Royal United Hospitals Bath
NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation Trust Annual Report and Accounts

1 April 2025 to 31 March 2026

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Contents

Statement from the Chair and Chief Executive

Welcome to the Royal United Hospitals Bath NHS Foundation Trust's (RUH) Annual Report and Accounts 2025/26. This is the third year of delivering the RUH's You Matter Strategy and the first full year of the BSW Hospitals Group, formed by the RUH, Great Western Hospitals and Salisbury Foundation Trust.

Over the past year, this formal Group collaboration has deepened, reflecting our shared belief that we can achieve more together than we can alone. By bringing together our skills, experience and resources, we are better placed to address our challenges and improve outcomes for patients and staff. Important progress has been made in establishing the Group, including new governance arrangements, the appointment of a Group leadership team and the establishment of a Joint Committee.

During the year, the Trust and wider Group have also undergone significant leadership change as part of the transition to a Group operating model. This has included the appointment of a single Group Chair and Managing Directors for the three Care Organisations. This has been a carefully planned and managed process, designed to build a sustainable leadership structure with clear accountability and resilience for the future.

Alongside this, we have continued to drive innovation and improvement through our shared methodology, Improving Together, supporting the spread of best practice and delivering tangible benefits for patients.

Our Cardiology service is a good example of this; successfully using Improving Together to achieve a positive patient-centred impact. The service, which was experiencing long waits for cardiology outpatient reviews and diagnostics, deployed Improving Together tools to analyse the problem and as a result reduced long waits and improved patient experience by increasing diagnostic and visibility of the referral to treat pathway.

The NHS continues to operate in a challenging financial and operational environment. We have strengthened our financial controls and delivered £15m of recurrent savings in 2025/26, with further transformation planned in 2026/27 to deliver £37.6m. This includes the development of a Commercial Strategy, with an initial focus on our private patient services in partnership with Sulis Hospital without detriment to the delivery our NHS duties and services.

We have also experienced sustained operational pressure, including a particularly challenging winter period, and increasing demand for our services. Last Autumn, our performance against the backdrop of these challenges came to the fore. This followed on from the publication of the Government's first National Oversight Framework, which seeks to provide a transparent way for patients to understand how their local NHS is performing. In September 2025, the RUH was ranked 112 out of 134 trusts; by the end of the year, this had improved by more than 30 places to 82, alongside a move from segment 4 to segment 3. This represents the most improved position in the South West for quarter 4 of 2025/26.

Our staff remain committed to delivering high-quality care and have achieved a great deal this year, including:

- The opening of the Sulis Orthopaedic Centre and Sulis Community Diagnostics Centre.
- Implemented the Gloves Off Campaign – helping to reduce our carbon footprint
- Opened the new Systematic Anti-Cancer Treatment (SACT) Unit at Frome Medical Centre
- Launched the Enhanced Care and Support Team
- Planted 120 trees across the site – so our patients and staff can enjoy our outdoor spaces

We recognise that our people are our greatest asset. In the 2025/26 NHS Staff Survey, 52% of colleagues responded.

Encouragingly, 60% recommend the RUH as a place to work, which is above the national average. 88% say their role makes a difference to patients, and team relationships remain a strong feature with 74% reporting kindness and respect amongst colleagues. At the same time, the survey highlights areas for improvement, particularly in career development and access to learning.

The results reflect both the strengths of our culture, and the pressures colleagues continue to face as we navigate complex challenges. Looking ahead, we will continue to focus on supporting and empowering our staff through our breakthrough objectives and emerging People Programme, aligned to the Group's People Strategy.

On behalf of the Board, we thank all of our staff and volunteers for their dedication to delivering high-quality care to the people of Bath, Somerset and Wiltshire.

Paul von der Hyde

BSW Hospitals Group Chair

Cara Charles-Barks

BSW Hospitals Group Chief Executive

Performance Report

Overview

This Performance Report provides an overview of the activities, strategy, and performance of the Royal United Hospitals Bath NHS Foundation Trust for the period 1 April 2025 to 31 March 2026. It is designed to support patients, regulators, and other stakeholders in understanding how the Trust has delivered its functions, responded to operational and financial challenges, and progressed its strategic objectives during the year.

The Trust delivers a broad range of acute hospital and community services to the population of Bath and North East Somerset and the surrounding areas, alongside a number of specialised services for a wider regional population. Services are delivered from the Royal United Hospital site, community settings, and through partnership working across the local health and care system.

During 2025/26, the Trust continued to operate within a challenging operating environment characterised by sustained demand for urgent and emergency care, pressure on elective recovery, workforce constraints, and financial pressures affecting the wider NHS. In response, the Trust has maintained a clear focus on patient safety, service quality, and operational recovery, while working with system partners to improve resilience and patient flow across organisational boundaries.

The Trust remains an active partner within the Bath and North East Somerset, Swindon and Wiltshire health and care system and continues to develop its role within the BSW Hospitals Group. Whilst each organisation remains statutorily independent, collaboration across the Group has supported shared planning, operational delivery, and the development of aligned leadership arrangements for the benefit of the populations served.

Performance against national standards and local priorities has been mixed. The Trust has continued to deliver high-quality care across many services, supported by the commitment and professionalism of its staff. However, performance has been impacted by system pressures, particularly in urgent and emergency care and elective waiting times. These challenges are reflected in the Trust's segmentation under NHS England's Oversight Framework, with further detail provided later in this report and within the Annual Governance Statement.

The Trust continues to operate within a challenging risk environment, with a number of principal risks affecting the delivery of its strategic objectives. The most significant risks during 2025/26 relate to sustained demand exceeding available capacity across urgent and emergency care pathways, the pace and trajectory of elective recovery, workforce capacity and availability, and the delivery of a financially sustainable plan. These risks are reflected within the Trust's Board Assurance Framework and represent threats to the achievement of key objectives relating to access, quality of care, operational performance, and financial balance.

These risks have remained present throughout the year, although their impact has fluctuated in response to system pressures, seasonal variation, and the delivery of internal recovery actions. Mitigation has focused on improving patient flow and reducing delays through system-wide working, increasing elective capacity including through the Sulis Hospital site, and implementing targeted workforce, productivity, and financial recovery measures. While progress has been made in a number of areas, these risks continue to impact the Trust's ability to consistently meet national performance standards and deliver planned trajectories.

Emerging risks include the continued growth in demand, ongoing system capacity constraints, workforce supply challenges, and the broader financial position across the NHS, all of which may affect the Trust's future performance and sustainability. Further detail on the principal risks, including their impact on delivery and progress in mitigation, is provided in the Performance Analysis section. The

Trust's approach to risk management, internal control, and the assessment of effectiveness is set out in the Annual Governance Statement.

Going Concern disclosure

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

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

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

This report should be read alongside the Performance Analysis section, which provides a detailed assessment of operational, financial, and quality performance, and the Accountability Report, which sets out how the organisation is governed, including the systems of internal control and assurance that support the delivery of safe and effective care.

Purpose and activities

The Trust provides a wide range of acute hospital and community health services to the population of Bath and North East Somerset and surrounding areas. Services are delivered from the Royal United Hospital site in Bath, community hospitals and health centres, and through outreach and community-based provision.

The Trust serves a population of approximately 500,000 people across Bath and North East Somerset, West Wiltshire, Mendip and South Gloucestershire, covering both urban and rural communities. In addition to our core local population, we also provide care for people visiting the area, including tourists, students and overseas visitors.

The Trust's core business is the provision of NHS services, primarily commissioned by the Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board, as well as other local commissioners and NHS England for specialised services.

The Trust operates through five clinical and non-clinical divisions: medicine; surgery; family and specialist services; estates and facilities; and corporate services. This structure supports the delivery of care across complex patient pathways and multidisciplinary teams.

The Trust provides emergency and unplanned care 24 hours a day, seven days a week, alongside a comprehensive range of planned surgical, medical and diagnostic services for adults and children. In addition, the Trust delivers a number of specialised services for patients from across the wider region, including cancer services, stroke and cardiac care, specialist orthopaedics, higher levels of critical care, care of older people, maternity services, pulmonary hypertension services, and rheumatology, pain and fatigue services delivered from the RNHRD and Brownsword Therapies Centre.

A small proportion of patients also choose to receive privately funded treatment, which is delivered in line with regulatory requirements and only when NHS capacity allows.

In 2021, the Trust acquired Sulis Hospital Bath, which provides planned diagnostic and surgical services for NHS and private patients. The site incorporates a Community Diagnostic Centre and the

Sulis Elective Orthopaedic Centre, supporting elective recovery and helping to improve resilience and capacity across the region.

The Trust also plays an important role in education and research, working in partnership with universities and colleges to support the training of the future health and care workforce and contributing to research and innovation that supports improvements in patient care.

In delivering its services, the Trust operates as part of a wider local health and care system alongside primary care, community providers, local authorities and voluntary, community and social enterprise organisations. The Trust's activities are shaped by population need, national policy and regulatory requirements, and local priorities agreed through system and place-based planning arrangements.

The Board is responsible for setting the Trust's strategic direction, overseeing performance and ensuring that services are delivered safely, effectively and in line with statutory and regulatory requirements.

Further detail on delivery during 2025/26, including the impact of system working and partnership arrangements on performance, is set out in the Performance Analysis section.

BSW Hospitals Group

In May 2025, Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust formed BSW Hospitals Group. Bringing together three NHS providers with a shared ambition to make a difference that really matters to colleagues, patients and their families, partners and wider communities across BSW and beyond.

With a combined workforce of over 17,600 colleagues and budget of 1.6 billion, the Group is united by a common purpose to deliver the best possible care to over 1 million people. Creating a heath and care system that works with them not around them. Reducing the differences people currently face in access, experience and outcomes, improving the experience of our colleagues and tackling shared challenges like sustainability and finances.

The five strategic initiatives the Group will focus on are:

- Transforming our models of care.
- Our people.
- Increasing sustainability.
- Delivering digital maturity.
- Developing our group.

The five priority programmes we will focus on to deliver our strategic initiatives over the next three years are:

- Transforming models of care: Clinical services transformation – focusing on patients and improving how healthcare services are delivered.
- Our people: Corporate services transformation – redesigning services around the needs of those who use them. Organisational Development and management of change programme.
- Increasing sustainability: Recovery – improving our performance and finances.
- Delivering digital maturity: Implementing a single Electronic Patient Record – bringing real time information together in one place to provide better, safer joined-up care for everyone.

- Developing our Group: getting the right structure in place to support us to work together effectively to truly serve our population.

This will help us to tackle the root causes of why our community does not always get the same quality of care or experience and means as a Group we can:

- Deliver care that is centred around patients, not organisations.
- Make sure our people and resources are focused where they can make the greatest difference.
- Create a solid foundation for the future where we can make the most of the opportunities available and be a strong voice for our community.

Integrated Care System and Partnership working

The Trust is a partner organisation within the Bath and North East Somerset, Swindon, and Wiltshire (BSW) Integrated Care System (ICS). The BSW Integrated Care Board (ICB) brings together NHS organisations, local authorities and other partners to plan and coordinate services, improve population health outcomes and reduce health inequalities across the system.

The Trust works with the BSW ICB and system partners to ensure alignment between Trust priorities and system strategies and plans. Partnership arrangements operate at system, place and provider-to-provider level and support collaboration across pathways, workforce, digital, and estates.

The Trust also participates in place-based partnerships across Bath and North East Somerset and Wiltshire, working with local authorities, community providers and the voluntary, community and social enterprise sector. Collaboration with other acute providers within BSW is supported through shared clinical networks and agreed provider-to-provider arrangements.

The Board oversees the Trust's partnership and collaborative arrangements and considers system relationships, opportunities, and risks as part of its strategic decision making and assurance processes. The Trust remains fully accountable for the quality, safety, and delivery of services for patients.

The impact of partnership working and system collaboration on operational performance during 2025/26 is described in more detail in the Performance Analysis section.

Our Strategy

The Trust's strategy sets out the long-term direction, priorities, and ambitions for the organisation. The Trust continues to deliver its "You Matter" strategy, launched in 2023 and covering the period to 2028/29. The strategy provides the framework for decision-making and performance during 2025/26.

The strategy is built on the Trust's core values of everyone matters, working together and making a difference, and focuses on delivering high-quality care, supporting, and developing staff, and strengthening relationships with the communities the Trust serves. These priorities provide a framework for how the Trust aligns its objectives within the Integrated Care System.

The Trust's strategic priorities are:

- **The people we care for:** ensuring that every patient receives timely, safe, and high-quality care, tailored to their individual needs.
- **The people we work with:** creating a supportive and inclusive environment where staff feel valued, engaged, and empowered.
- **The people in our community:** working in partnership with local organisations and stakeholders to improve health outcomes and reduce inequalities.

The publication of the strategy marked the first step in using these priorities to drive continuous improvement across the organisation and to focus on what matters most to patients, the local community, and staff. As the Trust's 'Improving Together' approach has continued to be embedded during 2025/26, priorities have been translated into key short- and long-term improvement projects and programmes. These are reflected in the Trust priorities summary and underpin delivery throughout the year.

Progress against these priorities during 2025/26 is set out in the remainder of this Performance Report.

