondents would recommend the organisation as a place to work.

The following table outlines our scores against the People Promise Themes since 2021, and the graphic below shows how we benchmark against the national average

RUH scores against People Promise themes		2021	2022	2023	2024
PP1	We are compassionate and inclusive	7.4	7.3	7.4	**7.4**
PP2	We are recognised and rewarded	6	5.9	6.1	**6**
PP3	We each have a voice that counts	6.8	6.7	6.8	**6.7**
PP4	We are safe and healthy	5.8	5.7	6	**6**
PP5	We are always learning	5.3	5.4	5.6	**5.6**
PP6	We work flexibly	6.1	6.1	6.3	**6.2**
PP7	We are a team	6.7	6.7	6.9	**6.8**
E_4	Staff Engagement	7	6.9	7.1	**6.9**
M_4	Morale	5.8	5.7	6	**5.9**

The story of the 2024 staff survey

High level trend:

There are some areas in which satisfaction scores have dipped, which accord with our focused organisational sustainability work. The removal of paid breaks was a recurrent theme during the engagement campaign.

Staff experience has been challenged by high levels of acuity and expectations around operational flow, coupled with a perception that there are insufficient resources to do the job.

We remain challenged to improve the psychological safety of reporting, team effectiveness, support to maintain health and wellbeing, and to ensure colleagues have a good worklife / homelife balance.

Areas to celebrate:

Colleagues reflected that there are ample opportunities to develop their careers within the organisation, with a strong sense of support for improving knowledge and skills. Immediate line managers are recognized for encouraging staff and providing clear feedback on their work, and for taking a positive interest in the health and wellbeing of their teams.

Most colleagues feel their teams are working well together with a clear set of shared objectives and a high level of respect and understanding among team members, contributing to a positive working environment.

The organisation continues to prioritize the care of patients and service users, which is a significant source of pride, and there is confidence that the organisation acts on concerns raised by patients and service users.

The general pattern of responses from the 2024 Staff Survey reflects some of the organisational challenges colleagues have been experiencing in relation to our targeted work on ensuring the Trust meets its sustainability and effectiveness targets. Whilst many of the identified areas for improvement have new or established programmes of work in place, the survey helps us to tailor this work to maximise impact.

Specific areas for continuation are:

- Civility and Kindness workstream is having an impact on how colleagues are communicating with each other and managers.
- Compassionate Team Working is a well-received intervention, which will be significantly enhanced by the Team Engagement and Development (TED) Platform.
- Our Violence Prevention and Reduction Programme is helping colleagues to tackle aggression, harassment, and bullying, and will continue to do so as the policy becomes embedded.
- We are currently developing our Employee Assistance Programme into a Wellbeing Hub. This will increase accessibility for all colleagues and focus much more specifically on proactive, preventative in-reach to divisional teams.
- Continued and ongoing support is required for the Basics Matter work, as perceptions that there is 'not enough' of something are likely to be linked to fundamental needs not being fully met (i.e., rest areas, staff taking breaks, financial support, health and wellbeing resources, staff recreational activity etc).

Progress made on addressing challenges identified in the Staff Survey is monitored by the RUH People Operational Group, our People PRM and our bimonthly People Committee.

Operationally, progress is planned and monitored through Divisional Performance Review Meetings (PRMs).

Areas for special focus:

- Embed reviewed flexible working policy and practices, and consolidate improvements made to workplace adjustments, supporting colleagues with disabilities and long-term conditions and sexual safety.
- Implement Trust recognition strategy and financial wellbeing programme
- Support better wellbeing and work/life balance conversations through line manager development
- Leadership and management competency framework (aligned with Improving Together)
- Further work to enhance reporting culture using reliable platforms (Updated Datix and Report + Support)
- Phase 2 review of wellbeing services to provide up-stream interventions for high-stress / high-acuity teams
- Renewed focus on our Safe and Inclusive Working Environments Programme and our newly-developed "Thriving through Change" work.

Relevant union officials

Percentage of time spent on facility time during the current and previous financial years.

Percentage of time	Number of employees 2024/25	2023/24
0-1%	24	25
1-50%	0	0
51-99%	1	1
100%	1	1
Total cost of facility time	£79,477	£78,877
Total pay bill	£368,200,000	£343,000,000
% of total pay bill spent on facility time	0.02%	0.02%

The total number of employees who were relevant union officials during 2024/25 was twenty-six. The headcount employee number was 6,447.

The time spent on paid trade union activities as a percentage of total paid facility time hours was 8.68% compared to 8.28% in 2023/24.

Off-payroll engagements

Table 1: Highly paid off-payroll worker engagements earning £245 per day or greater

1 April 2023 to 31 March 2024	Trust	Charity	Sulis	Total
Number of existing engagements	0	0	170	**170**
Of which				
Number that have existed for less than one year at time of reporting.	0	0	19	19
Number that have existed for between one and two years at time of reporting.	0	0	17	17
Number that have existed for between two and three years at time of reporting.	0	0	9	9
Number that have existed for between three and four years at time of reporting.	0	0	9	9
Number that have existed for four or more years at time of reporting.	0	0	116	116

1 April 2024 to 31 March 2025	Trust	Charity	Sulis	Total
Number of existing engagements	4	0	175	179
Of which				
Number that have existed for less than one year at time of reporting.	2	0	22	24
Number that have existed for between one and two years at time of reporting.	1	0	18	19
Number that have existed for between two and three years at time of reporting.	1	0	9	10
Number that have existed for between three and four years at time of reporting.	0	0	7	7
Number that have existed for four or more years at time of reporting.	0	0	119	119

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

1 April 2023 and 31 March 2024	Trust	Charity	Sulis	Total
Number of off-payroll workers engaged during the year ended 31 March 2024	6	1	174	181
Of which				
Number - not subject to off-payroll legislation	0	0	76	76
Number - not subject to off-payroll legislation and determined as in-scope of IR35	3	0	5	8
Subject to off-payroll legislation and determined as out of scope of IR35	3	1	93	97
Number of engagements reassessed for compliance or assurance purposes during the year	0	0	0	0
Of which: number of engagements that saw a change to IR35 status following review	0	0	0	0

1 April 2024 and 31 March 2025	Trust	Charity	Sulis	Total
Number of off-payroll workers engaged during the year ended 31 March 2024	5	1	180	6
Of which				
Number - not subject to off-payroll legislation	0	0	81	0
Number - not subject to off-payroll legislation and determined as in-scope of IR35	1	1	4	2
Subject to off-payroll legislation and determined as out of scope of IR35	4	0	95	4
Number of engagements reassessed for compliance or assurance purposes during the year	0	0	0	0
Of which: number of engagements that saw a change to IR35 status following review	0	0	0	0

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

1 April 2023 and 31 March 2024	Trust	Charity	Sulis	Total
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	1	0	0	**1**
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. **This figure must include both off-payroll and on-payroll engagements.**	40	0	6	**46**

1 April 2024 and 31 March 2025	Trust	Charity	Sulis	Total
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	1	0	1	**2**
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. **This figure must include both off-payroll and on-payroll engagements.**	35	4	7	**46**

Staff Exit Packages (figures subject to audit)

Staff exit packages include those made under nationally agreed arrangements or local arrangements for which Treasury approval is required. This does not include retirements due to ill health.

Staff exit packages include those made under nationally agreed arrangements or local arrangements for which Treasury approval is required. This does not include retirements due to ill health.

Figures for 2023/24 and 2024/25 are included in the following tables.

	2023/24		
Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	1	23	24
£10,000 - £25,000	1	8	9
£25,001 - 50,000	3	1	4
£50,001 - £100,000	4	0	4
£100,001 - £150,000	1	0	1
>£150,001	0	0	0
Total number of exit packages by type	10	32	42
Total cost (£)	**(558,000)**	**(252,000)**	810,000

	2024/25		
Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	-	14	14
£10,000 - £25,000	1	4	5
£25,001 - 50,000	1	1	2
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
>£150,001	1	-	1
Total number of exit packages by type	**3**	**19**	**22**
Total cost (£)	**£200,700**	**£127,900**	**£328,600**

Exit packages: other (non-compulsory) departure payments

	2023/2024		2024/25	
	Payments agreed number	Total value of agreements £0	Payments agreed number	Total value of agreements £0
Voluntary redundancies including early retirement contractual costs.	0	0	0	0
Mutually agreed resignations (MARS) contractual costs.	0	0	0	0
Early retirements in the efficiency of the service contractual costs.	0	0	0	0
Contractual payments in lieu of notice.	32	252	19	128
Exit payments following Employment Tribunals or court orders.	0	0	0	0
Non-contractual payments requiring MHT approval.	0	0	0	0
Total	**32**	**252**	**19**	**128**
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

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

Equality Report

Our Equality, Diversity, and Inclusion Policy is designed 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 and culture, religion or belief, sex or sexual orientation.

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

There are six staff networks:

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

The networks also help us to increase inclusivity through celebratory events such as History Months, Pride, and awareness days, providing opportunities for staff to both educate and share their lived experience. Our Annual EDI Report can be viewed via our Internet pages.

We are compliant with all statutory reporting for equality and diversity, including

- Workforce Race Equality Standard (WRES).
- Workforce Disability Equality Standard (WDES).
- Pay gap reporting.

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

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

As an organisation employing more than 250 staff, the RUH is required to publish information on its gender pay audit (Equality Act 2010). The data presented here form a snapshot as of 31 March 2025.

Key points:

- Our overall median pay gap between genders has decreased compared to 2023 and the previous year. The gap between male and female staff continues to remain close to equal (-0.20%).
- Our largest median pay gap is between male and female staff working in medical and dental roles, where we continue to see a slight widening of the gap despite targeted initiatives to redress the balance.
- Supporting medical and dental workforce teams to identify, understand and address the pay gap, and implementing national guidance on the recognised pay gap within the medical profession was an especial focus for us in 2024/25.

Median Pay Gap

The median pay gap for all staff groups combined is -0.22%. For staff on an Agenda for Change contract, the median pay gap is -12.84%. For our Medical and Dental staff the median pay gap is 31.28%.

Median hourly pay (£)	Female	Male
All staff groups combined	18.60	18.56
Agenda for Change staff only	18.10	16.04
Medical and Dental staff only	34.52	50.23

Mean Pay Gap

The mean pay gap for all staff groups combined is 16.29%. For staff on an Agenda for Change contract the median pay gap is +3.84%. For our Medical and Dental staff the median pay gap is -15.96%.

Mean hourly pay (£)	Female	Male
All staff groups combined	20.60	24.61
Agenda for Change staff only	18.01	18.73
Medical and Dental staff only	47.74	41.17

Monitoring our progress: Pay Gaps - Ethnicity

In line with the NHS High Impact Actions and our Public Sector Equality Duty under the Equality Act 2010, we are now also reviewing our Ethnicity pay gap on an annual basis. The data presented here form a snapshot as of 31 March 2025.

Key points:

- Our overall median pay gap between global majority and white staff is near equity (-5.15%) but slightly in favour of Global Majority Staff.
- This slight difference in median pay gap is due to the distribution of staff across the Agenda for Change banding, with Global Majority Staff mostly represented within our middle quartiles and more white staff represented at the lower and upper quartiles.
- It is our medical and dental staff that see the greatest difference in pay gap, favouring white staff (21.70%) with an almost £10 per hour difference. This is the first year we have looked at our ethnicity pay gap.
- We will be using the next 12 months to understand what is driving the pay gap in medical and dental staff, alongside the ongoing work to reduce the gender pay gap for the same workforce group.
- We will use this opportunity to consider intersectionality and how the two pay gaps may cause specific differences for our female, Global Majority colleagues within the Medical and Dental workforce.

This data relate to the 2023 survey to align with the pay data (which is always reported a year in arrears).

Survey Question : NHS Staff Survey 2023 Results	Male	Female
Satisfied with recognition for good work	61% ⟷	57% ⟷
Satisfied with extent organisation values my work	51% ↑	46% ↓
Satisfied with level of pay	30% ↑	29% ↓
Satisfied with opportunities for flexible working patterns	59% ↓	60% ↑
Would recommend organisation as place to work	72% ↑	69% ↑
Key: Increase from 2022 ↑		
Decrease from 2022 ↓		
No Change from 2022 ⟷		

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

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

Governance of the Trust

Role of the Board of Directors

The Board of Directors takes collective responsibility for the exercise of powers and the performance of the Trust. It is legally responsible for the delivery of high quality, effective services and for making decisions relating to the strategic direction, financial control, and performance of the Trust.

The Board of Directors attaches great importance to ensuring that the Trust operates to high ethical and compliance standards. In addition, it seeks to adhere to the principles of good corporate practice as set out in the Code of Governance for NHS provider Trusts implemented in April 2023.

The Board of Directors is responsible for:

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

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

The Board of Directors delegates other matters to its sub-committees and to the Executive Directors and senior management.

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 was ordered under the three People groups around which the Trust's new vision is structured:

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

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

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 (NEDs)

NEDs share the corporate responsibility for ensuring that the Trust is run efficiently, economically, and effectively.

They 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 NEDs also fulfil their responsibility for determining appropriate levels of remuneration for Executive Directors. They are appointed on a three-year term of office.

A NED 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.

Board of Directors Completeness

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

All of the Non-Executive Directors are considered to be independent in accordance with the NHS Foundation Trust Code of Governance, with the exception of one. Nigel Stevens has completed six years of service as a Board Member but through comprehensive review, was renewed for an additional term of office by the Council of Governors. Nigel brings a wealth of knowledge and experience that would benefit the Trust as it explores the group model.

The Board considers that the Non-Executive Directors bring a wide range of business, commercial, strategic, and financial knowledge required for the successful direction of the Trust.

All directors are equally accountable for the proper management of the Trust's affairs. The balance, completeness and appropriateness of the Board of Directors is reviewed at least annually to ensure its effectiveness.

Removal of the Chair

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.

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.

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

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

The Board of Directors undertakes an annual development review of its performance and its effectiveness as a unitary board.

The Board of Directors attend away day sessions as required throughout the year, which provide an opportunity for the Board to debate strategic issues in an informal setting. The Board of Directors has a programme of Board Seminars that are held on months when no public meetings are scheduled. These cover a range of topical issues and are often facilitated or attended by external colleagues.

Individual Directors attend a range of formal and informal training and networking events as part of their ongoing development.

Trust Management Executive

The Trust Management Executive (TME) is chaired by the Chief Executive and has delegated powers from the Board of Directors to oversee the day-to-day management of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives.

Meetings consist of a combination of regular updates on key aspects of performance, monitoring of specific areas of risk, including around financial recovery, as well as space for strategic thinking and team development, with Improving Together remaining a key driver for how agendas are designed. Membership of TME consists only of the Executive Directors and members of the divisional management triumvirates (heads of divisions, divisional directors of operations and heads of nursing/midwifery). These meetings are held monthly.

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:

Audit and Risk Committee

The Audit and Risk Committee has been Chaired by Paul Fox since September 2023. The Committee is responsible for:

- Governance - reviewing the establishment and maintenance of an effective system of internal control and probity across the whole of the organisation's activities.
- Internal Audit - ensuring that there is an effective internal audit function established by the Trust that meets mandatory NHS Internal Audit Standards.
- External Audit - reviewing the work and findings of the External Auditor and considering the implications and management response to their work.
- Local Counter-Fraud - ensuring that there is an effective counter-fraud function established by management that meets NHS Counter-Fraud standards.
- Management - reviewing reports and positive assurances from Directors and managers on the overall arrangements for governance, probity, and internal control.
- Risk Management - assuring the Board of Directors that the Risk Management system operating within the Trust is robust and effective.

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 2024/25.