Our Strategic Initiatives

The Trust's strategic initiatives are Trust-wide, large-scale programmes of work designed to deliver the strategy over a three to five-year period. Given their importance to strategic delivery, each initiative is supported by dedicated delivery arrangements.

During 2025/26, the Trust's strategic initiatives were:

1. Integrated Front Door
2. Patient Safety Incident Response Framework (PSIRF)
3. Sustaining the Improving Together Operational Management System
4. Collaboration as and at Group
5. Shared Electronic Patient Record (EPR) benefits realisation
6. Delivering a medium-term financial plan
7. Reducing carbon emissions

Breakthrough Objectives

Breakthrough objectives focus on addressing the Trust's most pressing organisational challenges. They are set annually, with clear measures and targets, and are deployed to frontline teams to support delivery.

The breakthrough objectives established for 2024/25, and progressed during 2025/26, were:

1. Valuing patient and staff time, measured through ambulance handover performance.
2. Recognising and valuing colleagues' work, measured by the increasing the percentage of staff that feel their work is valued.
3. Maximising value and eliminating waste, measured through productivity and delivery of the financial plan.

Corporate Projects

Corporate projects make a direct and significant contribution to the Trust's breakthrough objectives or respond to national requirements. Projects active during 2025/26 included:

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

Delivery of these projects was supported through the Trust's 'Engine Room,' a core element of the Improving Together approach. The Engine Room uses visual performance information to support regular performance review meetings, alignment to strategic priorities, and timely, data-informed decision-making by the Executive and senior leadership team.

Progress against the Breakthrough Objectives

During 2025/26, the Trust made meaningful progress across its breakthrough objectives, despite sustained operational pressures.

The people we care for — Valuing patient and staff time

Performance on ambulance handovers improved steadily from February 2025, with the Trust achieving an average handover time of 33 minutes during October, November, and December. From late December, increased system pressures led to prolonged waits and 18 days of critical incidents. Despite this, improvements were delivered across the emergency care pathway, including expanded Same Day Emergency Care, strengthened internal professional standards, and closer working with system partners to reduce long lengths of stay.

The people we work with — Recognising and valuing colleagues' work

The operating context for staff remained challenging throughout 2025. However, results from the 2025 NHS Staff Survey showed continued improvement in measures of kindness, civility, and involvement, with the Trust performing above the national average in key areas. A range of initiatives were introduced to support wellbeing, leadership development, reward and recognition, and the management of violence and aggression.

The people in our community — Maximising value and eliminating waste

The Trust ended the year with a £20.5 million deficit, representing a £12 million improvement against the mid-year forecast of £32 million. Productivity improved across most services, and the Trust achieved all national access standards except those relating to urgent care. Significant progress was made in reducing long waits, improving cancer and diagnostic performance, and increasing theatre productivity.

Delivery of Trust-wide Projects

During 2025/26, a wide range of Trust-wide projects supported delivery of the strategy and breakthrough priorities. Key developments included service expansions at Sulis Hospital, improvements in urgent and emergency care pathways, digital transformation in outpatient and maternity services, strengthened staff development and wellbeing support, and continued progress against the Trust's carbon reduction ambitions.

Performance Analysis

The Trust's performance during 2025/26 has been significantly influenced by a number of principal risks aligned to those set out in the Board Assurance Framework. These risks have affected the Trust's ability to deliver its operational, quality, and financial objectives within the planned trajectories.

The most significant risks relate to demand exceeding available capacity across urgent and emergency care pathways, the pace of elective recovery, workforce availability, and the delivery of a financially sustainable position. These risks have manifested in sustained pressure on urgent and emergency care performance, delays across elective pathways, and challenges in maintaining delivery of financial plans.

The profile of these risks has evolved over the period. Demand and capacity risks have remained consistently high, with periods of increased impact linked to seasonal pressures. Workforce risks have continued to present a constraint on service delivery, although targeted recruitment and retention actions have provided some mitigation. Financial risks have increased in significance over the year in the context of wider system pressures and cost constraints.

The Trust has taken a range of actions to mitigate these risks, including system-wide initiatives to improve patient flow and reduce delays, the use of additional elective capacity including the Sulis Hospital site, and targeted workforce and productivity measures. These actions have supported improvements in specific areas; however, the combined impact of these risks continues to affect the Trust's ability to consistently meet national performance standards and deliver planned operational and financial trajectories.

While the year-end performance targets were achieved against plan for RTT, DM01, and 2 of 3 Cancer wait time standards, the expectation is for RUH to return to pre-pandemic constitutional standards by 2028-29. This requires year on year step-change improvement in performance against the constitutional standards and is set out in our 3-year plan. Targeted investments have been made to expand clinical capacity and a programme of transformation and improvement initiatives agreed to support delivery of the required improvements across RTT, Diagnostics and Cancer.

Looking forward, these risks remain material and continue to present challenges to the delivery of the Trust's plans. Emerging risks include further growth in demand, system-wide capacity limitations, workforce supply constraints, and ongoing financial pressures across the NHS. These factors may affect the pace of recovery and the Trust's ability to deliver its plans and sustain improvements in performance in future years.

Further detail on the management of these risks and the systems of internal control in place is set out in the Annual Governance Statement.

Operational performance overview

The Trust produces an integrated balanced scorecard which outlines performance across three domains: People We Care For, People We Work With, and People in Our Community. This scorecard incorporates financial and operational performance at Sulis Hospital and contributes to the overall assessment of progress against agreed objectives.

Performance is measured against the NHS Oversight Framework, aligned to priorities within the NHS Long Term Plan and the legislative changes introduced by the Health and Care Act 2022. The Trust operates a well-established data quality assurance framework, led by the Quality and Safety Group, to ensure a high level of data integrity. Reporting against national standards is regularly reviewed and audited.

Introduction

2025/26 was a highly challenging year for performance with RUH being placed in Tier 1 of the NHS England performance regime against all 4 operational domains (Urgent and Emergency Care, Referral to Treatment, Cancer, and Diagnostics), and the lowest quartile of the National Outcomes Framework. Despite this, the Trust finished the year with significant advancements in all areas.

On the elective standards, RUH is forecast to achieve the Referral to Treatment (RTT) and DM01 (Diagnostics) trajectories in full and is expected to meet two of the three Cancer wait time standards. The improvements have been achieved in part, through the greater focus on strengthening waiting list management and capability through our internal "12-week challenge" which has been recognised by NHSE for its impact. The increased rigour in planning and performance management will set up the care organisation to maintain the improvements into 2026-27. Specific achievements include the elimination of >65-week waiters; exceeding the national standard of <1% of >52-week waiters which is a reduction from 2.43% to 0.57% of our total waiting list (792 fewer patients waiting over 52 weeks); and the improvement of RTT performance to 69.1%. This is better than our original agreed trajectory of 67.7% and our revised trajectory of 68.7%.

We are incredibly pleased with the progress that has been made in our cancer pathways because we recognise how important this is to our patients and their families. We have delivered the national performance standard for both 28 days and 31 days. We have not achieved the standard for 62-day performance, but we are seeing improvements and are expecting to be compliant in Q2 this year.

Our biggest improvement for Cancer has been achieved in the 28-day standard. In June 2025 it had declined to just 50% and our latest position for March 2026 was 82.2%. This improvement has been achieved across several specialities, with Colorectal, Breast and Skin having especially contributed to the overall positive position.

For Diagnostics, we agreed with NHS England an end of year performance of 16.1% of our patients waiting longer than 6 weeks for a diagnostic test. In September 2025 we were reporting a performance of 34.8%. As the result of the work undertaken by our clinical and operational teams, we are delighted to be able to report that we exceeded the agreed performance and have recorded an end of year performance of 13.9%.

This improvement will have made a positive contribution to the improvements that have been achieved in our 18 week and cancer pathways.

Urgent and Emergency Care (UEC) remained the Trust's most challenged constitutional standard during 2025/26. 2025/26 Type 1 performance declined to 58.1% when compared to 60% for 2024/25.

It should be noted that this deterioration has occurred alongside a significant increase in demand. Emergency Department (ED) attendances reached a record high of 107,136 (+5.6% on previous year), resulting in more patients being treated within 4 hours overall. The number of attendances seen within 4 hours increased to a record 62,209, representing a 2.2% increase compared to the previous year.

This growth in ED activity has occurred alongside increased utilisation of alternative UEC pathways. Emergency Direct Admissions rose by 20.7% to 20,031, with many of these patients being managed through Same Day Emergency Care (SDEC). The Trust achieved its highest recorded SDEC performance, with 38.5% of emergency admissions managed via this pathway.

Our No Criteria to Reside (NCTR) numbers have not reduced to agreed plan levels, and we continue to work with system partners to improve flow out of the organisation. Internally we are discharging 95% of pathway zero patients within 24 hours.

In summary, we are seeing, transferring, or discharging more patients within 4 hours but the improvement is being masked by the increase in activity which is above plan.

As a Tier 1 provider, we have had weekly meetings with regional and national colleagues, being held to account for performance improvement and patient safety assurance. The process has been constructive and supportive and has included detailed discussions about our ED physical infrastructure.

System and regional colleagues have recognised that the ED footprint is not equipped to accommodate current levels of activity. Lack of cubicle capacity is having a detrimental impact on our ability to make progress and makes it difficult to provide appropriate and dignified assessment space. We are delighted that discussions have resulted in a capital allocation that will allow us to provide a new Urgent Treatment Centre (UTC) facility. This will create additional space within the ED footprint which will support better flow and provide much needed side room capacity; working towards an October 2026 go live.

The UEC teams continue to work closely with Getting It Right First Time (GIRFT) colleagues and have made several positive changes to internal flow, the most recent being the introduction of our Extended Emergency Medicine Ambulatory Care (EEMAC) facility in January 2026 and improved streaming at the front door.

In October 2025 there was an unannounced CQC inspection of the ED, with the inspection taking place on one of our busiest attendance days of the year. The CQC team saw first-hand the impact of increased ambulance demand and the introduction of the W45 ambulance handover policy, under which patients are transferred from ambulance crews to emergency department teams within 45 minutes of arrival.

The ED experienced significant operational pressure, with limited flow within the hospital and into the community.

Our focus over the coming months will be to continue to deliver our improvement plan in response to the CQC inspection recommendations. Several of the key recommendations are already implemented and embedded.

- Recruitment of additional consultants and registrars across various departments including the Emergency Department and surgery continues to enable a clear focus on patient pathways.
- Funding has been made available to support a modular build to relocate our UTC to improve patient flow within the UTC and to free up space in the ED to facilitate service redesign.
- There is an opportunity to access significant additional funding to build and re-provide an integrated front door service.
- The UEC programme has been redesigned to improve focus and ownership in the Divisions for their part of the patients' pathways.
- Refreshed Internal Professional Standards have been launched with clear monitoring metrics as well as QR code feedback from clinical teams.
- There is a Long Length of Stay Initiative using the GIRFT approach, working hands on in supporting the wards with patients whose stay is over 14 days, with a view to embedding this into BAU.

How to read this table:

This table presents performance against key operational and financial metrics, showing the planned year-end position alongside mid-year (September 2025) and actual year-end (March 2026) performance to illustrate in-year trajectory and delivery against plan.

Performance is assessed against plan, with colour-coding used to show delivery against the agreed trajectory:

- Red denotes performance adverse to plan
- Amber indicates a position close to plan
- Green indicates delivery in line with plan

Domain	Metric	25/26 Year End plan	Mid-year (September 2025)	Year-end Performance (March 2026)
UEC	4-hour ED performance (type 1 / all types)	72% / 78%	57.6% / 67.6%	62.6% / 71.6%
	12-hour ED performance	4.9%	9.0%	8.2%
	Ambulance handover	33 mins	74.9 mins	44.9 mins
Elective	18w RTT Performance	68.7%	58.2%	69.1%
	52 Week Waiters	<1%	1.93%	0.55%
Diagnostics	DM01	*16.1%*	34.8%	13.9%
Cancer	28d FDS	80%	53.7%	82.2%
	31d	94%	91%	93.1%
	62d RTT	75%	58.3%	64.4%
Finance	Forecast Variance against Plan*	Deficit £20.5m	Deficit £32.0m	Deficit £20.5m

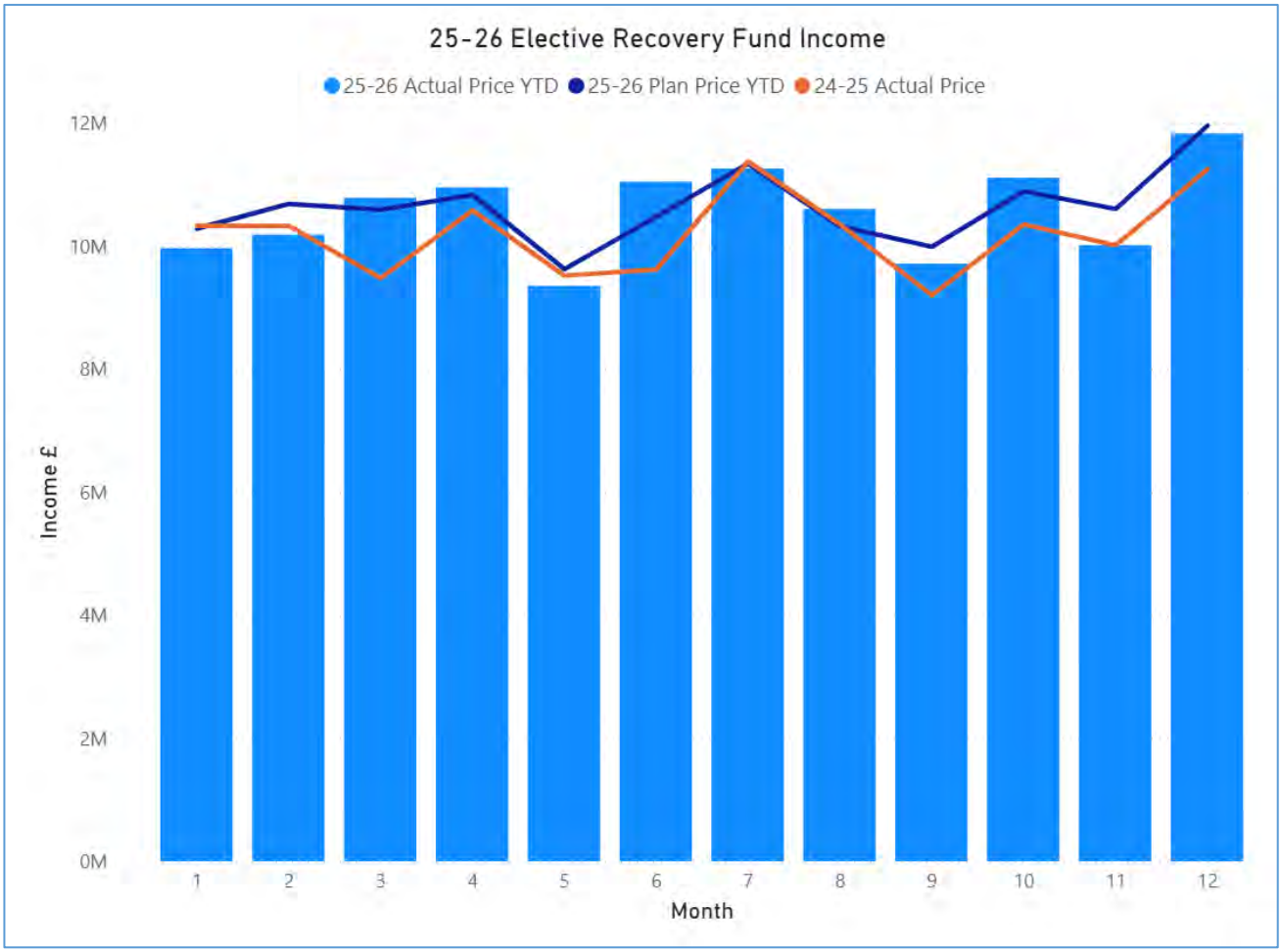
** as agreed with NHS England*

Elective Care

Increasing elective recovery to continue to reduce waiting lists remains a priority with productivity at the centre of this improvement. Targeted investments in specialties needing additional resource to reduce backlogs and longer waiting time has contributed to the improved overall Trust RTT performance. The biggest investments were in Cardiology, Gastroenterology and Gynaecology.

The Trust has been successful in increasing activity levels again this year to manage ongoing demand and see the patients waiting the longest for treatment. The Trust delivered 11,000 more outpatient appointments than originally planned, contributing to an increase in all elective income of over 3% from 2024/25. Day case and elective activity was slightly lower than plan due to delays in maximising capacity at the new Sulis Orthopaedic Centre; however due to treating more complex patients, the income for planned inpatient activity increased by 2.2% from 2024/25.

The below graph shows the Trust elective income compared to that delivered in 2024/25 and against the 2025/26 plan.



Elective waiting times and activity

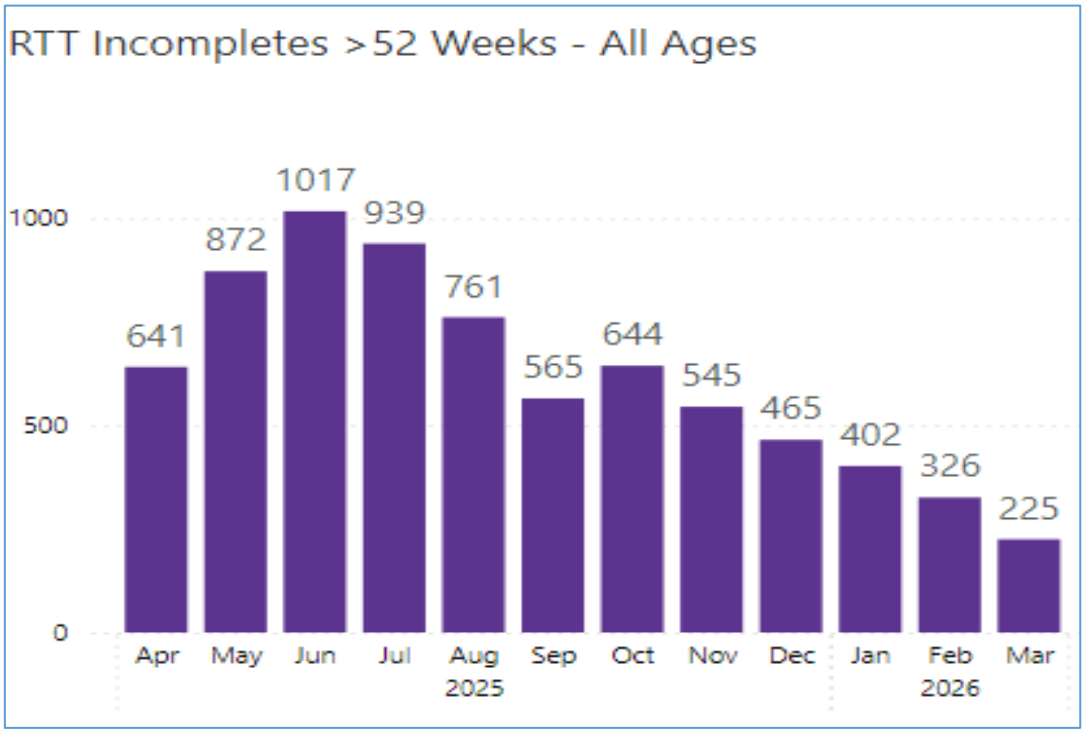
The Royal United Hospitals Bath NHS Foundation Trust continues to prioritise reducing waiting times for patients. During 2025/26, the Trust successfully delivered the NHS England requirement to eliminate waits of over 65 weeks, achieving zero patients waiting longer than 65 weeks by 31 December 2026.

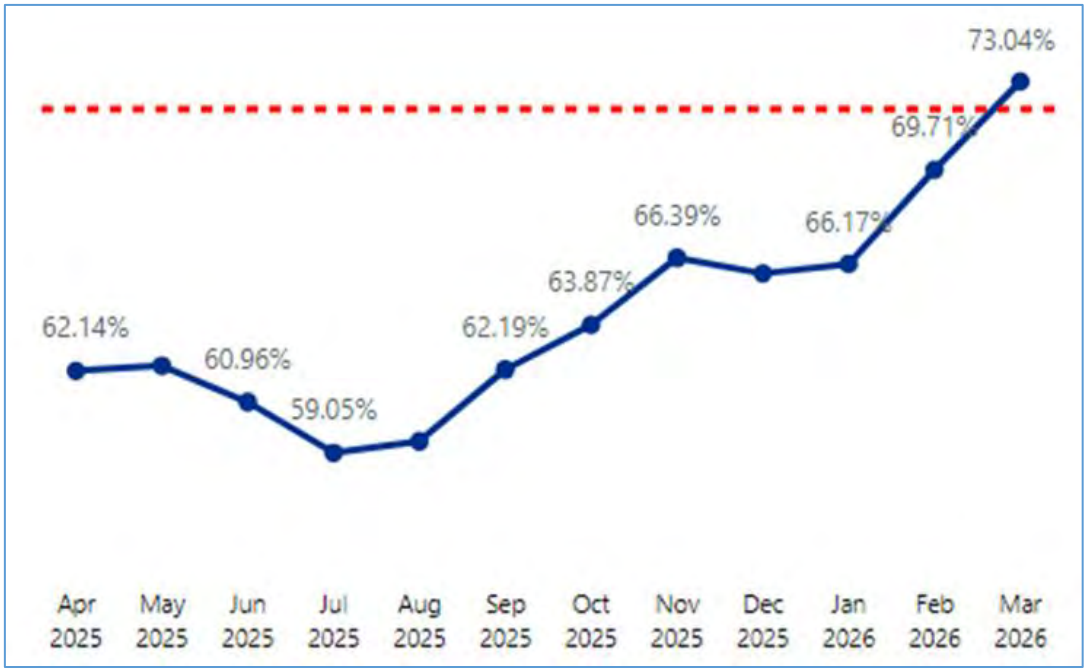
In addition, the Trust exceeded the national standard of fewer than 1% of patients waiting over 52 weeks for treatment. At year end, 0.59% of the waiting list - equating to 236 patients - were waiting longer than 52 weeks.

The Trust's Referral to Treatment (RTT) performance target for the year was 67.7%, increasing to 68.7% following the allocation of additional funding. The end of March validated position was 69.1%, which represents a 10.4% improvement between July 2025 and end of March 2026.

The Trust also met the national target of <18 weeks for first Outpatient appointment set at 72%, achieving 72.14%.

The graphs below demonstrate the reduction in patients waiting over 52 weeks for their treatment and the increase in patients waiting less than 18 weeks for their first Outpatient appointment.