Finance and Performance Committee

The Finance and Performance Committee has been chaired by Sumita Hutchison.

The Committee's key role is to provide assurance to the Board on the Trust's operational and financial performance. Specifically, it assesses the effectiveness of business planning and financial management systems, and the extent to which the organisation is operating in line with its annual business plan objectives. The Committee continues to have a key focus on the steps that the Trust is taking to address the backlogs in non-elective care, including assessing the impact that Sulis Hospital and other potential developments on that site could have both for the Trust and the wider BSW system.

Non-Clinical Governance Committee (NCGC)
The Non-Clinical Governance Committee is chaired by Sumita Hutchison. NCGC focuses primarily on providing assurance to the Board that the Trust has a robust framework for the management of risks arising from or associated with estates and facilities; capital development, environment, and equipment; digital developments; environmental sustainability; health and safety; information governance; business continuity; business development and other non-clinical areas as may be identified.

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

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

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

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

The Charities Committee
The Charities Committee is chaired by Sumita Hutchison. The Royal United Hospital Charitable Fund (working name RUHX) was formed under a Deed dated 10 September 1996 as amended by a Supplemental Deed of 9 December 2009. It is registered with the Charity Commission in England and Wales (Registered number 1058323).
The Trust is the Corporate Trustee of the Charity, acting through its voting Board of Director members who are collectively referred to as the Trustee's Representatives and their duties are those of trustees.

The main beneficiaries of the Charity are the Trust's patients and staff through the provision of grants to the Trust for purchasing and developing facilities; training and development of staff; and research and development.

The Charity's structure is diverse and reflects the breadth of variety of activities within the Trust.

There are in excess of 100 separate funds. Although the Charities Committee is a formal sub-committee of the Board of Directors, arrangements have been implemented to operate this group and the Full Corporate Trustee of the charity at arm's length from the Trust.

These arrangements include: a formal service level agreement between the Trust and the charity outlining the support and associated costs to the charity, presenting the Charity Annual Report and Accounts to the Full Corporate Trustee, and implementing a separate charity strategy.

	Appointment Date		Board of Directors' (6 Meetings)	Audit and Risk Committee (4 Meetings)	Charities Committee (4 Meetings)	Finance and Performance Committee (9 meetings)	Non-Clinical Governance Committee (4 meetings)	Nominations and Remuneration Committee (9 Meetings)	People Committee (5 Meetings)	Quality Assurance Committee (7 Meetings)	Subsidiary Oversight Committee (4 Meetings)
	From	To									
Non-Executive Directors											
Alison Ryan, Chair	01/04/19	30/06/25	6 (6)	-	4 (4)	1 (0)	-	8 (9)	-	-	-
Nigel Stevens	01/04/18	30/06/25	5 (6)	-	-	4 (9)	-	6 (9)	-	-	2 (4)
Antony Durbacz	01/11/20	31/10/26	5 (6)	-	-	9 (9)	-	6 (9)	-	-	3 (4)
Ian Orpen	07/09/20	31/08/24	1 (2)	1 (1)	-	-	-	1 (2)	-	5 (5)	1 (2)
Hannah Morley	01/04/23	31/03/26	4 (6)	-	-	-	3 (4)	5 (9)	4 (5)	5 (7)	-
Paul Fairhurst	01/10/22	30/09/25	4 (6)	-	-	7 (8)	-	8 (9)	5 (5)	7 (7)	-
Paul Fox	01/04/23	31/03/26	6 (6)	4 (4)	-	8 (9)	4 (4)	9 (9)	-	-	3 (4)
Sumita Hutchison	04/09/19	31/08/25	6 (6)	3 (4)	4 (4)	-	4 (4)	9 (9)	4 (5)	-	-
Simon Harrod	01/10/24	30/09/27	3 (3)	2 (2)	-	-	-	6 (6)	-	2 (2)	1 (1)

Executive Directors											
Cara Charles–Barks	01/09/20	31/10/25	3 (3)	1 (0)	-	3 (0)	-	4 (0)	1 (0)	-	-
Cara Charles – Barks	01/11/24	-	3 (3)	-	-	-	-	-	-	-	-
Andrew Hollowood Interim Managing Director	01/11/24	-	3 (3)	-	-	1 (0)	-	2 (0)	-	-	-
Andrew Hollowood Chief Medical Officer & Deputy CEO	14/11/22	31/10/24	2 (3)	0 (2)	-	3 (0)	-	-	1 (3)	2 (6)	1 (3)
Sarah Richards	01/11/24	02/02/25	1 (2)	0 (1)	-	-	-	-	2 (2)	-	1 (1)
Kheelna Bavalia	03/02/25	-	1 (1)	0 (1)	0 (1)	-	-	-	-	0 (1)	-
Antonia Lynch	01/04/21	-	5 (6)	-	3 (4)	-	4 (4)	-	4 (5)	4 (7)	4 (4)
Paran Govender	02/10/23	-	3 (6)	-	-	8 (9)	1 (3)	-	4 (5)	3 (7)	0 (4)
Libby Walters	01/06/18	04/04/24	-	-	-	-	-	-	-	-	-
Jon Lund	01/05/24	11/03/25	6 (6)	3 (3)	4 (4)	6 (7)	4 (4)	-	-	-	3 (3)
Simon Truelove	17/03/25	-	-	-	-	1 (1)	-	-	-	-	-
Joss Foster	01/07/12	-	6 (6)	-	4 (4)	-	3 (4)	-	5 (5)	-	0 (4)
Alfredo Thompson	31/01/22	-	5 (6)	-	-	-	-	5 (0)	5 (5)	-	2 (2)
Christopher Brooks-Daw	05/01/24	-	**6 (6)**	**-**	**-**	**1 (0)**	**-**	**1 (0)**	**-**	**-**	**-**

** The number in brackets is the total number of meetings individuals should have attended. This is included to provide clarity where there were changes in Committee membership and attendance, or where appointments ceased or commenced.

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 Remuneration 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
- People
- Strategy and Business Planning
- Quality

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.

2024/25 Governor Elections

During 2024/25 the Trust held a by-election to elect a Public Governor for the constituency of Mendip. The election was uncontested. The full by-election report is available from the Membership Office at ruhmembership@nhs.net.

The Trust commenced the year with two Governor vacancies, these were for Stakeholder Governors and work took place to appoint a BaNES representative from BSW ICS and a representative from the University of Bath as a matter of priority.

Governors by constituency – 1 April 2024 to 31 March 2025

The Governors' terms of appointment can be seen in the table below. There are 3 vacancies.

Staff Governors	Term of Appointment	Staff Governors	Term of Appointment
Narinder Tegally	01/11/2019 - 31/10/2022 01/11/2022 - 31/10/2025	Baz Harding-Clark	02/11/2020 - 31/10/2023 01/11/2023 –27/01/2025
Beas Bhattacharya	01/11/2022 – 25/11/2024	Craig Jones	01/11/2023 - 31/10/2026
Craig Sanders	03/03/2025 - 31/10/2026	Gary Chamberlain	01/11/2023 - 31/10/2026

Public Governors	Constituency	Term of Appointment
Nicola James	City of Bath	01/11/2022 – Stood down on 11/07/2024
Sue Toland	City of Bath	17/07/2024 - 31/10/2025
Viv Harpwood (Lead Governor from Nov 2023)	City of Bath	01/11/2022 – 31/10/2025
Anna Beria	North East Somerset	01/11/2022 - 31/10/2025
Vic Pritchard	North East Somerset	01/11/2023 - 31/10/2026
Chris Norman	Somerset (Mendip)	27/06/2024 - 31/10/2025
Kate Cozens	Somerset (Mendip)	01/11/2023 - 31/10/2026
Nick Gamble	North Wiltshire	01/03/2023 - 31/10/2025
Paul Newman	North Wiltshire	01/11/2023 - 31/10/2026
Di Benham	South Wiltshire	01/11/2022 - 31/10/2025
Ian Lafferty	South Wiltshire	01/11/2023 - 31/10/2026
Anne-Marie Walker	Rest of England & Wales	01/11/2023 - 31/10/2025

Stakeholder Governors	Organisation	Term of Appointment
Cllr Alison Born	BaNES Council	20/05/2021
Cllr Johnny Kidney	Wiltshire Council	01/10/2017
Dr Catrinel Wright	BSW ICS (Wiltshire)	20/05/2021 – 26/04/2024
Lucy Baker	BSW ICS (BaNES)	16/09/2024
Prof Deborah Wilson	University of Bath	01/11/2024 – 31/10/2026

Council of Governors Meetings

The Council of Governors has met formally four times during the year. Attendance is detailed in the table overleaf, but good attendance by Governors has meant that they have been kept up to date on current matters relating to the Trust and Community.

The Chief Executive and Interim Managing Director provides an update report to Governors as a standing agenda item and other members of the Executive Team attend as required.

All of the Council of Governors meetings were held in person at various venues around Bath during 2024/25. The Trust website was updated with the details of each meeting to allow for public viewing. Among the decisions taken in 2024/25 were the following:

- Approved the content of the Chair's appraisal and the suggested objectives.
- Approved the appointment of Non-Executive Directors.
- Helped set the strategic direction of the Trust.

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 2024/25

The following table sets out Governor Attendance at Council of Governors meetings during the period 1st April 2024 to 31st March 2025. 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.

Governors

Anna Beria	4/4	Anne-Marie Walker	2/4	Baz Harding-Clark	2/3
Beas Bhattacharya	0/2	Chris Norman	2/3	Cllr Alison Born	2/4
Cllr Johnny Kidney	1/4	Craig Jones	3/4	Craig Sanders	0/0
Di Benham	4/4	Gary Chamberlain	2/4	Ian Lafferty	3/4
Kate Cozens	4/4	Lucy Baker	0/2	Narinder Tegally	2/4
Nick Gamble	3/4	Paul Newman	3/4	Vic Pritchard	4/4
Prof Deborah Wilson	2/2	Sue Toland	2/3	Viv Harpwood	4/4

Non-Executive Directors

Alison Ryan (Chair)	4/4	Nigel Stevens	2(0)	Sumita Hutchison	4(0)
Anthony Durbacz	2(0)	Ian Orpen	1(0)	Simon Harrod	2(0)
Paul Fairhurst	4(0)	Hannah Morley	0(0)	Paul Fox	2(0)

Executive Directors

Cara Charles-Barks	3	Jon Lund	0	Alfredo Thompson	0
Andy Hollowood	2	Joss Foster	0	Paran Govender	0
Toni Lynch	0	Christopher Brooks-Daw	0		

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 or in a printed form found around the hospital.

Public members receive 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 Council of Governors established a task and finish group this year to revise the existing strategy.

This targeted working group was specifically formed to enhance the strategic framework and enhance meaningful Governor input throughout the development process. Once completed the strategy passes through the Membership and Outreach working group for approval before it is presented at the Council of Governors for ratification.

The strategy still 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 2025, the Trust had 17,240 members, made up of 10,613 public members (patients, carers, and the public) and 6,627 staff members. The Trust has a number of channels for engaging and communicating with its members, including:

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

Ongoing operational pressures have meant that the Trust has continued to be limited in the scale and scope of its engagement activities during 2024/25 but some progress has been made in terms of resuming face to face engagement.

A number of Governors have attended local Patient Participation Group meetings, RUH Careers Fairs and for the first time this year, the RUH Community Day. During these events Members had the opportunity to interact with Governors and were able to find out more about the role of the Governor and how they could become involved in supporting the RUH.

The Trust held its Annual General Meeting combined with Annual Members Meeting at the Apex City of Bath Hotel on Tuesday 17th September 2024.

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

Membership size and movements 2024/25:

Public constituency	Members		Staff constituency	Members
As at 31st March 2024	10,600		As at 31st March 2024	6,602
As at 31st March 2025	10,613		As at 31st March 2025	6,627

The analysis section of this report excludes: 759 public members with no dates of birth, 1,232 members with no stated ethnicity and 143 members with no gender stated.

Analysis of current membership			
	Public constituency	**Number of members**	**Eligible Membership**
Age (years):	0-16	6	166,986
	17-21	57	61,901
	22+	9,768	698,903
Ethnicity:	White	8,937	855,768
	Mixed	89	19,169
	Asian or Asian British	199	23,630
	Black or Black British	127	9,364
	Other	39	0
Scio-economic groupings*	AB	3,192	103,034
	C1	3,122	119,037
	C2	2,126	81,169
	DE	2,150	83,662
Gender Analysis	Male	3,572	455,441
	Female	6,890	472,347

NHS Foundation Trust Code of Governance disclosures

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

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

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

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

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

Code section	**Code Provision**	**Annual Report and Accounts Section**
A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency, and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Performance report, Stakeholder relations and Environmental matters

Code section	Code Provision	Annual Report and Accounts Section
A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices, or behaviour throughout the business are aligned with the trust's vision, values, and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding, and promoting the wellbeing of its workforce.	Staff report
A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Performance report, purpose, and activities. Also, Stakeholder relations.
B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director, or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors, or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment	**Directors' report** All independent except Nigel Stevens who is in his seventh year.

Code section	Code Provision	Annual Report and Accounts Section
	• is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	
B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Governance of the Trust
B 2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	Directors' report and Council of Governors
C 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	Additional Directors' report disclosure
C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	Directors' Report - Council of Governors
C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise, and experience.	Directors' Report
C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Additional Directors' report disclosure and Annual Governance Statement

C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	Remuneration report Staff Report
C 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Directors' Report - Council of Governors
D 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit	Financial Performance Board Governance

	• an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	
D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced, and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Annual Governance Statement
D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Annual Governance Statement
D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Annual Governance Statement
D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	In annual accounts and Financial Performance section of Annual Report.
E 2.3	Where a trust releases an executive director, e.g., to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Not applicable
Appendix B, para 2.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Directors' Report - Council of Governors

Appendix B, para 2.14	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	Directors' Report - Council of Governors
Appendix B, para 2.15	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, e.g., through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Directors' Report - Council of Governors
Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. 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

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. During quarter 3 of 2024/25, the Trust moved into segment 3 as a result of:

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

Table 2: Support segments: description and nature of support needs

	Segment description		Scale and nature of support needs
	ICB	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective ICB Plans that have the support of system partners are in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an ICB	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

Statement of Accounting Officer's responsibilities

Statement of the Chief Executive's responsibilities as the accounting officer of the Royal United Hospitals Bath NHS Foundation Trust.

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust.

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

NHS England has given Accounts Directions which require Royal United Hospitals Bath NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Royal United Hospitals Bath NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

• observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis

• make judgements and estimates on a reasonable basis

• state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements

• ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance

• confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and

• prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS 65 foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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

Signed:

Cara Charles-Barks
Chief Executive
26 June 2025

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Royal United Hospitals Bath NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Royal United Hospitals Bath NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Chief Executive, I have overall leadership responsibility for providing the Trust with the necessary organisational resources to produce, implement and manage to ensure that any risk we face is understood, with realistic controls and actions in place to manage it.

Risk Management is delegated at an executive level to the Chief Nursing Officer.

The Chief Nursing Officer is also responsible for patient safety, patient experience and medical legal matters (jointly with the Chief Medical Officer (CMO).

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

The Chief Finance Officer has responsibility and accountability for financial risks, as well as being designated as Senior Information Risk Officer (SIRO) responsible for maintaining and assuring the framework for managing information governance-related risks.

The Chief Finance Officer attends the Trust's Audit and Risk Committee and consults with internal audit, external audit, and counter fraud services, who undertake programmes of audit with a risk-based approach.

The Audit and Risk Committee is the delegated committee of the Board charged to provide independent oversight of the governance risk and internal controls in an organisation.