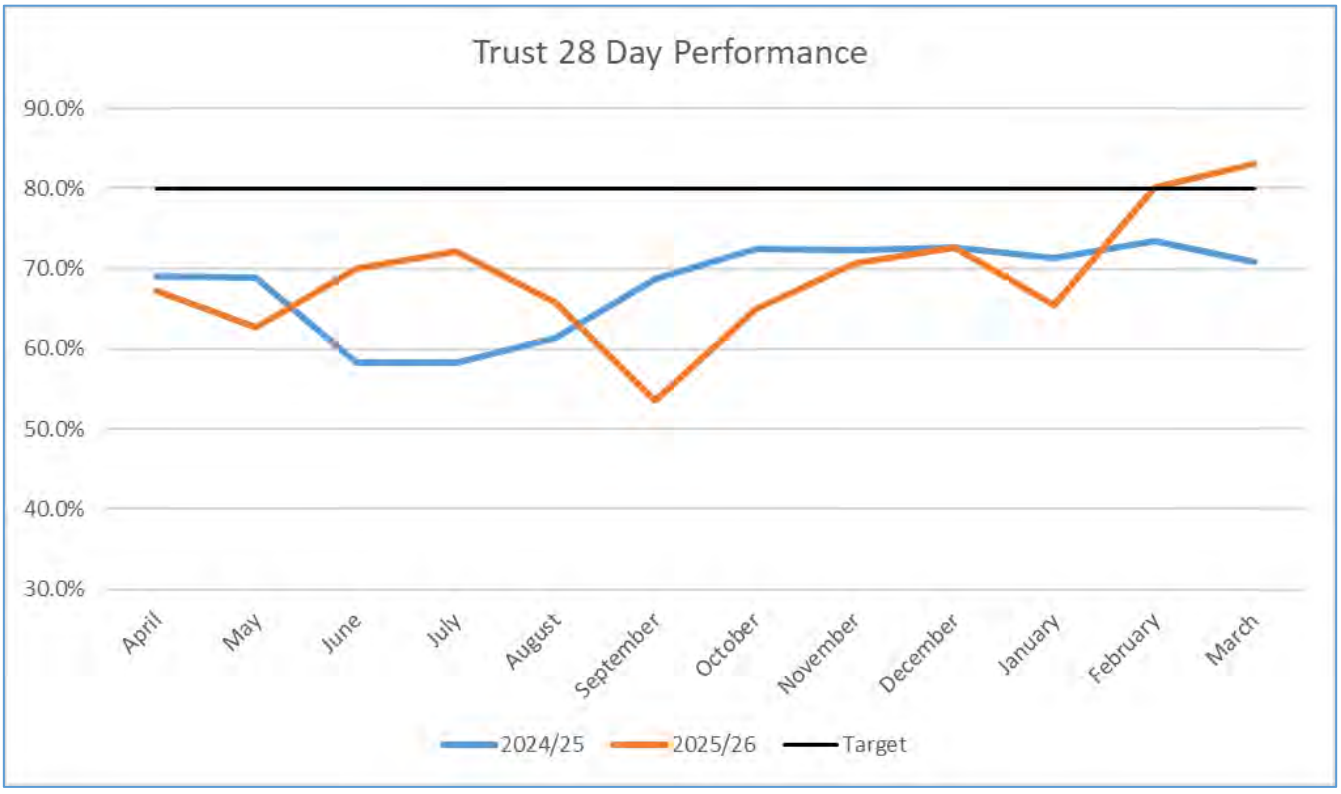


Cancer

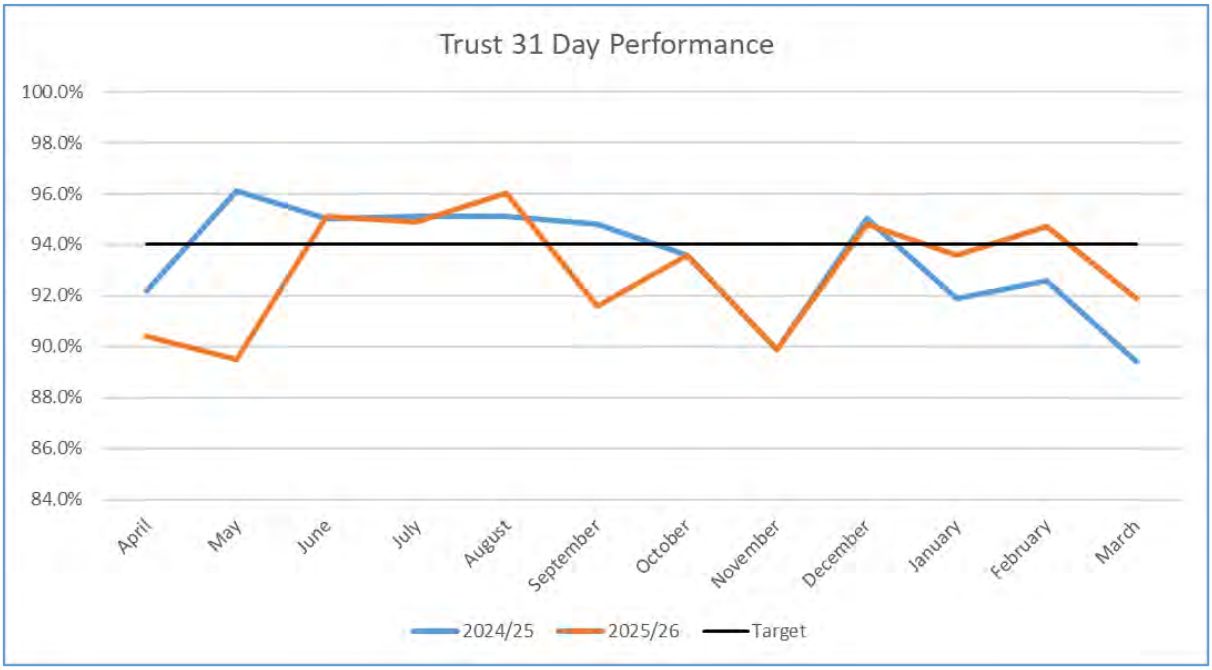
2025/26 was a challenging year for the RUH performance against the 28 Day Faster Diagnosis Standard (FDS), and 62 Day Combined Referral to Treatment Standard, although the Trust performed well against the 31 Day Combined Treatment Standard. As a result of the challenged performance the Trust had remained in NHSE Tier 1.

Following improvement in 28 Day performance in Q1, the position deteriorated in Q2 following periods of high demand in Skin, long term recruitment difficulties in Breast, Pathology and Skin, and fluctuations in the amount of temporary capacity available through locums and insourcing in Breast, Colorectal (endoscopy), and Skin.

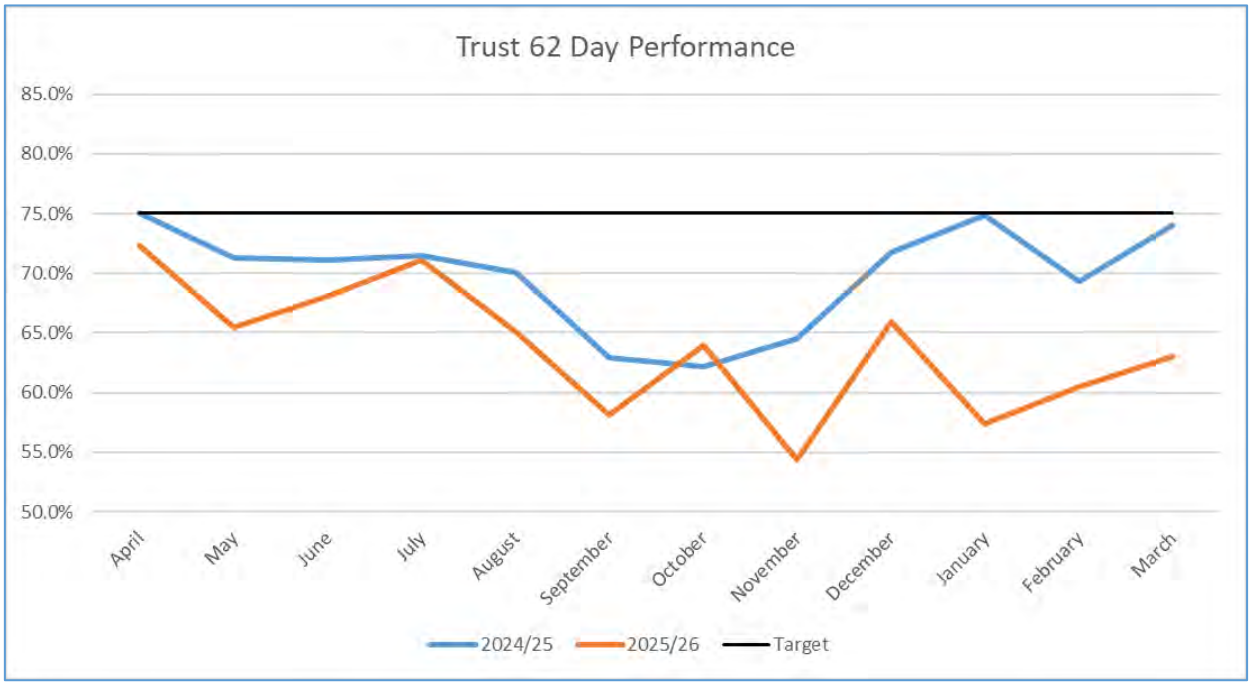
The stability of the temporary capacity within those key tumour sites has considerably improved, alongside implementation of key initiatives including delivery of a full one-stop service in Breast, ring-fenced cancer capacity in endoscopy and utilisation of capacity at Sulis and GWH via mutual aid, and new hysteroscopy guidance in Gynaecology, which combined are expected to deliver performance above the national standard for the first time in five years in February and March, and sustaining the position into 26/27.



Performance against the 31 Day standard has been good for extended periods throughout the year. Initial performance in Q1 was below the national target due to surgical capacity in Breast, Skin and Urology. Performance then recovered until September when waiting times for excisions in Skin increased due to a temporary reduction in medical staffing, alongside extremely high demand in July and August. The Skin surgical waiting list reduced over several months through increased insourcing which contributed to the Trust achieving the 31-day standard overall.



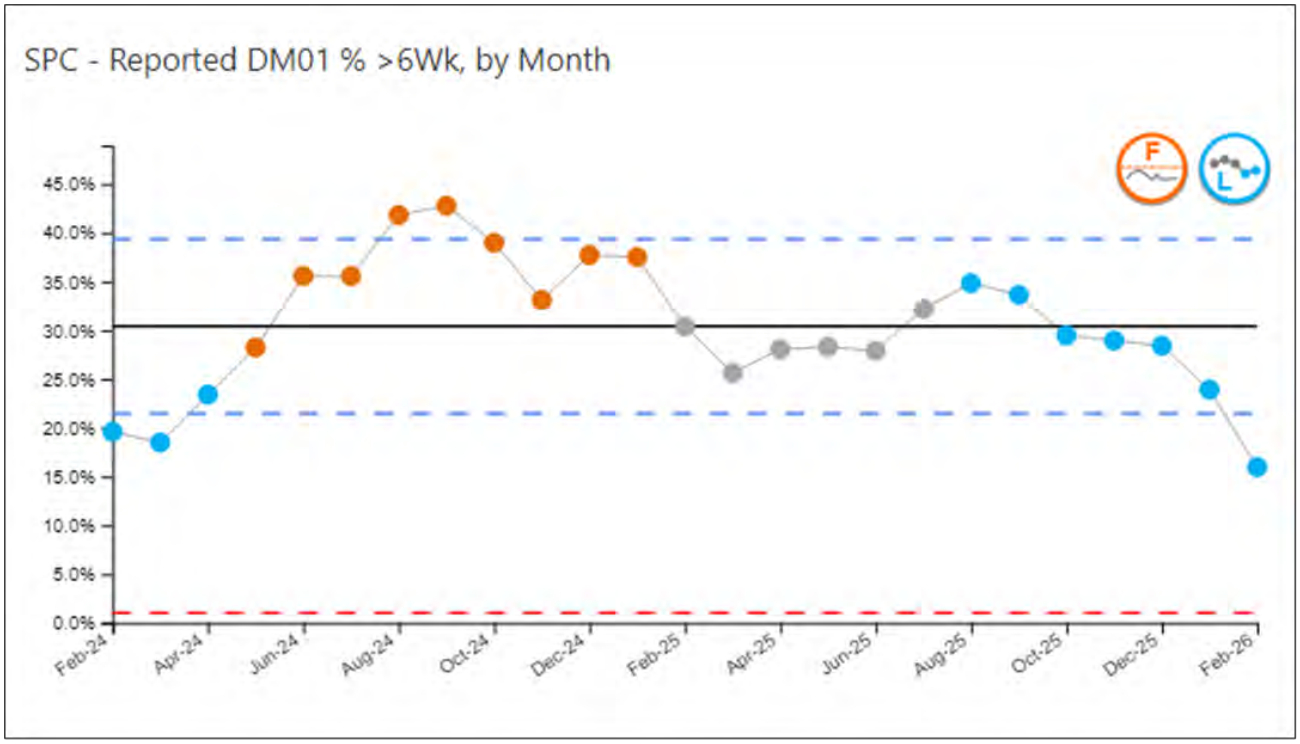
Against the 62 Day standard the RUH has seen more sustained challenge with a noticeable reduction in performance in 2025/26 compared with the previous year. The longer waiting times in the initial outpatient appointments and diagnostics including the imaging and histology reports, have had the most impact on 62 Day performance. Breast, Colorectal, Skin and Urology have consistently been responsible for the largest numbers of breaches. Performance in tumour sites treating slightly fewer patients has also been below the required standard with diagnostic waiting times both at the RUH and specialist centres contributing to longer pathways particularly in Lung and Upper GI.



Significant progress has been made on reducing the number of patients actively waiting on suspected cancer pathway above 62 days. The number peaked in November due to the aforementioned waiting times for Skin first outpatient and treatment appointments but targeted work increasing capacity and establishing more robust scrutiny waiting lists has reduced the number of patients by almost three quarters (276 fewer patients waiting over 62 days). This reduction coupled with the recently improved 28 Day performance is expected to deliver improvements in 62 Day performance going into 2026/27. Improvement plans and substantive recruitment plans are in place in several key areas which will deliver a more sustainable and robust service model, allowing the Trust to meet the increased national target of 80% by the end of the financial year.

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 additional demand pressures from RTT recovery schemes. This target was set at 84.10% compliance by end of 2025/26.



In 2025/26, 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 September 2025, additional recovery actions have been in place to support DM01 performance improvement:

- Waiting lists initiatives (WLI)
- Ultrasound (USS) insourcing
- Increased Community Diagnostic Centre (CDC) capacity

Following this ambitious recovery plan, 86.08% of patients received their diagnostic within the 6 weeks against the 84.10% target, by end of March 2026. Year-end performance was 2% better than target.

For 2026/27, DM01 performance is expected to continue to improve following the continuation of additional activity schemes into the new financial year. These include maintaining WLIs for key modalities, insourcing (USS), utilising all CDC capacity made available and productivity improvements. The Radiology workforce business case was approved and will support a reduction is costs and increased activity over the next 2 years, support not only DM01, but also Cancer and RTT targets.

Maternity and neonatal services

During 2025/26, maternity and neonatal services at the Royal United Hospitals Bath NHS Foundation Trust delivered safe, effective and compassionate care, with performance remaining strong against key national standards. Performance and outcomes were monitored through established governance arrangements, including the Perinatal Quality Surveillance Model (PQSOM), enabling triangulation of workforce, safety, quality and outcome measures alongside patient experience.

Monthly reporting through PQSOM, together with the quarterly Perinatal Quality Report, supported a combined review of performance and quality metrics, including service user feedback. This enabled a holistic understanding of service delivery and informed the prioritisation and monitoring of quality improvement actions across the service.