The Trust Board is committed to identifying and managing all risks associated with its service delivery, support functions and the organisation. Risk management is an integral part of good governance and management practice and to be most effective, must be part of the Trust's culture.

The Board is committed to ensuring that risk management forms an integral part of its philosophy, practices and business plans and that responsibility for implementation is accepted at all levels.

The Trust takes all reasonable steps in the management of risk with the overall objective of delivering the Trust's vision and strategic goals, whilst protecting patients, staff, and assets.

The Board has approved the Strategic Framework for Risk Management which provides a clear and systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial, and financial processes across the Trust.

The Strategic Framework sets out the role of the Board of Directors, the Trust Management Executive, the Divisional Boards, and the Board of Director Committees, together with the individual responsibilities of the Chief Executive, Executive Directors, and all staff in managing risks.

Training is available to all staff via Learn Together on the intranet.

As well as scheduled training sessions on risk management, the team provides a wide range of coaching support options from 1:1 to small groups. This rolling programme allows them to regularly refresh the training offered through the changing of scenarios or risks scores. At the heart of the training is the core work of risk assessment.

Managers knowledge and skills are also developed through regular reviews of the risk register where they are encouraged to look at the quality of the control in place and what effect it may be having; or how robust the assurance being offered is.

The Risk and Control Framework

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

The strategic framework:

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

The Trust uses a risk assessment matrix to score individual risks. The risk assessment matrix enables the Trust to assess the level of risk in a standardised way, using a 5x5 (impact x likelihood) risk matrix methodology.

This prioritisation tool is based on national guidance. Each risk is given a score for both the consequence/severity of the potential risk and its likelihood of occurring. The two scores are then multiplied together to give an overall risk impact score.

The higher the final score the greater the risk. All risks are recorded and held on the Datix risk management system, which is used to produce reports across all levels of management.

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

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

The Trust Management Executive are also responsible for reviewing and approving any current risks that have been downgraded from a major risk.

The Trust has a robust Quality Governance reporting structure in place through an established Quality Assurance Committee. The Quality Governance arrangements are described in the Integrated Governance Framework which is reviewed on an annual basis.

This framework is a means by which the Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the strategic objectives.

The Trust seeks to ensure that opportunities for learning from patient safety events, complaints and other investigations are used to update and improve practice. These issues are regularly communicated to the Trust Quality and Safety Group (TQSG) where Trust-wide representatives can discuss themes which may emerge from these investigations and make recommendations for, and implement, policy or procedural change.

The Upward Report from TQSG shares and communicates key messages to the Quality Assurance Committee to ensure Board visibility of emerging themes, learning and improvement and how they are being disseminated across the organisation.

The way we respond to patient safety incidents changed from 1st April 2024 as we transitioned to using the Patient Safety Incident Response Framework (PSIRF) as part of national improvements linked to the NHS Patient Safety Strategy.

This is described in our associated incident policies, supported by our governance structures and teams from Board to point of care.

Our Integrated Quality and Performance Report, reflecting activity and quality improvement is reported at each Board of Directors' meeting and is published on the Trust's website.

Additionally, the Quality Assurance Committee receives routine reports across incidents, risks, learning from deaths and improvements, sharing this through its upward report to Board.

Board Members

The following executive board members were in post for 2024/25

- Antonia Lynch - Chief Nursing Officer
- Paran Govender - Chief Operating Officer
- Alfredo Thompson- Chief People Officer
- Jocelyn Foster - Chief Strategic Officer
- Christopher Brooks-Daw - Chief of Staff
- Cara Charles-Banks moved into the Group Chief Executive position on 1 November 2024
- Andrew Hollowood was the Chief Medical Officer and Deputy Chief Executive until 1November 2024 when he became the Interim Managing Director
- Sarah Richards was the Acting Chief Medical Officer from 1 November 2024 – 1 February 2025
- Kheelna Bavalia became the Interim Chief Medical Officer from 1 February 2025
- Libby Walters was the Chief Finance Officer until 20 April 2024
- Jon Lund was the interim Chief Finance Officer from 1 May 2024 – 1 March 2025
- Simon Truelove is the Interim Chief Finance Officer from 1 March 2025

The following non-executive board members were in post for 2024/25

- Alison Ryan – Chair
- Nigel Stevens - Non-Executive Director
- Sumita Hutchison - Non-Executive Director
- Paul Fox - Non-Executive Director
- Paul Fairhurst - Non-Executive Director
- Antony Durbacz - Non-Executive Director
- Hannah Morley - Non-Executive Director
- Simon Harrod - Non-Executive Director
- Ian Orpen, Non-Executive Director, retired from the Board on 31 August 2024

Committee Structure

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

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

The key responsibilities of each Committee in relation to risk management are set out below:

Audit and Risk Committee

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

Quality Assurance Committee

- Provides oversight of divisional approaches to risk management.
- Reviews allocated risks on the BAF.

Non-Clinical Governance Committee

- Reviews allocated risks on the BAF.

People Committee

- Provides assurance that systems for managing people-related risk are sound.
- Reviews allocated risks on the BAF.

Subsidiary Oversight Committee

- Provide the RUH Board with "line of sight" of Sulis' activities without overriding the independence of the Sulis Board. Specifically, its roles are to
- Ensure that the aims and objectives of acquiring or setting up a subsidiary unit or organisations 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 subsidiaries are being responsibly managed.

Finance and Performance Committee

- Reviews allocated risks on the BAF.

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.

BSW Group Joint Committee

During the 2024/25 year there has been planning and development of terms of reference for a joint committee, made up of membership of the three organisations that form the BSW Group. Under a single Chief Executive, the Committee will look at what developments can be made to progress the group model.

After each meeting, the Committee Chair presents a report to the next available meeting of the Board of Directors highlighting the key issues discussed, any risks identified, key decisions and recommendations using an 'ALERT, ASSURE, ADVISE' template.

One Committee may also recommend that another Committee considers a matter that has been brought to its attention that would be of relevance to that other committee.

Quality Governance

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

The Trust has a robust Quality Governance reporting structure in place through an established Quality Assurance Committee. The Quality Governance arrangements are described in the Integrated Governance Framework which is reviewed on an annual basis.

This framework is a means by which the Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the strategic objectives.

The Integrated Governance and Accountability Framework makes it clear that quality governance is the responsibility of the Board supported by the Quality Assurance Committee for continuously improving the quality of services and safeguarding standards of care by creating an environment in which excellence in clinical care will flourish.

The Quality Assurance Committee reviews on-going compliance in meeting the Care Quality Commission's (CQC) essential standards informed by any CQC Inspection and reviews the monthly quality performance report. The Quality Account, this Annual Report and Accounts describe quality improvements and quality governance in more detail.

The Chief Executive is accountable for quality governance. There is an Executive Director lead for each objective. The responsible officers for quality are the Chief Medical Officer who leads on clinical effectiveness and the Chief Nursing Officer who leads on patient safety and patient experience.

Improving Together is the operational management system we share across the BSW Group. It aligns with the five components of NHS Impact and links improvement tools and routines with the behaviours needed for a culture of continuous improvement.

It is founded on the development of a coaching approach, which enables every member of staff to improve the services they work in and contribute to achieving our strategy.

Evidence shows that Trusts that have a continuous improvement approach like this provide better patient care, and colleagues working in these Trusts have greater job satisfaction.

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

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

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes on the quality of services.

The equality/quality impact assessment (EQIA) process involves a structured risk assessment using a standard template which requires Divisional Management Team sign off.

The Chief Medical Officer and Chief Nursing Officer are responsible for assuring themselves and the Board that Cost Improvement Programmes will not have an adverse impact on quality and equality. This process is currently under review to further strengthen the process.

Delivery of the Trust's strategic objectives is underpinned by the publication of the annual quality account which sets out the progress made against our quality priorities in 2024-25 and the quality priorities selected for 2025-26.

Progress of the priorities is monitored via the Trust Quality and Safety Group and Quality Assurance Committee; reviewing a suite of quality metrics that track performance against key quality indicators.

The Integrated Performance Report (IPR) is aligned to our key areas of focus within the strategic planning framework.

It comprises of detailed reports on quality, operational performance, finance, and workforce, has been received by the Board monthly and is considered in detail. Our divisions follow the same approach via the Executive Performance Review Meetings.

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

Risk management is embedded in the activity of the organisation in a variety of ways. A suite of risk management policies and guidelines underpins the Risk Management Strategy and are available to staff on the intranet. Training sessions are available to staff across the Trust.

Divisions and Corporate Functions proactively identify risks which are recorded on risk registers. The specialties and divisions also retrospectively identify risk through adverse incident reporting, receipt of and response to complaints and claims, patient and staff surveys and feedback, and concerns raised by the coroner.

Due to the devolved nature of risk management and compliance of incident reporting and investigation at a local level, quality and quantity of incident reporting continues to improve and develop. The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning takes place and improvement actions are taken.

The ICS quality leads are an integral part of the Trust quality governance arrangements and attend key quality committees. The Trust works in partnership with our commissioners to share learning and improvement actions.

The Trust launched the new National Patient Safety Incident Response Framework (PSIRF) on the 1st of April 2024. The framework sets out an innovative approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

This is a meaningful change to how staff work and respond to patient safety events and the Trust is developing documentation and training to support effective implementation. The National Reporting Learning System has also been replaced with the Learning from Patient Safety Events (LfPSE) system. The Trust has actively engaged with this transition.

As a learning organisation that embraces quality improvement, the Trust has taken the following actions to improve the quality of its services and reduce the rate of patient safety incidents that have resulted in severe harm or death by:

- Regular oversight by the Board of the Board Assurance Framework and application of the Board approved risk appetite and risk tolerances which has enabled a focus on risks outside of tolerance.
- Monitoring ward to board reporting on key patient safety and experience indicators and reporting these monthly to the Board via the Integrated Performance Report.
- Reviewing a sizeable proportion of deaths in hospital through the Trust's Medical Examiners, Learning from Deaths Process and Mortality Review Group. Specific consideration has been given to how we monitor and capture patient safety risks and our policies for both audit/effectiveness and mortality were updated accordingly.

- The Patient Safety Incident Response plan details our ongoing transition to the Patient Safety Incident Response Framework.
- Weekly review of all reported patient safety events of concern to agree the appropriate level of review and identify any immediate actions to mitigate identified risk.
- A Patient Safety Event Oversight group was established to ensure that themes and learning from patient safety events reports are maximised and inform safety improvement work.
- A Quality and Safety Improvement group was established to ensure improvement work reflects the insights from patient safety event reports and to oversee the delivery of improvement aligned to our patient safety priorities.
- Our Risk Management System, Datix, provides a range of quantitative data to support analysis across services and wards to provide assurance that we have effective systems for the monitoring of patient safety events.
- Improving the voice of patients, families, and carers in the management of patient safety events by; recruiting patient safety partners and incorporating patient engagement into the process for managing patient safety events as part of our PSIRP.

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

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

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

Risks on the risk register

The following provides an overview of the risks rated as ≥15 on our organisational risk register. The organisational risk register, alongside our Board Assurance Framework form core components of our risk framework.

Board Assurance Framework Risks

There are 11 risks that make up the Board Assurance Framework. These risks if not carefully managed could prevent us from achieving our corporate objectives.

Each BAF risk has an Executive Lead who is responsible for the management of that individual risk. The BAF risks are aligned to the corporate objectives. Each Committee has oversight of the risks that fall within their remit.

The risks are reviewed each month by the Executive Leads and presented to the Committee prior to their presentation at the Board.

A key risk to the organisation is the financial challenges that it faces and the current financial position. This was also noted in the external audit who gave an opinion that there was significant weakness in the financial sustainability.

2025/26 looks set to be another very challenging financial year for the RUH. This is because the funding available to the NHS is reducing as additional funding added through the Covid pandemic is withdrawn back to sustainable levels. The new Government is demanding further recovery of key performance standards, such as a 5% improvement in elective patients treated within 18weeks, and shorter ambulance handover waiting times and waiting time in ED.

After accounting for the costs of pay awards NHS England Operational Planning guidance set out an expectation of 1% real terms cost reductions and 4% increases in productivity.

As the Trust has been operating at a deficit and is having deficit support funding withdrawn; and is also experiencing higher levels of growth in demand for its services through ED attendances and elective care referrals and cancer diagnoses this translates into a cost reducing savings programme of 4.7% and an overall productivity of 6.7%.

The Trust Savings Plan for 25/26 is £29.7m. Whilst last year much of the success was from maximising income from the Elective Recovery Fund and enhancing controls, particularly reducing pay costs and almost eliminating the use of premium agency expenditure; the challenge for 25/26 will need to be met through improving productivity and maximising use of core capacity and redesigning clinical and corporate services.

There are 3 key pillars to delivery of this challenge:

1. Integration with partners in BSW Integrated Care System, such as benefits of transformed Adult Community Services on demand for RUH care
2. Closer collaboration with BSW Hospitals group partners, such as benefits of new investment & transformed care models such as Sulis Orthopaedic Centre, Community Diagnostic Centres and new Electronic Patient Record and redesigning Corporate Service
3. Internal Trust Transformation and Improvement Plan have been evolved with 5 key Delivery Groups, which are sponsored by Executive Directors and clinician-led where appropriate:
    a. Urgent & Emergency Care
    b. Elective Theatres
    c. Outpatients
    d. Corporate services
    e. Central Delivery Programme

At the time of writing the full £29.7m has not yet been identified and the Trust has entered a financial turnaround period, with the support of a Recovery Director. Controls and limits of discretionary expenditure are being put in place; whilst the BSW Hospitals Group newly established Joint Committee is developing a medium-term Financial Stability and Recovery Plan.

The BAF risks are:

- Without delivering the financial plan and ensuring financial accountability across the organisation the Trust may not achieve financial recovery and sustainability, affecting our control to provide safe, appropriate and effective care to our patients.
- There is a risk that not meeting internally and externally set standards of quality and safety may result in harm to patients and/or experience below expected.
- Increasing demand for both emergency and planned care is exceeding our capacity to treat patients promptly, leading to longer wait times for procedures. This could negatively impact patient outcomes and satisfaction.
- Without fostering a culture of inclusion and actively addressing possible managerial discrimination, we may hinder staff recruitment and retention, expose the Trust to financial and reputational damage, and undermine our ability to deliver the best possible patient care.
- Without strong management and leadership development, including succession planning, we risk limiting our ability to transform and innovate, cultivate a positive culture and sustain improvements. This could negatively impact patient care, staff satisfaction, and workforce stability.
- If Sulis Hospital does not deliver its financial target it may have a direct financial impact to RUH's financial position.
- Without reducing unwanted variation and addressing inequity of care, people may not receive appropriate levels of care.
- Our aging estate with increasing backlog maintenance needs could lead to service disruptions, compromised patient safety, failure to meet regulatory requirements in addition to degrading the experience for patients and staff.
- Climate change and its accelerating consequences may threaten the health of patients, staff, and the wider community. Failure to achieve net zero goals and adapt to climate-related risks (e.g., overheating, flooding) may jeopardise the Trust's sustainability, its ability to provide care, and its commitment to future generations.
- Insufficient digital capabilities may hinder the Trust's potential to enhance patient and staff experiences, optimise efficiency, and improve overall effectiveness and care delivery.
- Cyber-security breaches, caused by deliberate malicious acts or inadvertent actions by staff, could result in an inability to use digital platforms, resulting in loss of services and data across the Trust, and in turn causing risk to patients.

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

The Trust has assessed compliance with the NHS provider licence section 4 (governance).

The Trust believes that effective systems and processes are in place to maintain and monitor the following conditions:

- The effectiveness of governance structures

The Trust has a good structure which avoids duplication and ensures that the Committees can cover the remit of the Trust's areas of work. The values of the Trust align well to the Committees and the Council of Governors working parties.

- The responsibilities of Directors and subcommittees

The Chief Executive/Managing Director chairs the Trust Management Executive (TME) which manages the Trust and leads implementation of decisions by the Board / its committees. The Chief Executive reports to the Board on the work of TME, with it having specific delegated authorities from the Board as set out in the Scheme of Reservation and Delegation.

- Reporting lines and accountabilities between the Board, its subcommittees, and the Executive Team

There are clear reporting lines between the Board and its Committees and terms of reference were updated during the year to ensure all committees were meeting statutory and regulatory requirements. The Chairs of each committee provide an assurance report to each Board in Public meeting, summarising the business considered and any issues or significant risks for escalation to the Board.

- The submission of timely and accurate information to assess risks to compliance with the Trust's licence

Committees also lead on different areas of corporate responsibility or legislation. The Quality Assurance Committee for example, would look at the Quality Registration requirements with the Care Quality Commission (CQC). The Quality Assurance Committee would also see any inspections outcomes and actions. These committees meet regularly, upwardly escalating concern to the Board through its formal reporting.

- The degree and rigour of oversight the Board has over the Trust's performance

At each Board meeting, the Board reviews the Integrated Performance Report (IPR) which presents data on the previous month. This data is scrutinised by the executives, sub committees, Board, Commissioners, as well as the public and the Council of Governors.

Compliance with the Care Quality Commission

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

During 2024-25 the Trust received an inspection of the Surgery core service.

The CQC undertook a focused unannounced inspection of the Surgery core service from 13 March 2024 to 14 June 2024 which included site visits on 20 and 21 March 2024.

The inspection was undertaken on three surgical wards due to information of concern the CQC had received regarding the quality and safety of the surgical service.

The inspection was conducted under the new CQC Single Assessment Framework and reviewed specific quality statements for the safe, effective, caring, and well-led domains.

The CQC published the inspection report in October 2024 giving a rating of 'Good' for Surgery. The report found that people the CQC spoke with were positive about the way they were cared for in the ward environment and staff were positive about the working environment provided by the Trust.

Staff understood duty of candour and were open and honest with people when things went wrong.

Staff had the right skills and experience. Inspectors saw that staff were approachable and openly discussed compassionate care, ensuring people with protected characteristics received individualised support. All staff emphasised treating people equally and without judgement. Medicines were stored and management safely.

The service is effective and worked in line with legislation and current evidence-based good practice and standards. The CQC noted the service was well-led with a clear strategy, vision and goals which was developed in collaboration with staff, patients and interested community members.

The Trust had a cultural improvement programme which was actively encouraging staff to speak up about any concerns with a network of Freedom To Speak Up Guardians. Staff the CQC spoke to said they felt able to bring any issues to the attention of their direct line manager and were aware of the freedom to speak up guardians.

The CQC identified small areas for improvement and informed the Trust of the actions it needs to take. This included how the Trust reviewed incidents, fire risk assessments, and auditing how they monitored people's food and fluid intake and blood clot assessments when people were admitted to the surgical wards.

An improvement plan was put in place following the inspection, and progress in implementing the actions from this plan is being reviewed through the Trust Quality and Safety Group on a quarterly basis.

Clinical Audit

Clinical Audit is one method 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 was approved by the Trust Quality and Safety Group and includes topics identified from the National Clinical Audit and Patient Outcomes Programme, National Institute for Health and Clinical Excellence guidance, Central Alerting System Alerts and Serious Incidents. The Clinical Effectiveness Committee receives a quarterly progress report on the outcome of the Clinical Audit programme.

Well-Led Developmental Review:

Aqua were commissioned to carry out Well-Led Developmental Reviews in each of the three organisations of Royal United Hospitals NHS Foundation Trust, Salisbury NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust. The review began in May 2024 and will concluded in the summer of 2024. The final report describes the findings of the review. Key areas include:

- Maintaining alignment as individual strategies evolve with the Clinical Strategy and the People Plan within the context of the financial challenges.
- Embedding governance and wider risk changes that are in the process of being reviewed and developed.
- Developing the maturity of the divisions in terms of accountability, autonomy, visibility with the board, increased awareness of wider corporate issues etc.
- As the community bid progresses, assessment of community leadership expertise and giving a voice to all partners.

A single Well-Led Improvement Programme (WLIP) will be developed. Oversight of the programme will be through the Executive Team/Trust Management Executive, linking into existing workstreams. Key responses include:

- Aligning/mapping existing work to development recommendations. For example, significant work has been ongoing across quality to ensure a robust quality oversight and assurance framework. Additionally, strengthening of the core architecture that supports Trust Board and sub-committee effectiveness is well underway.
- Engagement and inclusion of Divisional (clinical and corporate) to develop and oversee actions.
- Implementation of changes/improvements.
- Establishing the oversight mechanism through the Executive Team/TME with the WLIP.

Developing workforce safeguards

The following approaches and mechanisms are used to ensure that short, medium and long-term workforce strategies support staffing systems to ensure that staff processes are safe sustainable and effective:

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

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

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

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

Transparency

Our Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff in line with the national guidance.

Pensions

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with.

This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, diversity, and human rights

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

Our workforce and retention plans are reflective of our equality, diversity and inclusion (EDI) priorities. Our organisation is working towards being a more inclusive employer, both in terms of how we attract, select and onboard candidates, manage diverse talent pathways and develop diverse and inclusive working environments.

Whilst still on a journey, we have good foundations set to be a regional centre of excellence for EDI, and an organisation that truly represents the population it serves.

We have six staff networks:

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

We also run regular topical support groups for colleagues (e.g. on menopause), convene a quarterly intersectional inclusion event, and are growing our network of inclusion champions, with the ambition to have one in each team.

The organisation retains a powerful focus on reducing discrimination and building psychological safety to speak up / report concerns. Current focus is on physical accessibility, improving workplace adjustments and supporting colleagues with long term conditions, whilst continuing to embed our violence reduction and anti-racist programmes (including our highly successful positive action programme: "Routes to Success").

Each of these networks, programmes and forums are sponsored by an Executive Director which enables our most senior leaders to learn from our colleagues who have a protected characteristic, to help take forward their learning for policy and process changes and lend visible and meaningful support to being a more inclusive organisation.

We are also committed to working to improve our practice and awareness in combating modern slavery and human trafficking and have a published Modern Slavery Statement in that regard.

Our Safeguarding Policy supports this statement, setting out the responsibilities of the Trust to help individuals who come into contact with our services who may be identified as at risk of modern slavery or human trafficking.

The Trust complies with the Public Contracts Regulations 2015 and uses the mandatory Crown Commercial Services Pre-Qualification Questionnaire on procurements, which exceed the prescribed threshold. Bidders are required to confirm their compliance with the Modern Slavery Act.

Greener NHS

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

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

Each year the Audit Committee creates and approves with the auditors an annual audit plan. This is a series of commissioned reviews spread across the budget year. Audits can be core and repeated each year; others are discretionary. The outcomes of these audits help to inform the Head of Internal Audit opinion.

This means that the organisation can select audit topics where it can gain the best value for money from the time that the Audit Team spends on it. This flexibility means that audit time can be used to quantify an emerging issue, undertake field work and review time or benchmark against others all saving time for the staff to do this work.

KPMG delivered the 2024/25 Internal Audit plan of 10 reviews with 9 completed to date. The plan was delivered as agreed by the Audit Committee on the 14 March 2024. The audit of Capital Programme Management was deferred until 2025/26, replaced by an audit of the Maternity Incentive Scheme. One review of Data Security and Protection Toolkit (DSPT) remains outstanding at the time of writing this report.

Two audits received *Significant assurance with minor improvement opportunities* and a further six *Partial assurance with improvements required*. These reviews generated nearly 70 management actions with only 4 of those actions being noted as high priority. They were as follows:

Item	Review	Finding	Risk	Action
1	Health and Safety	39% of the RIDDOR incidents were not reported to HSE within prescribed time period of 15 days	Non-compliance of the RIDDOR regulations can lead to legal action against Trust and reputational damage to Trust.	The Health and Safety team should design a RIDDOR specific training for managers to make them aware of the RIDDOR requirements.
2	Procurement	Sample testing of contracts awarded with a value greater than £75,000 identified instances where a COI form had not been completed.	Those involved in evaluating/moderating activities might have undisclosed conflicts which have not been taken into consideration or appropriately mitigated	Clarify in each Trusts' Procurement policy who is required to declare their COI.
3	Procurement	Sample testing of contracts awarded with a value greater than £75,000 identified instances where a CoI form had not been completed.	Those involved in evaluating/moderating activities might have undisclosed conflicts which have not been taken into consideration or appropriately mitigated	Declarations of Interest will be required to be embedded within Recommendation Reports prior to sign off and this will be reviewed during compliance checks
4	Improvement programme	There is a need to ensure that the key responsibilities for overseeing the Improvement Programme are clearly defined for 2025/26.	Projects within the improvement programme are not approved and overseen by the appropriate body.	Undertake a review of updated oversight arrangements to ensure that they are operating effectively to assess delivery against plan.

Information governance and data security

There have been three serious cyber-attacks in the budget year that we are reporting. These have been part of a wide or bigger national attack and were not specific to us.

At the time of drafting this report, a third party employed by the Integrated Care Board has reported an incident which is under review. They were subject to a cyber-attack, but the details have not yet been released. It is estimated that up to one hundred patient records could have been involved in the breach.

There was not any level 2 incident that needed to be disclosed to the ICO.

Risks to data security are managed through the Trust's risk management process. The Trust assesses risks to data security via the Data Security and Protection Toolkit, ensuring that evidence is externally assured through audit. The main elements cover:

- Managing default password settings.
- Penetration testing for vulnerabilities.
- Creation of a data security action plan.
- Creating a strategy for security updates.

Data quality and governance

The NHS has a target of ensuring that 90% of all patients on an open RTT pathway with a wait above 12 weeks have been validated and confirmed as part of our data checking.

We use the Federated Data Platform (FDP) as a source of management of these pathways. When 100% compliant, each day, all new pathways above 12 weeks without first validation are reviewed, and all pathways with a last validation date over 12 weeks ago are also reviewed, so we end every day remaining 100% compliant.

Validation of pathways is performed by the central Referral to Treatment Validation Team, but also by the departments themselves, including Specialty Managers, Performance and Operational Managers, the Elective Admissions Team, and Outpatients Team.

Administrators are also using the platform. Having a clean and up to date list that is visible and manageable in one platform offers that transparency that we can see progress is made to ensure patients are treated along their pathways.

The platform is also used at our weekly meetings, where the Specialty Managers, or a representative in their absence will talk through their patient lists and look at where we need to take action, to chase next steps and move the patients on through the pathway so that they can get their care as quickly and safely as possible.

To assist in monitoring the quality of our data, there are several internal reports created using PowerBI that highlight pathways that fall into specific cohorts that would note a review is required, but are also provided with external reports that feed back to us based on our weekly submissions to NHS Digital.

These reports break down to us any potential data quality issues that any pathway may fall into; so, we can review and rectify where necessary.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, Clinical Audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Quality Assurance Committee and the Non-Clinical Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place, via the Trust's Governance Improvement Plan for 2025/26.

Whilst this is an annual governance statement covering the period from 1 April 2024 to 31 March 2025, it also extends to cover the period up to the date of signing below.

KPMG delivered the 2024/25 Internal Audit plan of 10 reviews with 9 completed to date. The plan was delivered as agreed by the Audit Committee on the 14 March 2024. The audit of Capital Programme Management was deferred until 2025/26, replaced by an audit of the Maternity Incentive Scheme. One review of Data Security and Protection Toolkit (DSPT) remains outstanding at the time of writing this report.

Two audits received *Significant assurance with minor improvement opportunities* and a further six *Partial assurance with improvements required*. These reviews generated nearly 70 management actions with only 4 of those actions being noted as high priority.

The Head of Internal Audit concluded an opinion on the basis of their work of *Partial assurance with improvements required* can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control.

The Trust will now respond with significant improvement work in relation to internal audit actions, embedding corporate governance across all divisions, introduction of a refreshed Board Assurance Framework, enhanced approach to risk management and a committee review. The new Group Joint Committee will help to galvanise our efforts and maximise gains across the group.

In relation to financial sustainability, we are clear on the requirements of the next financial year, and as such we note the significant internal control issues identified and the challenge that lies ahead.

Cara Charles-Barks

Chief Executive

Date: 26 June 2025

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 2025 and of the group's and foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the group statement of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of changes in equity;
- the group and foundation trust statements of cash flows; and
- the related notes 1 to 42.

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

Basis for opinion
We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller & Auditor General and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

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

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

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

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

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

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

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

We have nothing to report in this regard.

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

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

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

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

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

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, 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, and local counter fraud about their own identification and assessment of the risks of irregularities, including those that are specific to the National Health Service and public sector.

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 and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists such as valuations, IT 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 area, and our specific procedures performed to address it are described below:

- determination of whether an expenditure is capital in nature, and for major projects the value of work completed at 31 March 2025, is subjective: we tested a sample of expenditure 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 correct accounting period.

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

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

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;

- enquiring of management, internal audit and external 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, reviewing internal audit reports and correspondence with the 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 in all material respects; 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.

On 13 June 2025 we reported to the foundation trust a significant weakness in the foundation trust's arrangements to secure financial sustainability, specifically how the trust is able to achieve its cost improvement target for the year ended 31 March 2026 and future periods. We noted that the delivery of the financial plan for 2025/26 is dependent upon material unidentified efficiency savings and that the trust's oversight framework segmentation is rated as 3.

Our recommendations for improvement included that the trust should:

- develop specific actions and schemes to reduce its costs on a timely basis and ensure all efficiency schemes are fully identified by the first quarter of the financial year they are expected to deliver savings; and
- ensure savings targets are based on realistic assumptions with clear timelines and responsibilities.

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 2025. 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

As at the date of this audit report, we have not received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete.