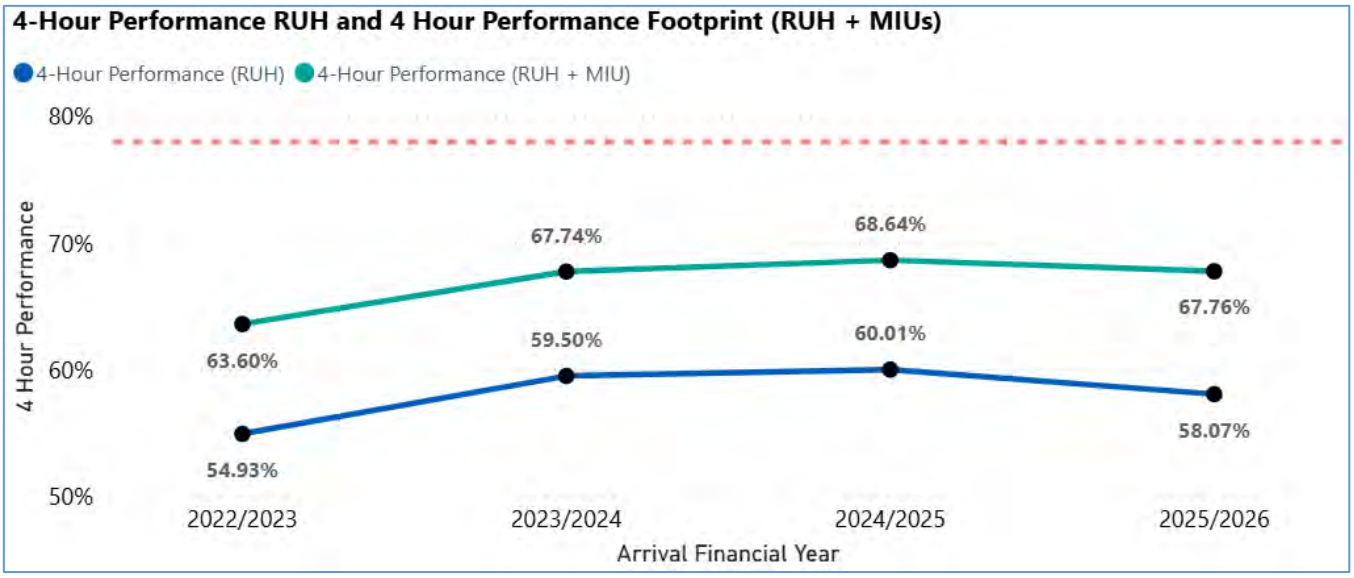
The service-maintained compliance with key national safety programmes, including the Saving Babies' Lives Care Bundle (version 3.2), the NHS Resolution Maternity Incentive Scheme (Year 7), and Avoiding Term Admissions into Neonatal Units (ATAIN). Mortality reporting requirements through MBRRACE-UK were met, with perinatal mortality rates remaining below the national average. Following the introduction of the Multiple Obstetric Signal System (MOSS) in Quarter 4, no signals were received.

Workforce stability improved during the year, with strong retention of newly qualified midwives and continued delivery of mandatory and specialist training. Periods of increased demand and acuity were managed through established escalation and risk management processes, ensuring safe and responsive care.

Emergency Department & Urgent Treatment Centre

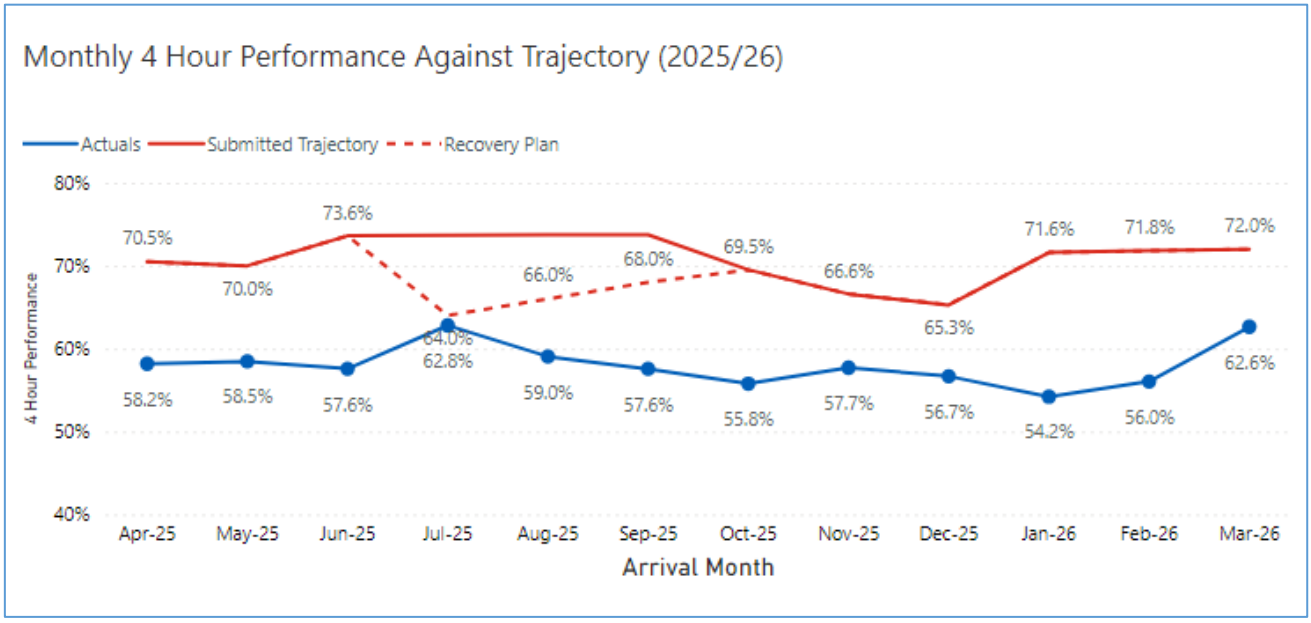
In 2025/26 the number of patients attending the Emergency Department (ED) and Urgent Treatment Centre (UTC) was 107,136, continuing growth over the last four fiscal years, and setting a record high. This is the equivalent of 294 patients per day. The ED and UTC are also seeing a pattern of increased acuity and complexity over the last four years.

ED attendances have increased by 3.1% in the year, alongside a stark increase of 18.5% in ambulance conveyances. The hospital has increased the GP direct access into Same Day Emergency Care (SDEC) areas (Medical Assessment Unit, Older Person Assessment Unit and Surgical Assessment Units); this equates to 38.5% all unplanned attendances (33.6% 2024/25, equivalent to 20k patients).



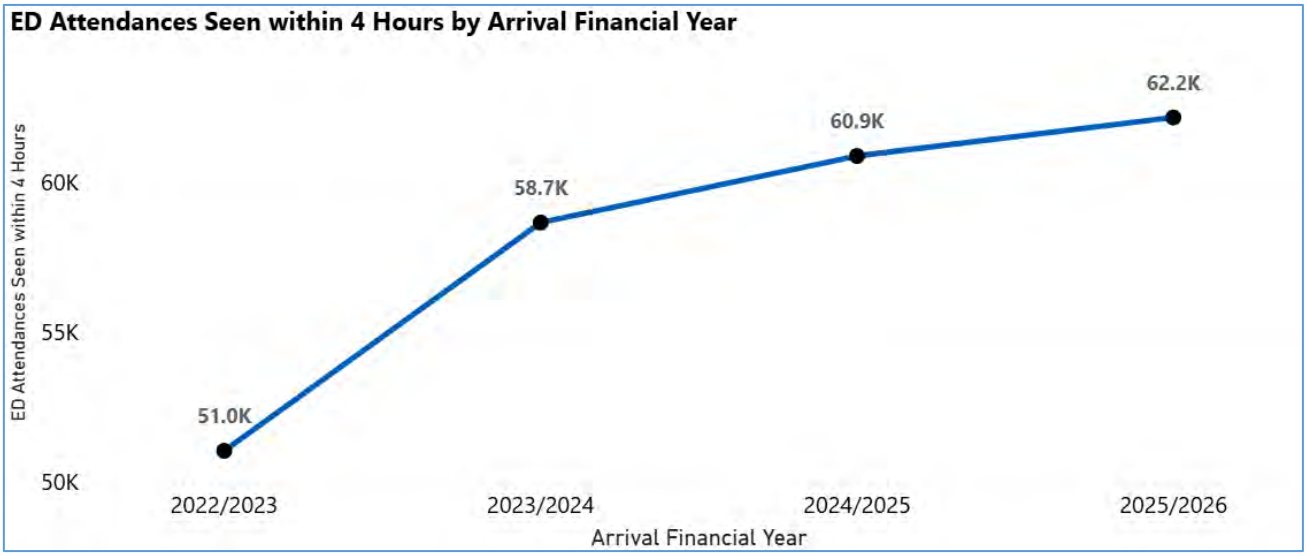
During 2025/26 the Trust continued to be monitored against the national access target of having admitted, transferred, or discharged 78% of patients attending its ED within 4 hours of arrival and achieved a combined performance including Minor Injury Units of 67.74% for the year.

Unmapped performance (thereby representing activity on the Combe Park site only), shown below, has shown a decrease to 58.06% in 2025/26 compared to 60.01% in 2024/25. The RUH has, alongside the rest of the NHS, seen significant challenges in the delivery of the 4-hour performance target due to increased demand, acuity, and complexity.



Flow out of the ED has also affected performance which is correlated to operating at high bed occupancy rates (adult general & acute occupancy was 95.9% over 2025/2026) and the number of patients with no criteria to reside exceeded the system target of 40 at 87 patients per day on average in 2025/26, a decrease from 90 in 2024/25.

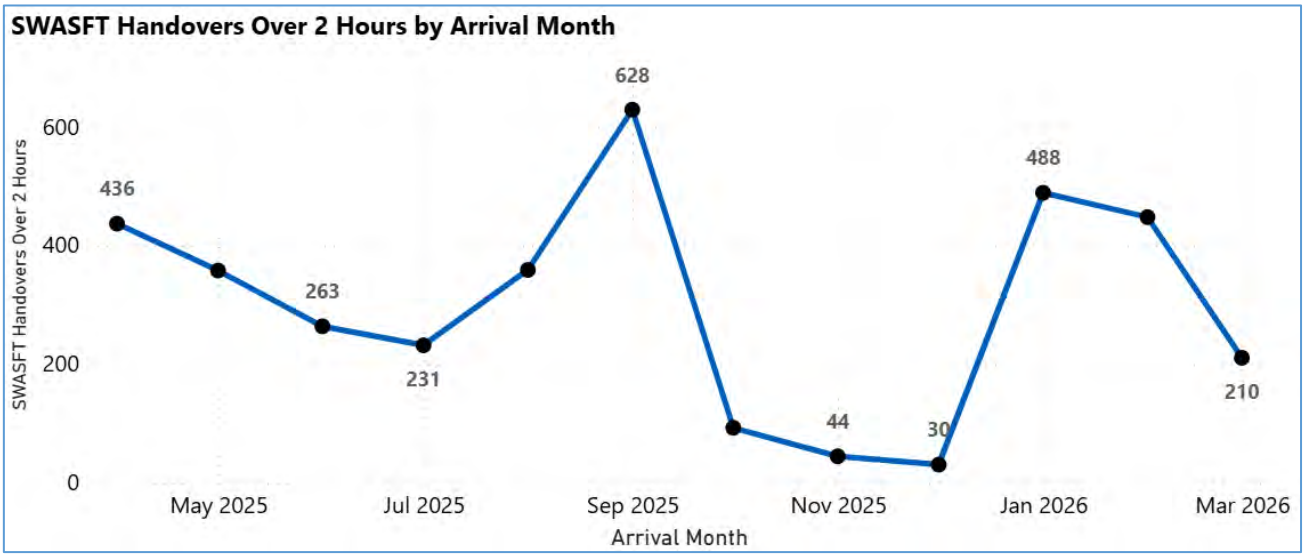
Capacity at the RUH, to see patients within 4-hours, has increased to the highest-level in the last four fiscal years, 62.2k patient attendances (170 patients per day), as shown in the chart below. Whilst Type 1 4-hour performance declined to 58.1%, this occurred alongside a significant increase in demand. ED attendances reached a record high of 107,136 (+5.6% on previous year), resulting in more patients being treated within 4 hours overall. The number of attendances seen within 4 hours increased to a record 62,209, representing a 2.2% increase compared to the previous year.



One of the other key urgent care measures is timely ambulance handovers. Performance in year has improved from 76.4 minutes in 2024/25 to an average of 53.7 minutes 2025/26 though is currently not meeting the target of 33 minutes.

The number of extended ambulance handovers (greater than 2 hours) has followed a downwards trend from early 2025 to December 2025. Over winter, the increase in delays can be attributed to an increase in infections throughout inpatient areas, though is now showing signs of recovery.

Mitigation has been put in place to improve handover times, including the use of improved ambulatory pathways through ED focusing on treatment from a chair rather than through trolley spaces.