In accordance with Auditor Guidance Note 07, we are therefore unable to certify that we have completed our audit of Royal United Hospitals Bath NHS Foundation Trust for the year ended 31

March 2025 in accordance with the requirements of the National Health Service Act 2006 and the National Audit Office Code of Audit Practice. We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

Use of our report
This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Royal United Hospital 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 FCA (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Bristol, UK
26 June 2025

Royal United Hospitals Bath NHS Foundation Trust

Annual accounts for the year ended 31 March 2025

Foreword to the accounts

Royal United Hospitals Bath NHS Foundation Trust

These accounts, for the year ended 31 March 2025, 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 **26 June 2025**

Consolidated Statement of Comprehensive Income

		Group	
		2024/25	2023/24
	Note	£000	£000
Operating income from patient care activities	3	561,694	507,561
Other operating income	4	57,196	48,205
Operating expenses	6	(614,485)	(555,115)
Operating surplus from continuing operations		**4,405**	**651**
Finance income	10	2,321	2,871
Finance expenses	11	(1,873)	(1,925)
PDC dividend expenses		(8,149)	(6,551)
Net finance costs		**(7,701)**	**(5,605)**
Other gains	12	14	92
Share of losses of joint arrangements	25	-	(56)
Deficit for the year		**(3,282)**	**(4,918)**
Other comprehensive income:			
Will not be reclassified to income and expenditure:			
Impairments	7	(2,117)	(4,684)
Revaluations	20	2,959	1,086
Other reserve movements		(1)	(1)
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains on financial assets mandated at fair value through OCI	26	80	226
Total comprehensive expense for the period		**(2,361)**	**(8,291)**

Statements of Financial Position

		Group		Trust	
		31 March 2025	31 March 2024	31 March 2025	31 March 2024
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	14,15	8,070	7,105	7,097	6,132
Property, plant and equipment	17,18	334,216	301,392	330,247	297,029
Right of use assets	23,24	50,584	51,035	49,730	50,237
Other investments / financial assets	26	3,953	4,833	3,941	3,941
Receivables	30	1,947	1,862	5,184	5,455
Total non-current assets		**398,770**	**366,227**	**396,199**	**362,794**
Current assets					
Inventories	29	8,836	8,284	6,782	6,258
Receivables	30	36,722	30,482	30,747	26,622
Cash and cash equivalents	32	40,024	38,526	36,648	33,865
Total current assets		**85,582**	**77,292**	**74,177**	**66,745**
Current liabilities					
Trade and other payables	33	(67,670)	(55,298)	(61,625)	(50,152)
Borrowings	35	(2,662)	(3,070)	(2,530)	(2,796)
Provisions	36	(932)	(475)	(1,072)	(454)
Other liabilities	34	(10,857)	(13,298)	(8,634)	(11,388)
Total current liabilities		**(82,121)**	**(72,141)**	**(73,861)**	**(64,790)**
Total assets less current liabilities		**402,231**	**371,377**	**396,515**	**364,749**
Non-current liabilities					
Borrowings	35	(55,227)	(54,128)	(54,896)	(53,997)
Provisions	36	(1,315)	(1,370)	(1,175)	(1,370)
Total non-current liabilities		**(56,542)**	**(55,498)**	**(56,071)**	**(55,367)**
Total assets employed		**345,689**	**315,879**	**340,444**	**309,382**
Financed by					
Public dividend capital	SOCIE	285,706	253,535	285,706	253,535
Revaluation reserve	20	41,080	41,562	41,080	41,562
Income and expenditure reserve	SOCIE	11,267	12,303	13,658	14,286
Charitable fund reserves	28	7,636	8,479	-	-
Total taxpayers' equity		**345,689**	**315,879**	**340,444**	**309,383**

The notes on pages 168 to 231 form part of these accounts.

Name Cara Charles-Barks
Position Chief Executive
Date 26 June 2025

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
		£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - as previously stated		**253,535**	**41,562**	**12,303**	**8,479**	**315,879**
Deficit for the year		-	-	(5,003)	1,720	**(3,283)**
Total comprehensive expense		**-**	**-**	**(5,003)**	**1,720**	**(3,283)**
Other transfers between reserves		-	(1,324)	1,324	-	**-**
Impairments	7	-	(2,117)	-	-	**(2,117)**
Revaluations	20	-	2,959	-	-	**2,959**
Fair value gains on financial assets mandated at fair value through OCI		-	-	-	80	**80**
Public dividend capital received	Cashflow	32,171	-	-	-	**32,171**
Other reserve movements		-	-	2,643	(2,643)	**-**
Taxpayers' and others' equity at 31 March 2025		**285,706**	**41,080**	**11,267**	**7,636**	**345,689**

Consolidated Statement of Changes in Equity for the year ended 31 March 2024

Group	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
		£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward		**236,187**	**46,645**	**13,388**	**10,615**	**306,835**
Deficit for the year		-	-	(6,073)	1,155	**(4,918)**
Total comprehensive expense		**-**	**-**	**(6,073)**	**1,155**	**(4,918)**
Other transfers between reserves		-	(1,485)	1,485	-	**-**
Impairments	7	-	(4,684)	-	-	**(4,684)**
Revaluations	20	-	1,086	-	-	**1,086**
Fair value gains on financial assets mandated at fair value through OCI		-	-	-	226	**226**
Public dividend capital received	Cashflow	17,348	-	-	-	**17,348**
Other reserve movements		-	-	3,503	(3,517)	**(14)**
Taxpayers' and others' equity at 31 March 2024		**253,535**	**41,562**	**12,303**	**8,479**	**315,879**

Statement of Changes in Equity for the year ended 31 March 2025

Trust	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward		**253,535**	**41,562**	**14,286**	**309,383**
Deficit for the year		-	-	(1,949)	**(1,949)**
Total comprehensive expense		**-**	**-**	**(1,949)**	**(1,949)**
Other transfers between reserves		-	(1,324)	1,324	**-**
Impairments	7	-	(2,117)	-	**(2,117)**
Revaluations	20	-	2,959	-	**2,959**
Public dividend capital received	Cashflow	32,171	-	-	**32,171**
Other reserve movements		-	-	(3)	**(3)**
Taxpayers' and others' equity at 31 March 2025		**285,706**	**41,080**	**13,658**	**340,444**

Statement of Changes in Equity for the year ended 31 March 2024

Trust	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward		**236,187**	**46,645**	**15,457**	**298,289**
Deficit for the year		-	-	(2,659)	**(2,659)**
Total comprehensive expense		**-**	**-**	**(2,659)**	**(2,659)**
Other transfers between reserves		-	(1,485)	1,485	**-**
Impairments	7	-	(4,684)	-	**(4,684)**
Revaluations	20	-	1,086	-	**1,086**
Public dividend capital received	Cashflow	17,348	-	-	**17,348**
Other reserve movements		-	-	3	**3**
Taxpayers' and others' equity at 31 March 2024		**253,535**	**41,562**	**14,286**	**309,383**

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 28.

Statements of Cash Flows

	Note	Group 2024/25 £000	Group 2023/24 £000	Trust 2024/25 £000	Trust 2023/24 £000
Cash flows from operating activities					
Operating surplus		4,404	651	5,840	2,972
Non-cash income and expense:					
Depreciation and amortisation	6	22,019	19,374	21,035	18,572
Net impairments	7	10,400	2,497	10,400	2,498
Income recognised in respect of capital grants and donations	4	(10,956)	(683)	(13,078)	(683)
Increase in receivables and other assets		(444)	(120)	(4,325)	(3,117)
Increase in inventories		(552)	(1,281)	(524)	(435)
Increase / (decrease) in payables and other liabilities		4,056	(4,801)	8,719	(5,214)
Increase / (decrease) in provisions		171	(293)	423	(241)
Movements in charitable fund working capital		(1,324)	60	-	-
Other movements in operating cash flows		(222)	(3,309)	-	-
Net cash flows from operating activities		**27,552**	**12,096**	**28,490**	**14,352**
Cash flows from investing activities					
Interest received		2,063	2,571	2,063	2,704
Purchase of intangible assets		(3,344)	(1,975)	(3,528)	(1,975)
Purchase of property, plant and equipment		(51,017)	(29,071)	(57,008)	(28,558)
Sales of property, plant and equipment		44	149	41	124
Receipt of cash donations and capital grants to purchase assets		6,130	682	13,078	683
Finance lease receipts (principal and interest)		-	-	471	-
Net cash flows from charitable fund investing activities		1,212	2,180	-	-
Net cash flows used in investing activities		**(44,912)**	**(25,464)**	**(44,883)**	**(27,022)**
Cash flows from financing activities					
Public dividend capital received	SOCIE	32,171	17,348	32,171	17,348
Movement on loans from DHSC		(313)	(313)	(313)	(313)
Capital element of lease liability repayments		(2,705)	(2,808)	(2,585)	(2,830)
Interest on loans		(120)	(128)	(120)	(128)
Interest paid on lease liability repayments		(1,740)	(1,780)	(1,717)	(1,726)
PDC dividend paid		(8,435)	(7,531)	(8,435)	(7,531)
Cash flows (used in) from other financing activities		-	-	175	617
Net cash flows from financing activities		**18,858**	**4,788**	**19,176**	**5,437**
Increase / (decrease) in cash and cash equivalents		**1,498**	**(8,580)**	**2,783**	**(7,233)**
Cash and cash equivalents at 1 April - brought forward		**38,526**	**47,106**	**33,865**	**41,098**
Cash and cash equivalents at 31 March	32	**40,024**	**38,526**	**36,648**	**33,865**

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 2024/25 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 intangible assets.

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 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 Bath Ltd (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 (SOFP).

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 (WHC), in partnership with Salisbury NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust. WHC no longer exist as at 1 April 2025.

The LLP has a separate Board, but strategic control of the organisation remains with the partners as detailed in the Members Agreement signed by the three NHS Foundation Trusts.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.
The timing of satisfaction of performance obligations relates to the typical timing of payment (i.e. credit terms).

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

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. In 2024/25 CQUIN projects were paused with no contractual commitment to undertake them. CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead, they form part of the unit prices which are paid for overall performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

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 2024-25, this figure is 24.45% (2023-24 was 23.07%). Therefore, 24.45% of accrued ICR revenue should be 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 (SOCI) to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the SOCI 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 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. Annual leave accrual is based on actual payments made in lieu of annual leave to staff over the preceding year which is then used to estimate year-end accrual.

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 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 SOCI 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-SOFP 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 SOCI 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.

Note 1.8 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	2	62
Dwellings	30	46
Plant & machinery	2	22
Information technology	2	7
Furniture & fittings	3	17

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets 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, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset where it meets recognition criteria.

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	10
Licences & trademarks	2	9

Note 1.10 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 SOFP.

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 Statement of Financial Position. 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 1.11 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.

Between 2020/21 and 2023/24, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

Note 1.12 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 1.13 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.

Note 1.13 Financial assets and financial liabilities continued

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 leasing arrangements 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 SOCI 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 RUH 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.

Note 1.13 Financial assets and financial liabilities continued

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 SOCI and reduce the net carrying value of the financial asset in the SOFP.

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 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

Note 1.14 Leases continued

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 include 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 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

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 (leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000) is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 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 SOFP 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 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

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 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 36.2 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 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 37 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 37, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 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 1.18 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 1.19 Corporation tax
Under current legislation, Foundation Trusts are not liable for corporation tax.

The Trust's subsidiary company files a separate tax return to the Trust. The subsidiary is not expected to pay any corporation tax in this financial period due to accumulated tax losses.

Deferred taxes are provided for on temporary differences and carry forwards. This is in line with the expected corporation tax rate increase, and the deferred tax assets not expected to be realised before this time. The rate change may affect future tax charges. In addition, the utilisation of any tax losses and temporary differences for which no deferred tax asset has been recognised may also affect future tax charges. Deferred taxes at the reporting date have been measured using these enacted tax rates and reflected in these financial statements.

Note 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the SOCI as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 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 SOFP 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.

Note 1.21 Foreign exchange continued

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the SOFP 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 1.22 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 1.23 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 accrual's 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 1.24 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 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been adopted early in 2024/25.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 17 Insurance Contracts - The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016 and is not applicable to DHSC group bodies.

IFRS 18 Presentation and Disclosure in Financial Statements. The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted continued

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measure under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets w be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in th intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a moder equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total book value of £331m as at 31 March 2025. The Trust does not have assets valued on an alternative site basis as at 31 March 2025.

Note 1.27 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.

Note 1.27 Critical judgements in applying accounting policies continued

For the purpose of the MEA valuation, the Trust has assumed that the modern equivalent asset for Royal United Hospital would be a multi storey building, which would occupy less land. For the purpose of the MEA valuation, the Trust has not included unused space, unused land, underutilised space and any space not used for healthcare purposes or required to directly support the delivery of healthcare, in the calculation of modern equivalent asset.

Classification of the Sulis Hospital Lease
The Trust has performed a review of IAS40 “Investment Property” and considered the classification of the Trust’s external lease of the Sulis hospital site which is sub leased to the wholly owned subsidiary. As a result of this review, it has been concluded that this does not meet the definition of an investment property within the Trust only statement of financial position. The Hospital lease has been classified as a right of use asset under IFRS16.

Note 1.28 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 SOFP at current value in existing use. The assessment of current value represents a key source of estimation 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 2025.

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.

Note 2 Operating Segments

The Trust Board is the Chief Operating Decision Maker and considers the Trust's healthcare services, along with the three operating segments due to them having similar economic characteristics.

On 1st June 2021 the Royal United Hospitals Bath NHS FT acquired Sulis Hospital Bath Ltd. Sulis Hospital is a Private Limited Company. The financial performance of Sulis Hospital is consolidated and reported to the Board monthly. Consolidation with the Trust's Charity is done at month 9 and as at year-end. The financial position of Sulis and the Charity has been shown in the segmental analysis below.

Income and Expenditure analysis by Segment

2024/25

	Trust	**Sulis**	**Charity**	**Adjustments for intracompany eliminations**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Operating income	580,235	44,325	3,200	(8,871)	**618,889**
Operating expenditure	(574,395)	(43,633)	(4,122)	7,665	**(614,485)**
Operating surplus/(deficit)	**5,840**	**692**	**(922)**	**(1,206)**	**4,404**
Net finance costs	(7,789)	(536)	-	638	**(7,687)**
Surplus/(deficit) for the period	**(1,949)**	**156**	**(922)**	**(568)**	**(3,283)**
Impairments	(2,117)	-	-	-	**(2,117)**
Revaluations	2,959	-	-	-	**2,959**
Fair value gains on financial assets mandated at fair value through OCI	-	-	80	-	**80**
Total comphrensive income/(expense) for the period	**(1,107)**	**156**	**(842)**	**(568)**	**(2,361)**

Income and Expenditure analysis by Segment

2023/24

	Trust	**Sulis**	**Charity**	**Adjustments for intracompany eliminations**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Operating income	522,234	39,757	2,762	(8,988)	**555,766**
Operating expenditure	(519,262)	(38,844)	(5,410)	8,402	**(555,115)**
Operating surplus /(deficit)	**2,972**	**913**	**(2,648)**	**(586)**	**651**
Net finance costs	(5,630)	(619)	-	736	**(5,513)**
Other	-	-	-	(56)	**(56)**
Surplus/(deficit) for the period	**(2,659)**	**294**	**(2,648)**	**94**	**(4,918)**
Impairments	(4,684)	-	-	-	**(4,684)**
Revaluations	1,086	-	-	-	**1,086**
Fair value gains on financial assets mandated at fair value through OCI	-	-	226	-	**226**
Other reserve movements	-	-	(1)	-	**(1)**
Total comphrensive Income for the period	**(6,257)**	**294**	**(2,423)**	**94**	**(8,291)**

Note 2 Operating Segments continued

Statement of Financial Position analysis by Segment

2024/25

	Trust £000	Sulis £000	Charity £000	Adjustments for intracompany eliminations £000	Total £000
Non-Current Assets	396,199	12,360	3,953	(13,742)	**398,770**
Current Assets	74,177	8,787	4,058	(1,439)	**85,583**
Current Liabilities	(73,721)	(11,610)	(372)	3,581	**(82,122)**
Total assets less liabilities	**396,655**	**9,537**	**7,639**	**(11,600)**	**402,231**
Non-current liabilities	(56,211)	(11,450)	-	11,119	**(56,542)**
Total net assets employed	**340,444**	**(1,913)**	**7,639**	**(481)**	**345,689**

Statement of Financial Position by Segment

2023/24

	Trust £000	Sulis £000	Charity £000	Adjustments for intracompany eliminations £000	Total £000
Non-Current Assets	362,794	14,297	4,833	(15,697)	**366,227**
Current Assets	66,745	7,712	4,814	(1,979)	**77,292**
Current Liabilities	(64,790)	(9,988)	(1,168)	3,805	**(72,141)**
Total assets less liabilities	**364,749**	**12,021**	**8,479**	**(13,872)**	**371,377**
Non-current liabilities	(55,367)	(13,778)	-	13,647	**(55,498)**
Total net assets employed	**309,382**	**(1,757)**	**8,479**	**(225)**	**315,879**

Note 3 Operating income from patient care activities

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)	2024/25 £000	2023/24 £000
Income from commissioners under API contracts - variable element*	54,676	43,148
Income from commissioners under API contracts - fixed element*	418,210	396,424
High cost drugs income from commissioners	37,022	28,494
Other NHS clinical income	5,270	3,783
Income from other sources (e.g. local authorities)	-	1,694
Private patient income	15,428	16,768
Additional pension contribution central funding**	21,595	13,409
National pay award central funding***	1,184	252
Other clinical income****	8,309	3,879
Total income from activities	**561,694**	**507,851**

*Aligned payment and incentive (API) contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation. In the current year, the API contracts were split into its variable and fixed elements in line with NHS England requirements.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

**** Other clinical income	2024/25 £000	2023/24 £000
Clinical income	3,072	1,180
Patient care	2,919	2,085
Slam income	1,533	-
Overseas visitors	369	211
Prescriptions	1,202	1,052
Intercompany adjustments	(787)	(649)
	8,309	**3,879**

Note 3.2 Income from patient care activities (by source)	2024/25 £000	2023/24 £000
Income from patient care activities received from:		
NHS England	109,050	82,309
Integrated care boards	429,161	400,004
Other NHS providers	2,808	2,249
NHS other	717	1,316
Local authorities	1,318	1,388
Non-NHS: private patients	15,428	16,768
Non-NHS: overseas patients (chargeable to patient)	369	211
Injury cost recovery scheme	634	554
Non NHS: other	2,209	2,762
Total income from activities	**561,694**	**507,561**
Of which:		
Related to continuing operations	561,694	507,561
Related to discontinued operations	-	-

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

	2024/25	2023/24
	£000	£000
Income recognised this year	369	211
Cash payments received in-year	203	154
Amounts written off in-year	57	3

Note 4 Other operating income (Group)

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	4,804	-	**4,804**	4,519	-	**4,519**
Education and training	18,722	1,249	**19,971**	16,417	1,031	**17,448**
Non-patient care services to other bodies	8,315	-	**8,315**	12,258	-	**12,258**
Income in respect of employee benefits accounted on a gross basis	3,875	-	**3,875**	3,763	-	**3,763**
Receipt of capital grants and donations	-	10,956	**10,956**	-	683	**683**
Charitable and other contributions to expenditure	-	-	**-**	-	111	**111**
Revenue from operating leases	-	469	**469**	-	515	**515**
Charitable fund incoming resources	-	2,942	**2,942**	-	2,758	**2,758**
Other income	6,058	(194)	**5,864**	6,269	(119)	**6,150**
Total other operating income	**41,774**	**15,422**	**57,196**	**43,226**	**4,979**	**48,205**
Of which:						
Related to continuing operations			57,196			48,205
Related to discontinued operations			-			-

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

	2024/25	2023/24
	£000	£000
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	117	997

Note 4.2 Income from activities arising from commissioner requested services

The Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2024/25	2023/24
	£000	£000
Income from services designated as commissioner requested services	561,694	507,561
Income from services not designated as commissioner requested services	57,196	48,205
Total	**618,890**	**555,766**

Note 4.3 Fees and charges (Group)

The following disclosure is of income from charges to service users where the full cost of providing that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2024/25	2023/24
	£000	£000
Income	3,879	3,601
Full cost	(3,009)	(2,706)
Surplus	**870**	**895**

Fees and charges relate to car parking and retail catering.

Note 5 Operating leases - Royal United Hospitals Bath NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where Royal United Hospitals Bath Foundation Trust is the lessor.

The expected lease payments relate to leases between the Trust and Sulis Hospital, for the Hospital building and medical equipment.

Note 5.1 Operating leases income (Group)

	2024/25	2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	469	515
Total in-year operating lease income	**469**	**515**

Note 5.2 Future lease receipts (Trust)

	31 March 2025	31 March 2024
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	2,456	2,505
- later than one year and not later than two years	2,506	2,422
- later than two years and not later than three years	2,339	2,470
- later than three years and not later than four years	2,823	2,520
- later than four years and not later than five years	661	2,570
- later than five years	-	652
Total	**10,785**	**13,139**

During 2022/23, the Trust entered into a lease arrangement with Sulis Hospital which was accounted for under IFRS 16. The most significant of the leases was the Hospital lease. Total income that the Trust received for all leases from Sulis in 2024/25 was £2.4 million (2023/24: £3.0 million). The income received covered the cost of the leases and the Trust did not make any profit from the leasing arrangements in place.

The Hospital lease is classified as an operating lease within the Trust accounts, and as such retains the rights over the asset. The remaining leases are not material to the accounts.

Note 6 Operating expenses (Group)

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2	-
Purchase of healthcare from non-NHS and non-DHSC bodies	3,678	3,447
Staff and executive directors costs	386,781	356,505
Remuneration of non-executive directors	185	187
Supplies and services - clinical (excluding drugs costs)	58,099	51,705
Supplies and services - general	10,534	9,397
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	63,077	56,102
Consultancy costs	-	24
Establishment	5,968	6,953
Premises	22,826	19,258
Transport (including patient travel)	1,315	1,369
Depreciation on property, plant and equipment	19,382	16,849
Amortisation on intangible assets	2,637	2,525
Net impairments	10,400	2,497
Movement in credit loss allowance: contract receivables / contract assets	668	(24)
Increase in other provisions	297	48
Change in provisions discount rate(s)	18	(251)
Audit services- statutory audit	311	110
Other auditor remuneration (external auditor only)	80	49
Clinical negligence	17,176	15,506
Legal fees	306	153
Insurance	592	549
Research and development	4,611	4,229
Education and training	4,313	4,525
Expenditure on low value leases	102	140
Hospitality	31	79
Losses, ex gratia & special payments	84	27
Other NHS charitable fund resources expended	684	1,001
Other	328	2,156
Total	**614,485**	**555,115**
Of which:		
Related to continuing operations	614,485	555,115
Related to discontinued operations	-	-

Note 6.1 Other auditor remuneration (Group)

	2024/25	2023/24
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit of accounts of any associate of the Trust	80	49
Total	**80**	**49**

Note 6.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1 million (2023/24: £1 million).

Note 7 Impairment of assets (Group)

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	333	336
Changes in market price	10,067	2,161
Total net impairments charged to operating surplus / deficit	**10,400**	**2,497**
Impairments charged to the revaluation reserve	2,117	4,684
Total net impairments	**12,517**	**7,181**

Note 8 Employee benefits (Group)

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	300,160	277,417
Social security costs	31,307	28,950
Apprenticeship levy	1,413	1,363
Employer's contributions to NHS pensions	54,548	44,408
Pension cost - other	408	71
Temporary staff (including agency)	5,073	10,113
NHS charitable funds staff	777	892
Total gross staff costs	**393,686**	**363,214**
Recoveries in respect of seconded staff	-	-
Total staff costs	**393,686**	**363,214**
Of which		
Costs capitalised as part of assets	2,111	1,772

Note 8.1 Retirements due to ill-health (Group)

During 2024/25 there were no early retirements from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £0k (£0k in 2023/24).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 10 Finance income (Group)

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

	2024/25	2023/24
	£000	£000
Interest on bank accounts	2,063	2,571
NHS charitable fund investment income	258	300
Total finance income	**2,321**	**2,871**

Note 11 Finance expenditure (Group)

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

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	118	127
Interest on lease obligations	1,740	1,780
Total interest expense	**1,858**	**1,907**
Unwinding of discount on provisions	15	18
Total finance costs	**1,873**	**1,925**

Note 12 Other gains / (losses) (Group)

	2024/25	2023/24
	£000	£000
Gains on disposal of assets	29	97
Losses on disposal of assets	(15)	(5)
Total other gains	**14**	**92**

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 £1.9 million (2023/24: £2.6 million). The Trust's total comprehensive expense for the period was £1.1 million (2023/24: £6.3 million).

Note 14 Intangible assets - 2024/25

Group	Software licences	Licences & trademarks	Goodwill	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**1,520**	**15,784**	**974**	**1,032**	**19,310**
Additions	1,174	158	-	2,196	**3,528**
Reclassifications	74	-	-	-	**74**
Disposals / derecognition	(70)	(665)	-	-	**(735)**
Valuation / gross cost at 31 March 2025	**2,698**	**15,277**	**974**	**3,228**	**22,177**
Amortisation at 1 April 2024 - brought forward	**746**	**11,459**	**-**	**-**	**12,205**
Provided during the year	327	2,310	-	-	**2,637**
Disposals / derecognition	(70)	(665)	-	-	**(735)**
Amortisation at 31 March 2025	**1,003**	**13,104**	**-**	**-**	**14,107**
Net book value at 31 March 2025	**1,695**	**2,173**	**974**	**3,228**	**8,070**
Net book value at 1 April 2024	**774**	**4,325**	**974**	**1,032**	**7,105**

Note 14.1 Intangible assets - 2023/24

Group	Software licences	Licences & trademarks	Goodwill	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**989**	**17,054**	**974**	**-**	**19,017**
Additions	737	206	-	1,032	**1,975**
Reclassifications	55	-	-	-	**55**
Disposals / derecognition	(261)	(1,476)	-	-	**(1,737)**
Valuation / gross cost at 31 March 2024	**1,520**	**15,784**	**974**	**1,032**	**19,310**
Amortisation at 1 April 2023 - brought forward	**987**	**10,430**	**-**	**-**	**11,417**
Provided during the year	20	2,505	-	-	**2,525**
Disposals / derecognition	(261)	(1,476)	-	-	**(1,737)**
Amortisation at 31 March 2024	**746**	**11,459**	**-**	**-**	**12,205**
Net book value at 31 March 2024	**774**	**4,325**	**974**	**1,032**	**7,105**
Net book value at 1 April 2023	**2**	**6,624**	**974**	**-**	**7,600**

Note 15 Intangible assets - 2024/25

Trust	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**1,520**	**15,784**	**1,032**	**18,336**
Additions	1,174	158	2,196	**3,528**
Reclassifications	74	-	-	**74**
Disposals / derecognition	(70)	(665)	-	**(735)**
Valuation / gross cost at 31 March 2025	**2,698**	**15,277**	**3,228**	**21,203**
Amortisation at 1 April 2024 - brought forward	**746**	**11,458**	**-**	**12,204**
Provided during the year	327	2,310	-	**2,637**
Disposals / derecognition	(70)	(665)	-	**(735)**
Amortisation at 31 March 2025	**1,003**	**13,103**	**-**	**14,106**
Net book value at 31 March 2025	**1,695**	**2,174**	**3,228**	**7,097**
Net book value at 1 April 2024	**774**	**4,326**	**1,032**	**6,132**

Note 15.1 Intangible assets - 2023/24

Trust	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**989**	**17,054**	**-**	**18,043**
Additions	737	206	1,032	**1,975**
Reclassifications	55	-	-	**55**
Disposals / derecognition	(261)	(1,476)	-	**(1,737)**
Valuation / gross cost at 31 March 2024	**1,520**	**15,784**	**1,032**	**18,336**
Amortisation at 1 April 2023 - brought forward	**987**	**10,430**	**-**	**11,417**
Provided during the year	20	2,504	-	**2,524**
Disposals / derecognition	(261)	(1,476)	-	**(1,737)**
Amortisation at 31 March 2024	**746**	**11,458**	**-**	**12,204**
Net book value at 31 March 2024	**774**	**4,326**	**1,032**	**6,132**
Net book value at 1 April 2023	**2**	**6,624**	**-**	**6,626**

Note 16 Impairment of Goodwill

Under IAS 36 the Trust is required to annually assess its goodwill intangible asset for impairment. The core principle in IAS 36 is that an asset must not be carried in the financial statements at more than the highest amount to be recovered through its use or sale.

The recoverable amount is the higher of;

- fair value less costs to sell. This is the arm's length sale price between knowledgeable willing parties less costs of disposal (FVLCD); and

- value in use (VIU). This is the expected future cash flows that the asset in its current condition will produce, discounted to present value using an appropriate discount.

The Trust considers that the FVLCD will always be lower than both the carrying value of the goodwill and the value in use for the Trust. The value in use to the Trust is broader than simply the cashflows of the business as it will also reflect the extent to which the Trust can deploy the service potential of the business.

The Trust believes that there were clear indicators that the goodwill had been impaired, following post-acquisition analysis of the business in the financial year 2021/22, as set out below.

	2024/25	**2023/24**
	£000	**£000**
Goodwill at purchase date	1,384	1,384
Less impairment of goodwill at reporting date	(410)	(410)
Goodwill at reporting date	**974**	**974**

The impairment was charged to the accounts in 2021/22. No impairment charge has been made in 2024/25 accounts.

Note 17 Property, plant and equipment - 2024/25

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 - brought forward	**10,774**	**181,653**	**4,261**	**62,941**	**72,378**	**14,620**	**1,794**	**348,421**
Additions	-	12,346	31	33,896	8,631	2,477	118	**57,499**
Impairments	-	(14,000)	-	(333)	-	-	-	**(14,333)**
Reversals of impairments	-	1,816	-	-	-	-	-	**1,816**
Revaluations	954	(4,139)	(206)	(9)	-	-	-	**(3,400)**
Reclassifications	-	53,580	-	(54,893)	826	69	344	**(74)**
Disposals / derecognition	-	(14)	-	-	(5,097)	(434)	(107)	**(5,652)**
Valuation/gross cost at 31 March 2025	**11,728**	**231,242**	**4,086**	**41,602**	**76,738**	**16,732**	**2,149**	**384,277**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**874**	**-**	**-**	**37,647**	**7,444**	**1,064**	**47,029**
Provided during the year	-	6,567	141	-	5,958	2,164	189	**15,019**
Revaluations	-	(6,218)	(141)	-	-	-	-	**(6,359)**
Disposals / derecognition	-	(8)	-	-	(5,083)	(433)	(104)	**(5,628)**
Accumulated depreciation at 31 March 2025	**-**	**1,215**	**-**	**-**	**38,522**	**9,175**	**1,149**	**50,061**
Net book value at 31 March 2025	**11,728**	**230,027**	**4,086**	**41,602**	**38,216**	**7,557**	**1,000**	**334,216**
Net book value at 1 April 2024	**10,774**	**180,779**	**4,261**	**62,941**	**34,731**	**7,176**	**730**	**301,392**

Note 17.1 Property, plant and equipment - 2023/24

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**11,334**	**179,132**	**4,411**	**58,984**	**68,423**	**10**	**16,308**	**2,060**	**340,662**
Additions	-	7,190	108	13,548	8,132	-	3,136	51	**32,165**
Impairments	(560)	(6,283)	(3)	(336)	-	-	-	-	**(7,182)**
Revaluations	-	(4,336)	(255)	-	-	-	-	-	**(4,591)**
Reclassifications	-	6,146	-	(9,255)	2,680	-	374	-	**(55)**
Disposals / derecognition	-	(196)	-	-	(6,857)	(10)	(5,198)	(317)	**(12,578)**
Valuation/gross cost at 31 March 2024	**10,774**	**181,653**	**4,261**	**62,941**	**72,378**	**-**	**14,620**	**1,794**	**348,421**
Accumulated depreciation at 1 April 2023 - brought forward	**-**	**568**	**-**	**-**	**39,667**	**10**	**11,030**	**1,231**	**52,506**
Provided during the year	-	6,036	144	-	4,785	-	1,612	150	**12,727**
Impairments	-	192	-	-	-	-	-	-	**192**
Reversals of impairments	-	(193)	-	-	-	-	-	-	**(193)**
Revaluations	-	(5,533)	(144)	-	-	-	-	-	**(5,677)**
Disposals / derecognition	-	(196)	-	-	(6,805)	(10)	(5,198)	(317)	**(12,526)**
Accumulated depreciation at 31 March 2024	**-**	**874**	**-**	**-**	**37,647**	**-**	**7,444**	**1,064**	**47,029**
Net book value at 31 March 2024	**10,774**	**180,779**	**4,261**	**62,941**	**34,731**	**-**	**7,176**	**730**	**301,392**
Net book value at 1 April 2023	**11,334**	**178,564**	**4,411**	**58,984**	**28,756**	**-**	**5,278**	**829**	**288,156**