Bed occupancy

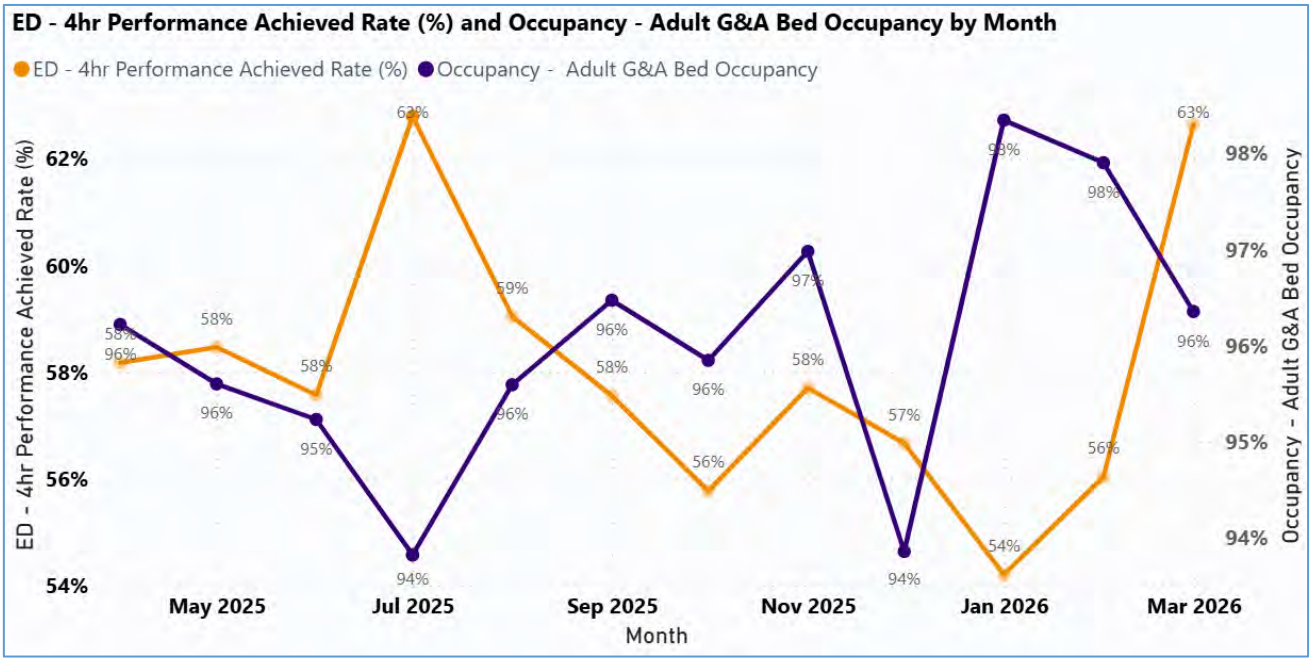
One of the major factors influencing performance against both the 4-hour ED target and the requirement to reduce ambulance handover delays is the ability to admit patients into the hospital in a timely manner.

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%.

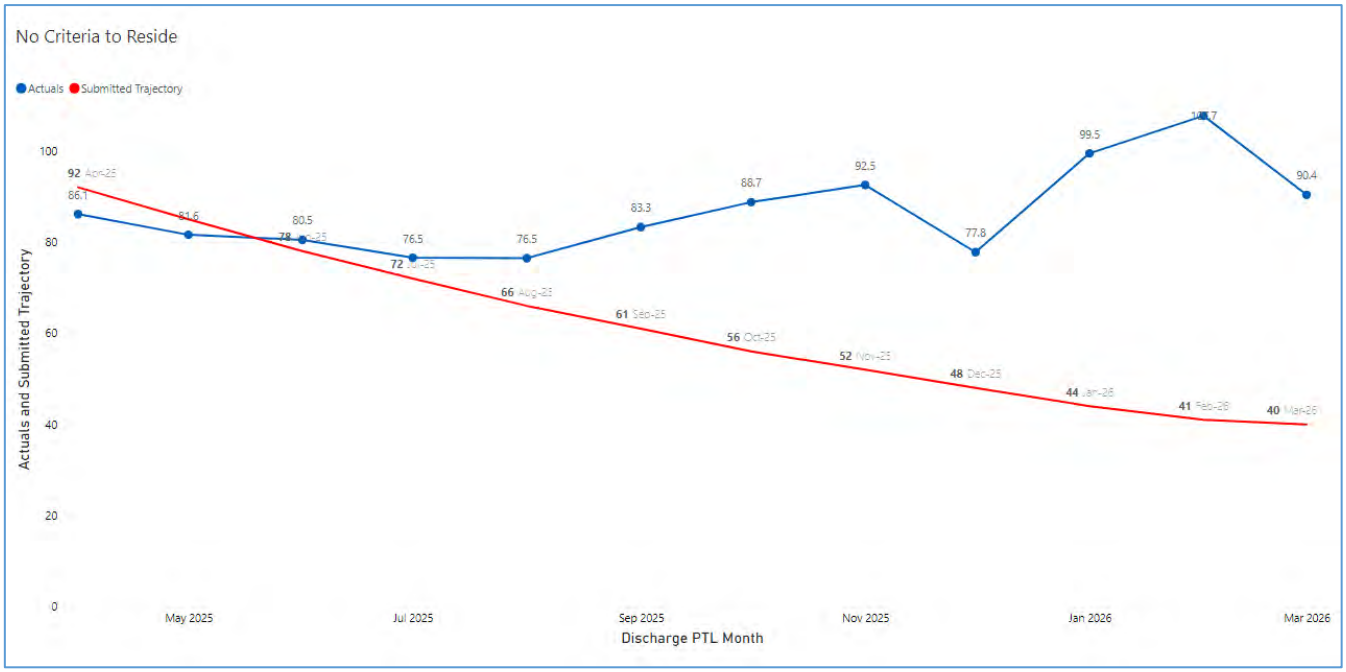
The graph overleaf demonstrates that the RUH bed occupancy is consistently well above this level, averaging 95.9% in 2025/26 for adult acute beds, which is consistent with previous financial years. It is known that bed occupancy above this point increases the operational challenges and increases internal 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 2025 and January 2026.

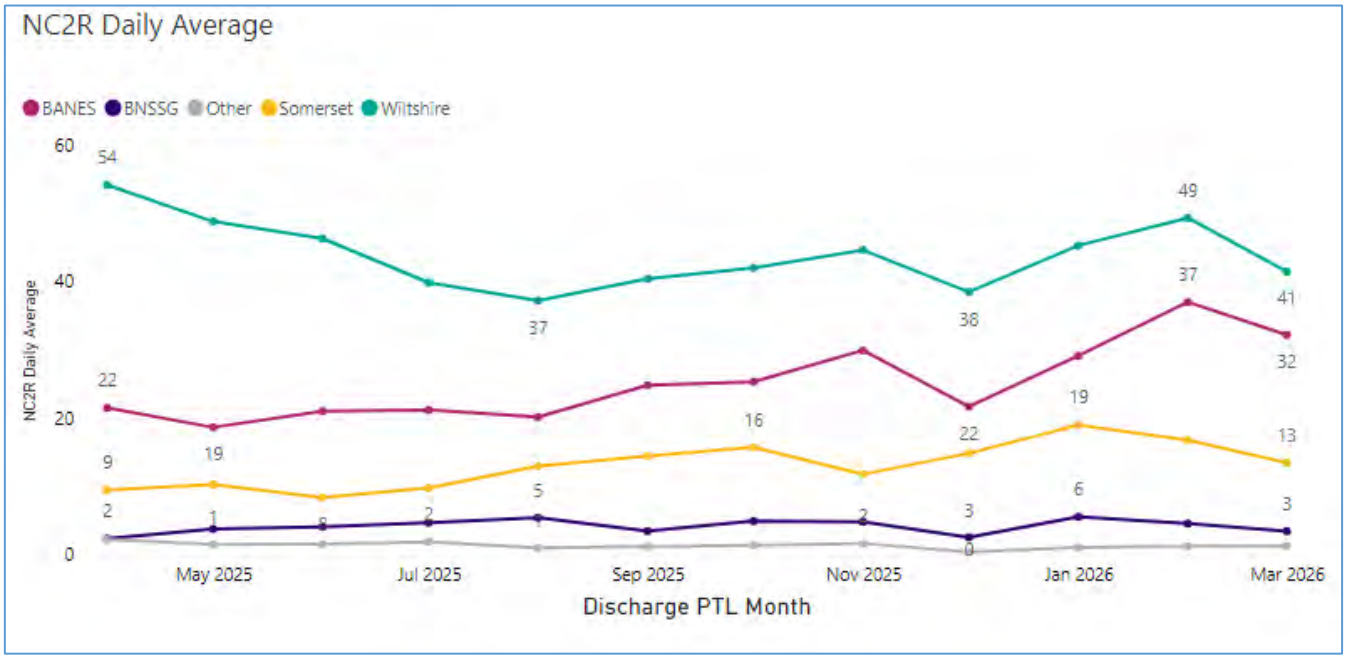
Bed capacity due to infection prevention and control measures also adversely affected occupancy in January and February 2026 with empty bed capacity not accessible for new admissions.



Patients' length of stay and time of discharge also affects bed occupancy. There were 0.5% more patients discharged before 10am and 1.4% more patients discharged before midday by March 2026 (23% of all discharges) when comparing financial years performance, peaking at 25% in May 2025. 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 overleaf shows that throughout this financial year, the number of patients who no longer have criteria to reside is increasing, from a daily average of 86.1 patients in April 2025 to 90.4 patients in March 2026, peaking at 107.7 patients in February 2026. There was significant improvement in December due to the opening of 20 beds in St Martins Ward 4 as part of the winter plan; however numbers returned to the higher daily average in the New Year, aligning to the predicted increase in admissions of frail elderly patients.



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: Wiltshire, Somerset, and BNSSG. BaNES was averaging 22 patients at the start of the year; however this has now risen to 32 patients in March 2026.

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 (HCRG, Wiltshire Local Authority, Somerset, and BNSSG) to deliver improvements within the non-criteria to reside position.

The Trust continues to support the following initiatives.

- Internal process improvement for:
    - Processed to reduce plus 14-day length of stay across the core medical wards for patients with and without criteria to reside applying the NHS England GIRFT toolkit of bi-weekly multidisciplinary ward reviews.
    - 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.
    - Monitoring and escalation against the BSW standards of discharge within 48 hours and 7 days for patients on Pathways 1–3, respectively.
- 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 transformation of community-based care partnership provided by HCRG for the people in Bath and North East Somerset, Swindon, and Wiltshire from April 2026, seeking opportunities to improve access for our patients who no longer need acute hospital care.

The Trust's Breakthrough Objectives for 2026/27

The Breakthrough Objectives for 2026/27 have been agreed as follows and will be reported on in next year's annual report:

The people we care for

- **Achieve safety standards**
    - Eliminate Corridor Care.
    - Reduce NC2R Length of Stay.
    - Zero 52 weeks waits.
    - 80% Cancer 28-day diagnosis.
    - 12.5% Diagnostic waits.

The people we work with

- **Support and empower our staff**
    - Improve sickness rate absence to 4.8%.

The people in our community

- **Making the most of our resources**
    - Deliver £37.6m of savings.
    - Exceed 2% Productivity.

These will be supported by various corporate projects, including:

- UTC Modular Build
- Advice & Refer
- Demand Management & Discharge
- Healthier Workforce Programme
- Clinical Admin Transformation
- Medical E-Rostering
- Staff Accommodation
- Digitalisation of Outpatients
- Shared EPR
- Trowbridge Neighbourhood & Community Diagnostic Centre
- Project Clean Heat

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.

Environmental matters

Introduction and Strategic Context

The Trust continues to recognise that environmental sustainability is fundamental to the delivery of safe, high-quality patient care and to the long-term resilience of NHS services. By improving our environmental and financial sustainability through more efficient use of resources, we can direct a greater proportion of funding towards frontline services. In addition, by improving our local environment and reducing pollution, we help to create healthier places for our patients, staff, and local communities.

During 2025/26, the Royal United Hospitals NHS Green Plan 2025–2028 was developed, setting the clear framework for embedding sustainability across the Trust's services and delivering low-carbon healthcare that is fit for the future.

The Green Plan was formally approved and ratified by the Board in April 2026 and will be embedded through agreed governance and reporting arrangements, aligned with the NHS's ambition to become a net-zero health service by 2045.

Governance & Accountability

The Trust's approach to environmental sustainability is governed through its Board-approved Green Plan, which establishes leadership, accountability, and delivery oversight. A Sustainability Steering Committee (SSC), chaired by the Board-level Net Zero Lead, is responsible for coordinating implementation of the Green Plan and maintaining the implementation tracker. The SSC reports quarterly to the Non-Clinical Governance Committee (NCGC) and provides an annual update to the Board.

Until the Sustainability Steering Committee is fully established, interim oversight is provided through existing governance arrangements, including the Estates and Facilities Board.

Progress against Green Plan actions and targets is monitored through a Green Plan implementation tracker, with named owners, baselines, measures and delivery dates, with escalation through established performance and governance routes where required.

Governance arrangements for climate-related risks and opportunities are set out in the Task Force on Climate-related Financial Disclosures (TCFD) section of this report.

Summary of Green Plan Progress and Delivery (Annual Progress)

This section provides the Trust's annual summary of progress in delivering the Green Plan including actions taken and progress achieved during the year. Quantitative performance data continues to mature and will be further developed under the oversight of the Sustainability Steering Committee.

The most recent available carbon footprint relates to 2024/25; the 2025/26 footprint is not yet available at the time of writing.