Note 17.2 Property, plant and equipment financing - 31 March 2025

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	11,728	218,748	4,086	30,780	31,152	7,555	974	**305,023**
Owned - donated/granted	-	11,279	-	10,822	7,064	2	26	**29,193**
NBV total at 31 March 2025	**11,728**	**230,027**	**4,086**	**41,602**	**38,216**	**7,557**	**1,000**	**334,216**

Note 17.3 Property, plant and equipment financing - 31 March 2024

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	10,774	174,115	4,261	56,671	29,780	7,174	701	**283,476**
Owned - donated/granted	-	6,664	-	6,270	4,951	2	29	**17,916**
NBV total at 31 March 2024	**10,774**	**180,779**	**4,261**	**62,941**	**34,731**	**7,176**	**730**	**301,392**

Note 17.4 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

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	108	-	-	-	-	-	-	**108**
Not subject to an operating lease	11,620	230,027	4,086	41,602	38,216	7,557	1,000	**334,108**
NBV total at 31 March 2025	**11,728**	**230,027**	**4,086**	**41,602**	**38,216**	**7,557**	**1,000**	**334,216**

Note 17.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	106	-	-	-	-	-	-	**106**
Not subject to an operating lease	10,668	180,779	4,261	62,941	34,731	7,176	730	**301,286**
NBV total at 31 March 2024	**10,774**	**180,779**	**4,261**	**62,941**	**34,731**	**7,176**	**730**	**301,392**

Note 18 Property, plant and equipment - 2024/25

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 - brought forward	**10,774**	**179,622**	**4,261**	**62,941**	**69,594**	**14,328**	**1,640**	**343,160**
Additions	-	12,346	31	33,895	8,173	2,448	115	**57,008**
Impairments	-	(10,058)	-	(342)	-	-	-	**(10,400)**
Revaluations	954	(6,265)	(206)	-	-	-	-	**(5,517)**
Reclassifications	-	53,580	-	(54,893)	826	69	344	**(74)**
Disposals / derecognition	-	-	-	-	(4,970)	(404)	(18)	**(5,392)**
Valuation/gross cost at 31 March 2025	**11,728**	**229,225**	**4,086**	**41,601**	**73,623**	**16,441**	**2,081**	**378,785**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**556**	**-**	**-**	**37,338**	**7,276**	**961**	**46,131**
Provided during the year	-	6,485	141	-	5,267	2,089	161	**14,143**
Revaluations	-	(6,218)	(141)	-	-	-	-	**(6,359)**
Disposals / derecognition	-	-	-	-	(4,956)	(404)	(17)	**(5,377)**
Accumulated depreciation at 31 March 2025	**-**	**823**	**-**	**-**	**37,649**	**8,961**	**1,105**	**48,538**
Net book value at 31 March 2025	**11,728**	**228,402**	**4,086**	**41,601**	**35,974**	**7,480**	**976**	**330,247**
Net book value at 1 April 2024	**10,774**	**179,066**	**4,261**	**62,941**	**32,256**	**7,052**	**679**	**297,029**

Note 18.1 Property, plant and equipment - 2023/24

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**11,334**	**179,110**	**4,411**	**58,984**	**67,932**	**10**	**16,080**	**1,948**	**339,809**
Additions	-	5,181	108	17,050	6,232	-	3,072	9	**31,652**
Impairments	(560)	(1,599)	(3)	(336)	-	-	-	-	**(2,498)**
Revaluations	-	(9,020)	(255)	-	-	-	-	-	**(9,275)**
Reclassifications	-	6,146	-	(9,255)	2,680	-	374	-	**(55)**
Disposals / derecognition	-	(196)	-	(3,502)	(7,250)	(10)	(5,198)	(317)	**(16,473)**
Valuation/gross cost at 31 March 2024	**10,774**	**179,622**	**4,261**	**62,941**	**69,594**	**-**	**14,328**	**1,640**	**343,160**
Accumulated depreciation at 1 April 2023 - brought forward	**-**	**564**	**-**	**-**	**39,770**	**10**	**10,942**	**1,156**	**52,442**
Provided during the year	-	5,721	144	-	4,438	-	1,532	122	**11,957**
Revaluations	-	(5,533)	(144)	-	-	-	-	-	**(5,677)**
Disposals / derecognition	-	(196)	-	-	(6,870)	(10)	(5,198)	(317)	**(12,591)**
Accumulated depreciation at 31 March 2024	**-**	**556**	**-**	**-**	**37,338**	**-**	**7,276**	**961**	**46,131**
Net book value at 31 March 2024	**10,774**	**179,066**	**4,261**	**62,941**	**32,256**	**-**	**7,052**	**679**	**297,029**
Net book value at 1 April 2023	**11,334**	**178,546**	**4,411**	**58,984**	**28,162**	**-**	**5,138**	**792**	**287,367**

Note 18.2 Property, plant and equipment financing - 31 March 2025

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	11,728	217,123	4,086	30,779	28,910	7,478	950	**301,054**
Owned - donated / granted	-	11,279	-	10,822	7,064	2	26	**29,193**
Total net book value at 31 March 2025	**11,728**	**228,402**	**4,086**	**41,601**	**35,974**	**7,480**	**976**	**330,247**

Note 18.3 Property, plant and equipment financing - 31 March 2024

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	10,774	172,402	4,261	56,671	27,305	7,050	650	**279,113**
Owned - donated / granted	-	6,664	-	6,270	4,951	2	29	**17,916**
Total net book value at 31 March 2024	**10,774**	**179,066**	**4,261**	**62,941**	**32,256**	**7,052**	**679**	**297,029**

Note 18.4 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	108	-	-	-	-	-	-	**108**
Not subject to an operating lease	11,620	228,402	4,086	41,601	35,974	7,480	976	**330,139**
Total net book value at 31 March 2025	**11,728**	**228,402**	**4,086**	**41,601**	**35,974**	**7,480**	**976**	**330,247**

Note 18.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	106	-	-	-	-	-	-	**106**
Not subject to an operating lease	10,668	179,066	4,261	62,941	32,256	7,052	679	**296,923**
Total net book value at 31 March 2024	**10,774**	**179,066**	**4,261**	**62,941**	**32,256**	**7,052**	**679**	**297,029**

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. Asset lives have been extended in 23/24 to reflect the usage of assets over their lifetime. The range of useful lives are shown in the table below:

	Min life	Max life
	Years	Years
Buildings, excluding dwellings	2	62
Dwellings	30	46
Plant & machinery	2	22
Information technology	2	7
Furniture & fittings	3	17

Note 19 Donations of property, plant and equipment

The Trust received donations from which assets were purchased to the value of £2.5(£4.0m 2023/24).

The donations were made up as follows:
- £2.3m from RUH X for the Linac and the completion of the Cancer Centre and various medical equipment.
- £0.1m from Bath Cancer Support Group for equipment for Radiotherapy and £0.1m from Friends of the RUH for medical equipment.

Note 20 Revaluations of property, plant and equipment

The Trust's policy is to complete a full revaluation at least every five years relating 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 full valuation using indices of the Trust's land and buildings as at 31 March 2025. 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 £10.4m, this is a result of the full valuation of land, buildings and dwellings as at 31 March 2025 following a valuation carried out by Gerald Eve in line with Trust’s policy.

Note 21 Leases - Royal United Hospitals Bath NHS Foundation Trust as a lessee

The Trust holds a number of finance leases under IFRS16 relating to medical equipment and buildings. The most signifcant of these relate to the lease of the Hospital site for Sulis Hospital.

Note 22 Heritage Assets

The Trust hold a number of art works. The art is across a variety of mediums and have either been donated or transferred from the acquisition of The Royal National Hospital for Rheumatic Diseases in 2015.

These assets are not operational and are not held to deliver front line services or back office functions. Therefore the assets will not be recognised in the statement of financial position.

The assets were last valued in 2015 for insurance purposes. The Trust has not obtained up to date valuations, as the cost will not be commensurate with the benefits to users of the financial statements.

The art works are held at various locations across the Trust site and a small number have been loaned to the Bath Medical Museum and the Victoria Art Gallery/Guildhall. The art collection is managed by the Art & Design Manager.

Note 23 Right of use assets - 2024/25

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**55,787**	**3,563**	**85**	**59,435**	**1,496**
Additions - lease liability	211	2,796	74	**3,081**	-
Remeasurements of the lease liability	662	-	-	**662**	-
Movements in provisions for restoration / removal costs	216	-	-	**216**	-
Disposals / derecognition	(78)	-	-	**(78)**	-
Valuation/gross cost at 31 March 2025	**56,798**	**6,359**	**159**	**63,316**	**1,496**
Accumulated depreciation at 1 April 2024 - brought forward	**6,600**	**1,745**	**55**	**8,400**	**412**
Provided during the year	3,601	735	27	**4,363**	218
Disposals / derecognition	(31)	-	-	**(31)**	-
Accumulated depreciation at 31 March 2025	**10,170**	**2,480**	**82**	**12,732**	**630**
Net book value at 31 March 2025	**46,628**	**3,879**	**77**	**50,584**	**866**
Net book value at 1 April 2024	**49,187**	**1,818**	**30**	**51,035**	**1,084**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	866

Note 23.1 Right of use assets - 2023/24

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**51,863**	**3,551**	**85**	**55,499**	**1,675**
Additions	2,426	27	-	**2,453**	-
Remeasurements of the lease liability	1,345	-	-	**1,345**	-
Movements in provisions for restoration / removal costs	332	-	-	**332**	-
Disposals / derecognition	(179)	(15)	-	**(194)**	(179)
Valuation/gross cost at 31 March 2024	**55,787**	**3,563**	**85**	**59,435**	**1,496**
Accumulated depreciation at 1 April 2023 - brought forward	**3,330**	**975**	**27**	**4,332**	**17**
Provided during the year	3,309	785	28	**4,122**	218
Disposals / derecognition	(39)	(15)	-	**(54)**	177
Accumulated depreciation at 31 March 2024	**6,600**	**1,745**	**55**	**8,400**	**412**
Net book value at 31 March 2024	**49,187**	**1,818**	**30**	**51,035**	**1,084**
Net book value at 1 April 2023	**48,533**	**2,576**	**58**	**51,167**	**1,658**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	1,084

Note 24 Right of use assets - 2024/25

Trust	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024 - brought forward	**53,248**	**2,621**	**85**	**55,954**	**1,497**
Additions - lease liability	-	2,796	74	**2,870**	-
Remeasurements of the lease liability	662	-	-	**662**	-
Movements in provisions for restoration / removal costs	216	-	-	**216**	-
Valuation/gross cost at 31 March 2025	**54,126**	**5,417**	**159**	**59,702**	**1,497**
Accumulated depreciation at 1 April 2024 - brought forward	**4,441**	**1,222**	**54**	**5,717**	**615**
Provided during the year	3,771	457	27	**4,255**	218
Accumulated depreciation at 31 March 2025	**8,212**	**1,679**	**81**	**9,972**	**833**
Net book value at 31 March 2025	**45,914**	**3,738**	**78**	**49,730**	**664**
Net book value at 1 April 2024	**48,807**	**1,399**	**31**	**50,237**	**882**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	664

Note 24.1 Right of use assets - 2023/24

Trust	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023 - brought forward	**49,491**	**2,435**	**85**	**52,011**	**1,676**
Additions	2,591	201	-	**2,792**	-
Remeasurements of the lease liability	1,345	-	-	**1,345**	-
Disposals / derecognition	(179)	(15)	-	**(194)**	(179)
Valuation/gross cost at 31 March 2024	**53,248**	**2,621**	**85**	**55,954**	**1,497**
Accumulated depreciation at 1 April 2023 - brought forward	**958**	**695**	**26**	**1,679**	**220**
Provided during the year	3,521	542	28	**4,091**	218
Reclassifications	-	-	-	**-**	177
Disposals / derecognition	(38)	(15)	-	**(53)**	-
Accumulated depreciation at 31 March 2024	**4,441**	**1,222**	**54**	**5,717**	**615**
Net book value at 31 March 2024	**48,807**	**1,399**	**31**	**50,237**	**882**
Net book value at 1 April 2023	**48,533**	**1,740**	**59**	**50,332**	**1,456**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	882

Note 24.2 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 35.

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Carrying value at 1 April	**52,000**	**51,145**	**51,595**	**50,756**
Lease additions	3,081	2,453	2,870	2,460
Lease liability remeasurements	662	1,345	662	1,345
Interest charge arising in year	1,740	1,780	1,717	1,726
Early terminations	(32)	(135)	-	(135)
Lease payments (cash outflows)	(4,445)	(4,588)	(4,301)	(4,557)
Carrying value at 31 March	**53,006**	**52,000**	**52,543**	**51,595**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 24.3 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	4,112	183	3,965	-
- later than one year and not later than five years;	15,463	548	15,106	-
- later than five years.	57,109	-	57,108	-
Total gross future lease payments	**76,684**	**731**	**76,179**	**-**
Finance charges allocated to future periods	(23,678)	(10)	(23,636)	-
Net lease liabilities at 31 March 2025	**53,006**	**721**	**52,543**	**-**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		721		-

Note 24.4 Maturity analysis of future lease payments at 31 March 2024

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2024	31 March 2024	31 March 2024	31 March 2024
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	4,260	225	4,141	225
- later than one year and not later than five years;	13,395	891	13,071	891
- later than five years.	58,907	-	58,908	-
Total gross future lease payments	**76,562**	**1,116**	**76,120**	**1,116**
Finance charges allocated to future periods	(24,562)	(25)	(24,524)	(25)
Net finance lease liabilities at 31 March 2024	**52,000**	**1,091**	**51,596**	**1,091**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		1,091		1,091

Note 25 Investments in associates and joint ventures

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**-**	**56**	**-**	**56**
Share of loss	-	(56)	-	(56)
Carrying value at 31 March	**-**	**-**	**-**	**-**

Note 26 Other investments / financial assets (non-current)

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Carrying value at 1 April - as previously stated	**4,833**	**6,483**	**3,941**	**3,941**
Acquisitions in year	40	41	-	-
Movement in fair value through OCI	80	226	-	-
Disposals	(1,000)	(1,917)	-	-
Carrying value at 31 March	**3,953**	**4,833**	**3,941**	**3,941**

Note 27 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. Wiltshire Health and Care LLP ceased trading on the 1st April 2025. 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 28 Analysis of charitable fund reserves

	31 March 2025	31 March 2024
	£000	£000
Unrestricted funds:		
Unrestricted income funds	3,977	2,664
Restricted funds:		
Other restricted income funds	3,659	5,815
	7,636	**8,479**

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 Trustees' 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 29 Inventories

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Drugs	3,249	2,041	2,508	1,963
Consumables	5,474	6,130	4,161	4,182
Energy	113	113	113	113
Total inventories	**8,836**	**8,284**	**6,782**	**6,258**

Inventories recognised in expenses for the year were £91,664k (2023/24: £78,152k). Write-down of inventories recognised as expenses for the year were £0k (2023/24: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £111k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

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 30 Receivables

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Contract receivables	23,321	23,191	19,119	19,938
Capital receivables	4,835	-	4,835	-
Allowance for impaired contract receivables / assets	(1,383)	(1,187)	(1,062)	(894)
Deposits and advances	15	54	15	47
Prepayments (non-PFI)	6,435	5,590	5,558	5,174
Finance lease receivables	-	-	361	349
PDC dividend receivable	1,192	906	1,192	906
VAT receivable	177	656	177	656
Other receivables	550	453	552	446
NHS charitable funds receivables	1,580	819	-	-
Total current receivables	**36,722**	**30,482**	**30,747**	**26,622**
Non-current				
Contract assets	1,516	1,396	1,521	1,396
Allowance for impaired contract receivables / assets	(307)	(266)	(307)	(266)
Finance lease receivables	-	-	3,232	3,593
Other receivables	738	732	738	732
Total non-current receivables	**1,947**	**1,862**	**5,184**	**5,455**
Of which receivable from NHS and DHSC group bodies:				
Current	14,682	15,443	12,789	11,739
Non-current	738	732	738	1,130

Note 30.1 Allowances for credit losses - 2024/25

	Group	Trust
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 Apr 2024 - brought forward	**1,453**	**1,160**
New allowances arising	235	206
Changes in existing allowances	555	556
Reversals of allowances	(122)	(122)
Utilisation of allowances (write offs)	(431)	(431)
Allowances as at 31 Mar 2025	**1,690**	**1,369**

Note 30.2 Allowances for credit losses - 2023/24

	Group	Trust
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 Apr 2023 - brought forward	**1,493**	**1,359**
New allowances arising	159	-
Changes in existing allowances	(183)	(183)
Utilisation of allowances (write offs)	(16)	(16)
Allowances as at 31 Mar 2024	**1,453**	**1,160**

Note 31 Finance leases (Royal United Hospitals Bath NHS Foundation Trust as a lessor)

This note discloses future lease payments receivable from lease arrangements classified as finance leases where the Royal United Hospitals Bath NHS Foundation Trust is the lessor.

There are a number of finance and operating leases between Sulis Hospital and the Trust. These relate to the lease of the Sulis Hospital Site and various medical equipment.

Note 31.1 Reconciliation of the carrying value of finance lease receivables (net investment in the lease)

	Trust	
	2024/25	2023/24
	£000	£000
Finance lease receivables at 1 April	**3,941**	**443**
Additions	-	3,836
Interest arising (unwinding of discount)	123	133
Lease receipts (cash payments received)	(471)	(471)
Finance lease receivables at 31 March	**3,593**	**3,941**

Note 31.2 Finance lease receivables maturity analysis as at 31 March 2025

	Trust	
	Total	Of which leased to DHSC group bodies:
	31 March 2025	31 March 2025
	£000	£000
Undiscounted future lease receipts receivable in:		
not later than one year;	361	-
later than one year and not later than two years;	451	-
later than two years and not later than three years;	354	-
later than three years and not later than four years;	353	-
later than four years and not later than five years;	353	-
later than five years.	2,683	-
Total future finance lease payments to be received	**4,555**	**-**
Unearned interest income	(962)	-
Net investment in lease (net lease receivable)	**3,593**	**-**
of which:		
Leased to other NHS providers		-
Leased to other DHSC group bodies		-

Note 31.3 Finance lease receivables maturity analysis as at 31 March 2024

	Trust	
	Total	Of which leased to DHSC group bodies:
	31 March 2024	31 March 2024
	£000	£000
Undiscounted future lease receipts receivable in:		
not later than one year;	348	-
later than one year and not later than two years;	482	-
later than two years and not later than three years;	451	-
later than three years and not later than four years;	354	-
later than four years and not later than five years;	353	-
later than five years.	3,036	-
Total future finance lease payments to be received	**5,024**	**-**
Unearned interest income	(1,083)	
Net investment in lease (net lease receivable)	**3,941**	**-**
of which:		
Leased to other NHS providers		-
Leased to other DHSC group bodies		-

Note 32 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	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
At 1 April	**38,526**	**47,106**	**33,865**	**41,102**
Net change in year	1,498	(8,580)	2,783	(7,237)
At 31 March	**40,024**	**38,526**	**36,648**	**33,865**
Broken down into:				
Cash at commercial banks and in hand	2,738	4,349	4	3
Cash with the Government Banking Service	37,286	34,177	36,644	33,862
Total cash and cash equivalents as in SoFP	**40,024**	**38,526**	**36,648**	**33,865**
Total cash and cash equivalents as in SoCF	**40,024**	**38,526**	**36,648**	**33,865**

Breakdown of cash and cash equivalents held by Sulis Hospital and RUH X Charity

	Sulis Hospital		RUH X Charity	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Cash at commercial banks and in hand	901	666	1,833	3,680
Cash with the Government Banking Service	-	-	642	315
	901	**666**	**2,475**	**3,995**

Note 32.1 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 2025	31 March 2024
	£000	£000
Bank balances	12	11

Note 33 Trade and other payables

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Current				
Trade payables	2,287	9,952	1,437	15,586
Capital payables	9,139	2,691	9,139	2,691
Accruals	19,801	22,792	16,153	14,268
Social security costs	7,394	8,053	7,394	7,717
Pension contributions payable	4,554	-	4,554	-
Other payables	24,123	10,866	22,947	9,890
NHS charitable funds: trade and other payables	372	944	-	-
Total current trade and other payables	**67,670**	**55,298**	**61,625**	**50,152**
Of which payables to NHS and DHSC group bodies:				
Current	4,034	5,024	3,877	17,544

Note 33.1 Early retirements in NHS payables above

There were no early retirements in the NHS payables stated above.

Note 34 Other liabilities

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	10,857	13,298	8,634	11,388
Total other current liabilities	**10,857**	**13,298**	**8,634**	**11,388**

Note 35 Borrowings

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Current				
Loans from DHSC	345	348	345	348
Lease liabilities	2,317	2,722	2,185	2,448
Total current borrowings	**2,662**	**3,070**	**2,530**	**2,796**
Non-current				
Loans from DHSC	4,538	4,850	4,538	4,850
Lease liabilities	50,689	49,278	50,358	49,147
Total non-current borrowings	**55,227**	**54,128**	**54,896**	**53,997**

Note 35.1 Reconciliation of liabilities arising from financing activities (Group)

Group - 2024/25	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2024	**5,198**	**52,000**	**57,198**
Cash movements:			
Financing cash flows - payments and receipts of principal	(313)	(2,705)	**(3,018)**
Financing cash flows - payments of interest	(120)	(1,740)	**(1,860)**
Non-cash movements:			
Additions	-	3,081	**3,081**
Lease liability remeasurements	-	662	**662**
Application of effective interest rate	118	1,740	**1,858**
Early terminations	-	(32)	**(32)**
Carrying value at 31 March 2025	**4,883**	**53,006**	**57,889**

Group - 2023/24	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2023	**5,512**	**51,145**	**56,657**
Cash movements:			
Financing cash flows - payments and receipts of principal	(313)	(2,808)	**(3,121)**
Financing cash flows - payments of interest	(128)	(1,780)	**(1,908)**
Non-cash movements:			
Additions	-	2,453	**2,453**
Lease liability remeasurements	-	1,345	**1,345**
Application of effective interest rate	127	1,780	**1,907**
Early terminations	-	(135)	**(135)**
Carrying value at 31 March 2024	**5,198**	**52,000**	**57,198**

Note 35.2 Reconciliation of liabilities arising from financing activities

Trust - 2024/25	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2024	**5,198**	**51,595**	**56,793**
Cash movements:			
Financing cash flows - payments and receipts of principal	(313)	(2,585)	**(2,898)**
Financing cash flows - payments of interest	(121)	(1,717)	**(1,838)**
Non-cash movements:			
Additions	-	2,870	**2,870**
Lease liability remeasurements	-	662	**662**
Application of effective interest rate	119	1,718	**1,837**
Carrying value at 31 March 2025	**4,883**	**52,543**	**57,426**

Trust - 2023/24	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2023	**5,511**	**50,756**	**56,267**
Cash movements:			
Financing cash flows - payments and receipts of principal	(313)	(2,830)	**(3,143)**
Financing cash flows - payments of interest	(128)	(1,726)	**(1,854)**
Non-cash movements:			
Additions	-	2,460	**2,460**
Lease liability remeasurements	-	1,345	**1,345**
Application of effective interest rate	128	1,725	**1,853**
Early terminations	-	(135)	**(135)**
Carrying value at 31 March 2024	**5,198**	**51,595**	**56,793**

Note 36 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2024	**725**	**15**	**-**	**1,105**	**1,845**
Change in the discount rate	18	-	-	(7)	**11**
Arising during the year	91	250	140	270	**751**
Utilised during the year	(90)	-	-	(86)	**(176)**
Reversed unused	(92)	(143)	-	-	**(235)**
Unwinding of discount	15	-	-	36	**51**
At 31 March 2025	**667**	**122**	**140**	**1,318**	**2,247**
Expected timing of cash flows:					
- not later than one year;	90	122	140	580	**932**
- later than one year and not later than five years;	318	-	-	-	**318**
- later than five years.	259	-	-	738	**997**
Total	**667**	**122**	**140**	**1,318**	**2,247**

Note 36.1 Provisions for liabilities and charges analysis (Trust)

Trust	Pensions: early departure costs	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2024	**725**	**15**	**-**	**1,084**	**1,824**
Change in the discount rate	18	-	-	(7)	**11**
Arising during the year	91	250	140	270	**751**
Utilised during the year	(90)	-	-	(65)	**(155)**
Reversed unused	(92)	(143)	-	-	**(235)**
Unwinding of discount	15	-	-	36	**51**
At 31 March 2025	**667**	**122**	**140**	**1,318**	**2,247**
Expected timing of cash flows:					
- not later than one year;	90	122	140	720	**1,072**
- later than one year and not later than five years;	318	-	-	-	**318**
- later than five years.	259	-	-	598	**857**
Total	**667**	**122**	**140**	**1,318**	**2,247**

Pensions - early departure costs
Early retirement costs and injury benefit payments for staff are 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 salaries and are therefore inherently uncertain. Other provisions includes a capitalised provision in relation to IFRS16 of £548,000.

Note 36.2 Clinical negligence liabilities

At 31 March 2025, £197,058k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal United Hospitals Bath NHS Foundation Trust (31 March 2024: £188,517k).

Note 37 Contingent assets and liabilities

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Value of contingent liabilities				
NHS Resolution legal claims	2	2	2	2
Gross value of contingent liabilities	**2**	**2**	**2**	**2**
Net value of contingent liabilities	**2**	**2**	**2**	**2**
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 2024/25 (nil in 2023/24).

Note 38 Contractual capital commitments

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	14,403	8,400	14,403	8,400
Intangible assets	517	394	517	394
Total	**14,920**	**8,794**	**14,920**	**8,794**

Note 39 Financial instruments

Note 39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with NHS England and Clinical Commissioning Groups and the way those bodies are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no establishment in other territories. The Foundation Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. Additionally the Trust's cash balances are held with the Government Banking Service. The Trust, therefore, has low exposure to interest rate fluctuations.

Credit risk
The majority of the Trust's income comes from other public sector bodies, hence, it has low exposure to credit risk. The maximum exposures as at 31 March 2025 are in receivables from customers, as disclosed in the trade and other receivables note. These funding arrangements ensure that the Trust is not exposed to any material credit risk.

Liquidity risk
The Trust's operating costs are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated funds. The Trust is not, therefore, exposed to significant liquidity risks.

Note 39.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	29,270	-	**29,270**
Cash and cash equivalents	37,549	-	**37,549**
Consolidated NHS Charitable fund financial assets	4,055	3,953	**8,008**
Total at 31 March 2025	**70,874**	**3,953**	**74,827**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	24,319	-	**24,319**
Cash and cash equivalents	34,531	-	**34,531**
Consolidated NHS Charitable fund financial assets	4,814	4,833	**9,647**
Total at 31 March 2024	**63,664**	**4,833**	**68,497**

Note 39.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	29,018	-	**29,018**
Cash and cash equivalents	36,644	-	**36,644**
Total at 31 March 2025	**65,662**	**-**	**65,662**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	25,294	-	**25,294**
Cash and cash equivalents	33,865	-	**33,865**
Total at 31 March 2024	**59,159**	**-**	**59,159**

Note 39.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	4,883	**4,883**
Obligations under leases	53,006	**53,006**
Trade and other payables excluding non financial liabilities	55,230	**55,230**
Provisions under contract	2,247	**2,247**
Consolidated NHS charitable fund financial liabilities	372	**372**
Total at 31 March 2025	**115,738**	**115,738**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	5,198	**5,198**
Obligations under leases	52,000	**52,000**
Trade and other payables excluding non financial liabilities	43,696	**43,696**
Provisions under contract	1,845	**1,845**
Consolidated NHS charitable fund financial liabilities	944	**944**
Total at 31 March 2024	**103,684**	**103,684**

Note 39.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	4,883	**4,883**
Obligations under leases	52,543	**52,543**
Trade and other payables excluding non financial liabilities	49,597	**49,597**
Provisions under contract	2,247	**2,247**
Total at 31 March 2025	**109,270**	**109,270**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	5,198	**5,198**
Obligations under leases	51,595	**51,595**
Trade and other payables excluding non financial liabilities	39,494	**39,494**
Provisions under contract	1,803	**1,803**
Total at 31 March 2024	**98,090**	**98,090**

Note 39.6 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
In one year or less	61,072	49,809	54,920	55,181
In more than one year but not more than five years	18,408	16,424	17,053	15,055
In more than five years	60,824	63,019	61,821	64,065
Total	**140,304**	**129,253**	**133,794**	**134,301**

Note 40 Losses and special payments

	2024/25		2023/24	
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	23	61	11	6
Stores losses and damage to property	1	1	-	-
Total losses	**24**	**62**	**11**	**6**
Special payments				
Compensation under court order or legally binding arbitration award	2	3	3	7
Ex-gratia payments	25	20	33	14
Total special payments	**27**	**23**	**36**	**21**
Total losses and special payments	**51**	**85**	**47**	**27**

Note 41 Related parties

During the year, none of the Department of Health Ministers, Royal United Hospitals Bath NHS Foundation Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Royal United Hospitals Bath NHS Foundation Trust.

The Department of Health is regarded as a related party. During the 12 month period to 31 March 2025, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

ICBs
NHS Bath and North East Somerset, Swindon and Wiltshire ICB
NHS Bristol, North Somerset and South Gloucestershire ICB
NHS Somerset ICB

NHS England Organisations
NHS England - Central Specialised Commissioning Hub
NHS England - South West Regional Office
NHS England - South West Specialised Commissioning Hub
NHS England - South East Regional Office
NHS England - Wessex Specialised Commissioning Hub
NHS England - Midlands Regional Office
NHS Confederation

NHS Trusts and Foundation Trusts
University Hospitals Bristol and Weston NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
North Bristol NHS Trust
Salisbury NHS Foundation Trust
Avon and Wiltshire Mental Health Partnership NHS Trust
Somerset Partnership NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust

Other Agencies
Health Education England
Department Of Health
Bath and North East Somerset Council
Wiltshire Unitary Authority
Welsh Assembly Government (including all other Welsh Health Bodies)
Public Health England
NHS Litigation Authority
NHS Blood and Transplant (excluding Bio products Laboratory).
Alzheimer's Society
System C Healthcare Ltd
Currys Plc

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 (RUH X), for which the Trust Board acts as Corporate Trustee. In 2024/25, the Trust received £2.3m (2023/24: £3.3m) from RUH X for various medical equipment including linac machine and Cancer Centre enabling works. The audited accounts of the Charitable Funds are available at www.ruh.nhs.uk.

The Trust provides financial services to Wiltshire Health and Care LLP. In 2024/25, the Trust received £0.1m (2023/24: £0.1m) for this arrangement.

Note 42 Events after the reporting date

Wiltshire Health and Care LLP, the Trust joint venture ceased trading on the 31st March 2025.