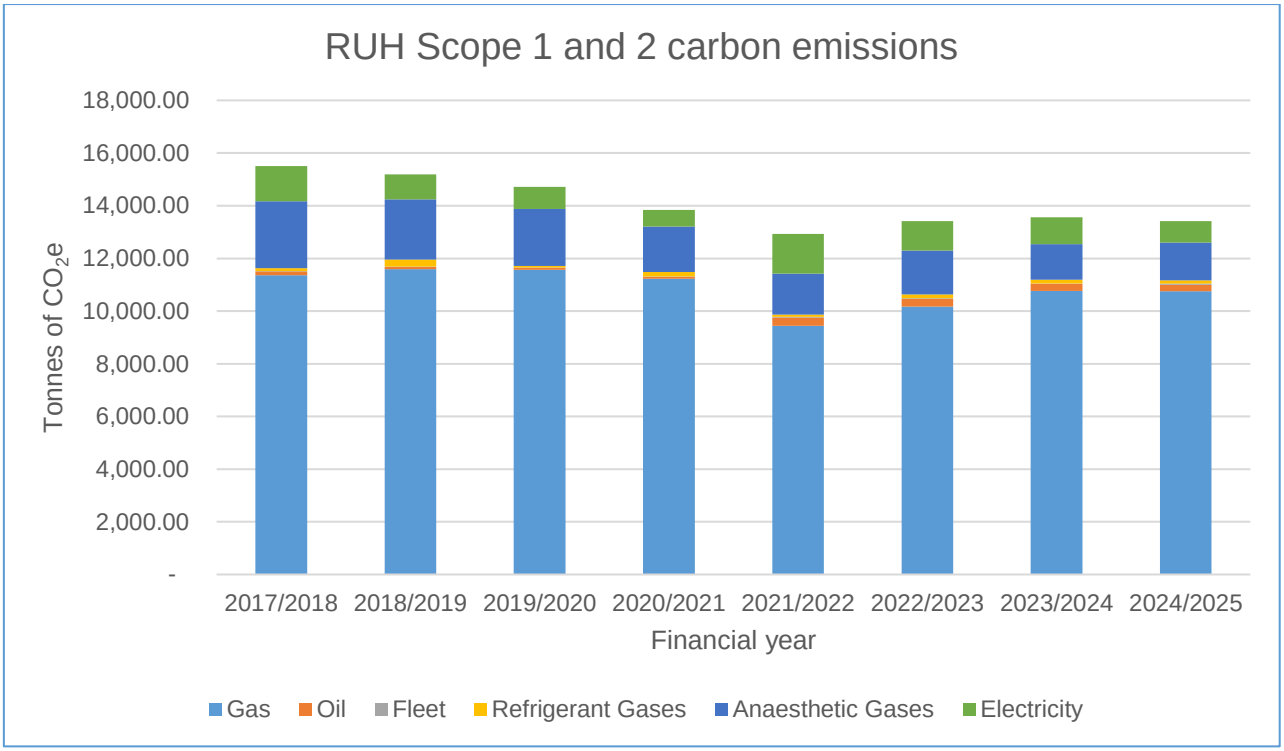


Figure 1: Scope 1 and 2 carbon emissions (eight-year trend)

Estates and Decarbonisation

Energy consumption and the associated carbon emissions remain a material operational and financial consideration for the Trust. Ongoing volatility in energy markets, alongside the requirement to maintain safe clinical environments, has reinforced the importance of active energy management and demand reduction. During the year, the Trust delivered a range of energy-saving initiatives, including night-time energy audits, energy management training, and building control system upgrades. Where viable, projects have been prioritised to deliver a combination of carbon reduction, financial sustainability and operational resilience.

The Trust's approach to estates decarbonisation continues to focus on delivering incremental improvements within a live hospital environment.

External funding secured during the year was successfully deployed, with £51,000 invested in upgrading critical Building Management System (BMS) controls and £6,000 allocated to installing two new electric vehicle charging points to support the NHS fleet. Additional capital investment enabled the replacement of ageing single-glazed windows with more thermally efficient double-glazing across both clinical and non-clinical areas.

2025/26 marked the second year of delivery under the two-year Public Sector Decarbonisation Scheme grant. In 2024, the Trust was awarded £21.6 million in capital funding to replace ageing steam heating networks and one of three steam boilers with low-carbon heating technology, including air-source heat pumps. This is currently in progress. The programme also incorporates the installation of three large solar photovoltaic arrays and over 2,500 smart LED lights across the site. Once complete, the project is expected to deliver carbon savings of approximately 3,212 tonnes per year, equivalent to more than 14,500 return journeys between Bath and Edinburgh in an average petrol car.

Waste, Resources and Environmental Impact

Resource efficiency and waste-reduction initiatives continued to deliver environmental and financial benefits during the year. These activities support emissions reduction while improving efficiency and the patient experience.

Key actions included portion-controlled catering supported by digital meal ordering to reduce food waste, expansion of plant-rich menu options, and refurbishment of patient kitchens to eliminate fossil fuel use in catering operations.

Task Force on Climate-related Financial Disclosures (TCFD)

In line with the Department of Health and Social Care (DHSC) Group Accounting Manual, the Trust has not yet fully complied with the requirements of the Task Force on Climate-related Financial Disclosures (TCFD) framework. Work is underway to address gaps and support full alignment over time.

For 2025/26, the Trust reports against the four TCFD pillars - Governance, Strategy, Risk Management, and Metrics and Targets - on a comply or explain basis. Areas of non-compliance reflect the continued development and maturity of underlying processes, controls, and data.

The Trust recognises that climate change presents risks and opportunities to the delivery of healthcare services, the resilience of its estate and infrastructure, and the achievement of its strategic objectives.

During 2025/26, the Trust developed its Green Plan and Climate Adaptation Plan, with formal approval of these plans taking place at the end of the reporting period. These documents establish the strategic and governance framework for managing climate-related risks and opportunities. Further information is available on the Sustainability Pages

The Trust's Green Plan (2025–2028) sets out a comprehensive programme to reduce environmental impact and embed sustainability across all areas of the organisation, aligned to the NHS Net Zero ambition.

Delivery is supported by a structured implementation framework, including defined workstreams, named executive and operational leads, and a central action tracker with associated risk register and KPI development. Oversight will be formalised through a Sustainability Steering Committee reporting into existing governance structures, with progress monitored through regular reporting cycles and annual review.

Key actions and priorities include:

- Governance and delivery: establishment of the Sustainability Steering Committee, defined workstream leads, and a Green Plan tracker to monitor actions, risks and performance
- Estates and energy: delivery of a heat decarbonisation programme, removal of oil-based heating, expansion of renewable energy generation, and energy efficiency improvements such as LED lighting and building upgrades
- Workforce and culture: embedding sustainability into induction, job descriptions, training programmes and quality improvement activity, supported by an expanded sustainability champions network
- Clinical transformation: increasing use of digital and virtual care pathways, embedding sustainability into service redesign, and delivering quality improvement projects aligned to the SusQI methodology
- Digital and infrastructure: implementation of a single electronic patient record, improved digital efficiency and reduced reliance on paper-based systems

- Waste and resources: improving segregation, increasing recycling rates, introducing reusable products and reducing overall waste volumes
- Travel and transport: transition to zero-emission fleet vehicles, development of a sustainable travel plan and initiatives to reduce staff travel emissions
- Procurement and supply chain: embedding NHS Net Zero supplier requirements, increasing use of sustainable products and strengthening supplier engagement on carbon reduction

The Climate Adaptation Plan, developed across the BSW Hospitals Group, sets out a structured approach to identifying and managing the risks posed by climate change to healthcare services, infrastructure and operations. It is supported by a comprehensive climate risk assessment and a detailed action plan, providing a framework for improving resilience to both acute weather events and longer-term climate change impacts.

Delivery is supported through defined adaptation actions, identified risk owners and alignment with organisational governance and risk management processes. A coordinated approach is being established across the system, with adaptation activities linked to Emergency Preparedness, Resilience and Response (EPRR), business continuity and infrastructure planning.

Key risks, actions and priorities include:

- Physical climate risks: identification of key risks such as overheating of healthcare environments, flooding affecting site access and infrastructure, and disruption to services from extreme weather events
- Risk integration: embedding climate risks into organisational risk registers, business continuity plans and governance processes to support monitoring and escalation
- Estates and infrastructure resilience: integrating climate adaptation into capital planning and design, including drainage improvements, passive cooling, and resilience of critical infrastructure
- Emergency preparedness: alignment with EPRR arrangements to ensure effective response to climate-related incidents and continuity of essential services
- Targeted mitigation actions: implementation of measures to address identified risks, including flood mitigation, overheating management and infrastructure resilience improvements
- System collaboration: coordinated working across BSW organisations and with external partners, including local authorities, to support a consistent and system-wide approach to climate resilience

While reporting for 2025/26 reflects the development of these foundations, further embedding of governance arrangements, risk management processes and performance monitoring will take place during 2026/27 as delivery progresses.

Governance

Oversight of climate-related risks and opportunities is provided through existing governance arrangements. This includes Non-Executive Director (NED) oversight via the Non-Clinical Governance Committee (NCGC), with escalation routes to the Board where required. Sustainability considerations are embedded in Board and Committee decision-making through the inclusion of sustainability content in Board papers and the Integrated Performance Report (IPR).

During the year, work progressed to define a Sustainability Steering Committee, chaired by the Board-level Net Zero Lead, to strengthen organisational oversight and support delivery of the Green Plan

and Climate Adaptation Strategy. This Committee is being established following plan approval and will support implementation during 2026/27.

Strategy

The Trust's approach to managing climate-related risks and opportunities is articulated through its Green Plan and the BSW Hospitals Group Climate Adaptation Strategy. These provide the strategic framework for reducing emissions, adapting to the current and future impacts of climate change, and maintaining safe and resilient services. Identifying key climate-related risks and opportunities relating to:

- Resilience of the estate to extreme heat, flooding and weather events
- Increasing demand on services linked to climate impacts
- Opportunities to improve efficiency and reduce emissions through energy, digital and service transformation

Delivery is supported by a developing KPI and reporting framework, with further detail provided in the Metrics and Targets section.

During the year, the Trust realigned its net zero targets to reflect updated national guidance and system-wide trajectories, moving from a 2030 ambition to 2040 for Scope 1 and 2 emissions and 2045 for Scope 3 emissions. This change supports a more deliverable, system-aligned pathway while maintaining ambition.

The Trust has not yet undertaken formal climate scenario analysis aligned to TCFD recommendations and will consider proportionate approaches to this as part of future development of its climate risk management approach.

Risk Management

Climate-related risks identified through the BSW Hospitals Group Climate Adaptation Pan are being incorporated into organisational risk management processes, including the organisations risk register.

Acute climate-related incidents are managed through established Emergency Preparedness, Resilience and Response (EPRR) arrangements. Further work is underway to strengthen integration with business continuity planning and to embed climate risk more consistently within organisational processes. Where full alignment with TCFD risk management disclosure expectations is still developing, the Trust has adopted a comply-or-explain approach and will continue to mature these arrangements over the coming year.

Metrics and Targets

The Trust monitors its carbon footprint and energy consumption to support delivery of the Green Plan and inform decision-making. While Scope 1, 2 and 3 emissions are reported nationally by NHS England, Scope 1 and 2 emissions are tracked locally, with an eight-year trend presented in Figure 1. This data is used to identify trends, prioritise investment and support delivery of emissions reduction initiatives.

A key initiative delivered during the year is Project Clean Heat, expected to achieve annual savings of approximately 3,212 tonnes of CO_2e once fully operational. Progress against net zero targets and Green Plan objectives is monitored through established governance arrangements.

Local metrics and reporting arrangements will continue to develop as organisational maturity increases.

Delivery of the Green Plan is supported by a developing KPI framework, with measures linked to key actions across workstreams. These include:

- energy and carbon performance (including renewable energy generation and estates decarbonisation)
- waste and recycling rates
- fleet emissions and sustainable travel uptake
- workforce engagement and training completion
- delivery progress against Green Plan actions through the central tracker

The Adaptation Plan is supported by an action plan and emerging monitoring framework to track progress and improve organisational resilience. This includes:

- tracking delivery of adaptation actions through the action plan
- monitoring climate-related risks through organisational risk registers and governance processes
- capturing and reviewing impacts of extreme weather events and resilience responses
- developing indicators relating to estate resilience, such as overheating and flood risk mitigation measures

Comply-or-Explain Statement

The Trust has undertaken a review of its climate-related disclosures against the TCFD framework and reports against all four pillars for 2025/26.

The reporting period primarily reflects the development and approval of key strategic plans, with formal approval occurring at the end of the financial year. While governance arrangements, strategic direction and risk identification processes are in place, further embedding of climate-related governance, risk management and performance monitoring will take place during 2026/27 as delivery progresses.

The disclosures within this report provide a fair and transparent reflection of the Trust's current position and organisational maturity, with further development planned in line with Green Plan implementation and strengthened governance arrangements.

The Trust has not yet fully complied with the requirements of the Task Force on Climate-related Financial Disclosures (TCFD) framework; however, work is underway to develop capability and move towards full alignment.

Adaptation and Climate Resilience

During 2025/26, the BSW Hospitals Group Climate Adaptation Strategy was completed. This work ensures that, alongside mitigating climate change, the Trust is prepared to adapt to the site-specific impacts of a changing climate, including flooding, overheating and water stress.

Delivery of the adaptation strategy requires close coordination with local authorities, emergency services and the wider NHS to maintain operational resilience during climate-related events. Progress will be monitored at both Trust and BSW level.

High-scoring climate risks are reflected within the Trust's risk register and Board Assurance Framework, with mitigation actions aligned to EPRR and business continuity planning.

Looking Ahead

While significant progress has been made, particularly through estates decarbonisation, further focus is required on clinical activity, travel, procurement, waste, digital etc that make up the majority of the Trust's Scope 3 emissions. Over the coming year, the Trust will prioritise:

- Embedding the Green Plan through agreed governance and reporting structure.
- Strengthening understanding and management of Scope 3 emissions.
- Monitoring delivery of Project Clean Heat and developing future investment proposals.
- Improving the use of metrics and time-bound measures to evidence progress.

The Trust recognises that achieving meaningful carbon reduction will require sustained investment, collaboration and innovation, and remains committed to balancing environmental objectives with its core responsibility to deliver safe, effective patient care.

Tackling Health Inequalities

This report provides the Trust's annual public summary of health inequalities analysis and action, in line with NHS England requirements, and complements the Trust's Quality Account and wider performance reporting.

During 2025/26, the Trust continued to strengthen its approach to identifying, analysing and reducing health inequalities in line with NHS England's Statement on Information on Health Inequalities (2025). This involved improving the collection and analysis of demographic data; publishing clear, accessible reporting; and using insights to target unwarranted variation across access, experience and outcomes.

The Trust has embedded health inequalities intelligence within divisional governance structures and strengthened cross-system collaboration with the Integrated Care Board (ICB), Local Authority and wider partners to ensure coordinated action across the BSW system.

Legal and Policy Context

Statutory Duty: Section 13SA Duty (NHS Act 2006) and NHS England's Statement on Information on Health Inequalities (2025).

The Trust must collect, analyse and publish information on health inequalities and explain how this information has informed decisions to reduce unwarranted variation. NHS England's 2025 Statement outlines expectations regarding data disaggregation, use of inequalities information, and annual public reporting.

Alignment with Core20PLUS5

The Trust's Health Inequalities Programme is aligned to Core20PLUS5, the national framework for tackling health inequalities, that sets the priorities for adults and children focussing on the most deprived 20% of the population, inclusion groups at risk of poorer access or outcomes and five key clinical priorities for adults and children (Figures 1 and 2).

As an organisation, we participate in the BANES Health Inequalities Group, which brings together the ICB, local authorities, primary care, VCSE partners and system providers. The group reviews performance against Core20PLUS5 priorities, identifies areas requiring intervention, and coordinates system responses. Through this structure, the Trust plays a key role in shaping collective action on health inequalities across the BSW system.

Figure 1: CORE20PLUS5 Children and Young People Source: NHS England

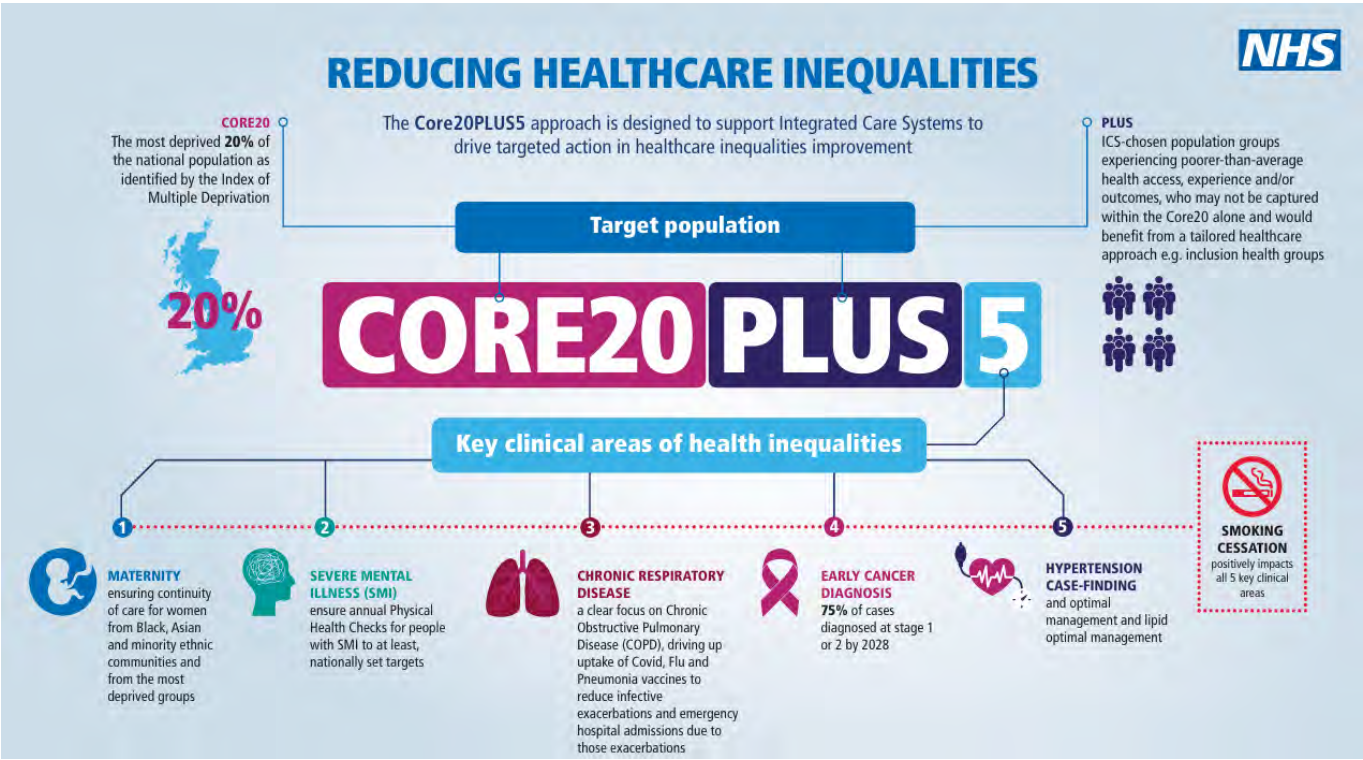


Figure 2: CORE20PLUS5 Adults Source: NHS England

Data Collection and Data Quality

Demographic Data Collection

The Trust has strengthened its ability to analyse and address health inequalities through the development of dashboards that enable data to be disaggregated by age, sex, ethnicity and deprivation. Deprivation is measured using the Index of Multiple Deprivation (IMD) at decile and quintile level.

This approach allows clinical and managerial teams to systematically assess variation in access, experience and outcomes for different population groups and to prioritise improvement activity where inequalities are identified.

Data Quality Improvement Actions

Ethnicity data completeness currently averages approximately 80%, with the remaining entries recorded as ‘unknown’ or ‘not stated’. Improving the completeness and consistency of ethnicity data remains a key priority, as high-quality data is essential for robust inequalities analysis and targeted intervention.

Actions already taken include:

- enhanced dashboard functionality to improve visibility of missing or unknown ethnicity data.
- routine monitoring of ethnicity recording at service and organisational level.
- participation in regional data quality and inequalities improvement programmes
- plans to strengthen local ethnicity recording processes and staff confidence in asking for this information.

In addition, the Trust will align its approach with the NHS Ethnicity Recording Improvement Plan, published by NHS England in October 2025. The national plan sets out evidence-based actions to improve the quality, consistency, completeness and use of ethnicity data across the NHS, recognising high-quality ethnicity data as a critical enabler of efforts to reduce health inequalities.

The Trust will incorporate the principles and recommended actions of the national plan into local work by:

- supporting staff to confidently and sensitively request self-reported ethnicity, in line with national standards.
- strengthening public, patient and staff understanding of why ethnicity data are collected and how they are used.
- improving consistency of recording across systems using standard NHS ethnicity codes, including transition towards 2021 Census categories where appropriate
- making more effective use of ethnicity data to identify, monitor and address inequalities in access, experience and outcomes, aligned with wider Trust and system health inequalities priorities.

Progress will be monitored through routine data quality reporting and will inform ongoing inequalities analysis and service improvement activity.

Priority Areas of Analysis

For 2025/26, the Trust focused on the following areas, in response to national priorities and local population needs:

- smoking-related inequalities
- elective care variation
- ethnicity recording and data quality
- urgent and emergency care inequalities in access

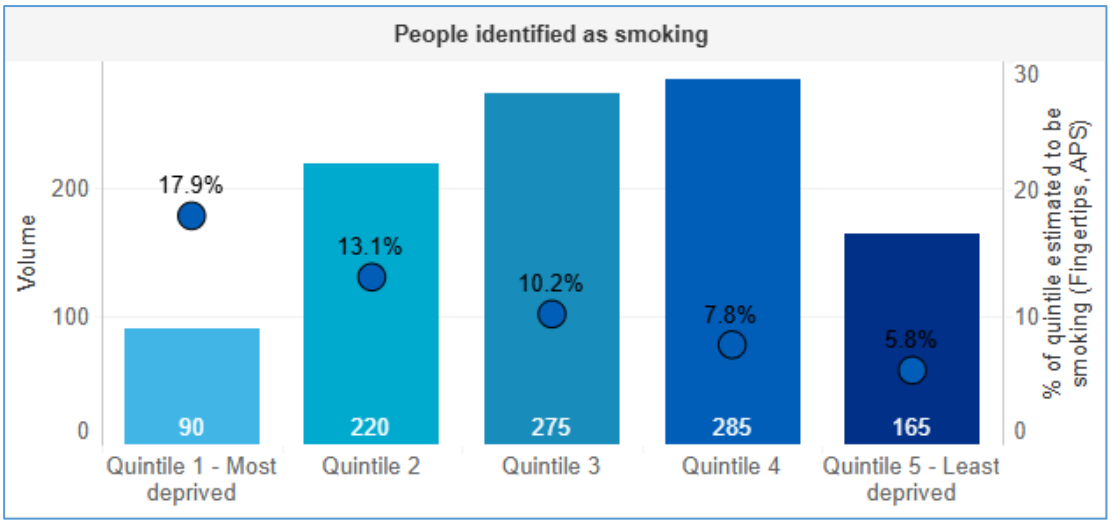
Key Findings

Smoking Cessation

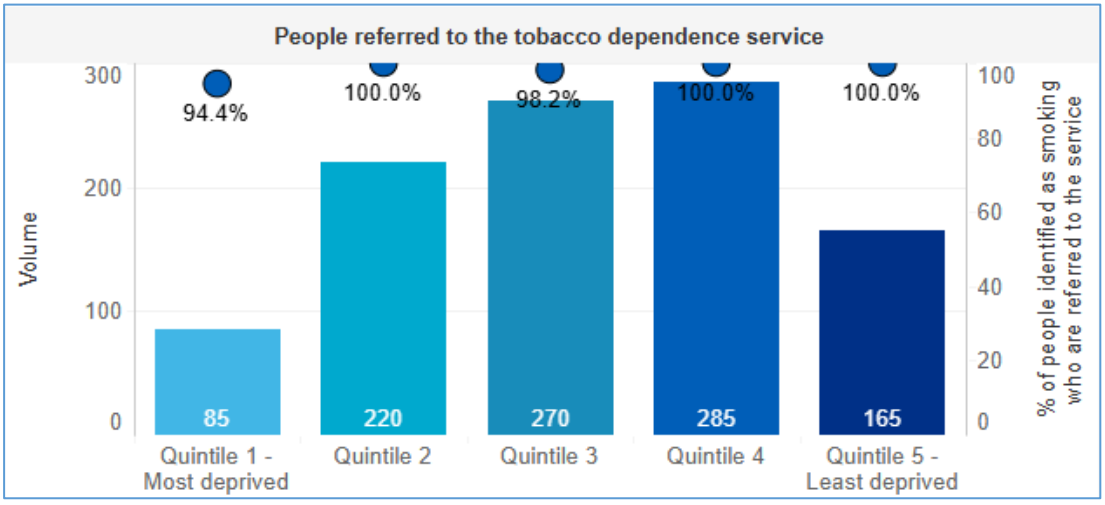
Analysis of inpatient smoking data demonstrates a strong and predictable deprivation gradient, consistent with national evidence (Graphs 3 and 4). Smoking cessation interventions support the Trust's continued focus on Core20PLUS5.

- 17.9% of patients in IMD Quintile 1 (most deprived) were smokers.
- 5.8% in IMD Quintile 5 (least deprived) were smokers.

Graph 3: People identified as smoking broken down by deprivation.



Graph 4: People referred to the service broken down by deprivation.



This indicates that patients from the most deprived areas are approximately three times more likely to be admitted as smokers. Absolute numbers of smokers are highest in IMD Quintiles 3 and 4, reflecting the demographic profile of the RUH catchment area.

Despite higher prevalence in deprived communities, the Trust demonstrates high equity of access to cessation support. Referral rates to the Tobacco Dependence Service are 94 -100% across all deprivation groups, ensuring patients with the greatest need are not disadvantaged upon admission.

Analysis also shows that referrals overwhelmingly represent patients whose ethnicity is recorded as White (Table 5), 80 in IMD 1, rising to 250 in IMD 4 reflecting local population structure where more than 80% of residents are White. Non-recorded ethnicity appears in all quintiles, highlighting ongoing data quality challenges.

Smoking inequalities in the Trust are primarily driven by deprivation, not ethnicity. The clear socioeconomic gradient in smoking rates reinforces tobacco dependence as a key driver of the local life expectancy gap.

Ethnic group	Quintile 1 – Most deprived	Quintile 2	Quintile 3	Quintile 4	Quintile 5 – Least deprived	Unknown
Asian or Asian British	0	0	0	0	0	0
Black, African, Caribbean or Black British	0	0	0	0	0	0
Is not stated	10	35	30	30	30	0
Mixed or multiple ethnic groups	0	0	0	0	0	0
Other ethnic group	0	0	0	0	0	0
White	**80**	**185**	**235**	**250**	**130**	0

Table 5: Number of people referred to the service broken down by deprivation and ethnicity.

Ethnicity Data Completeness

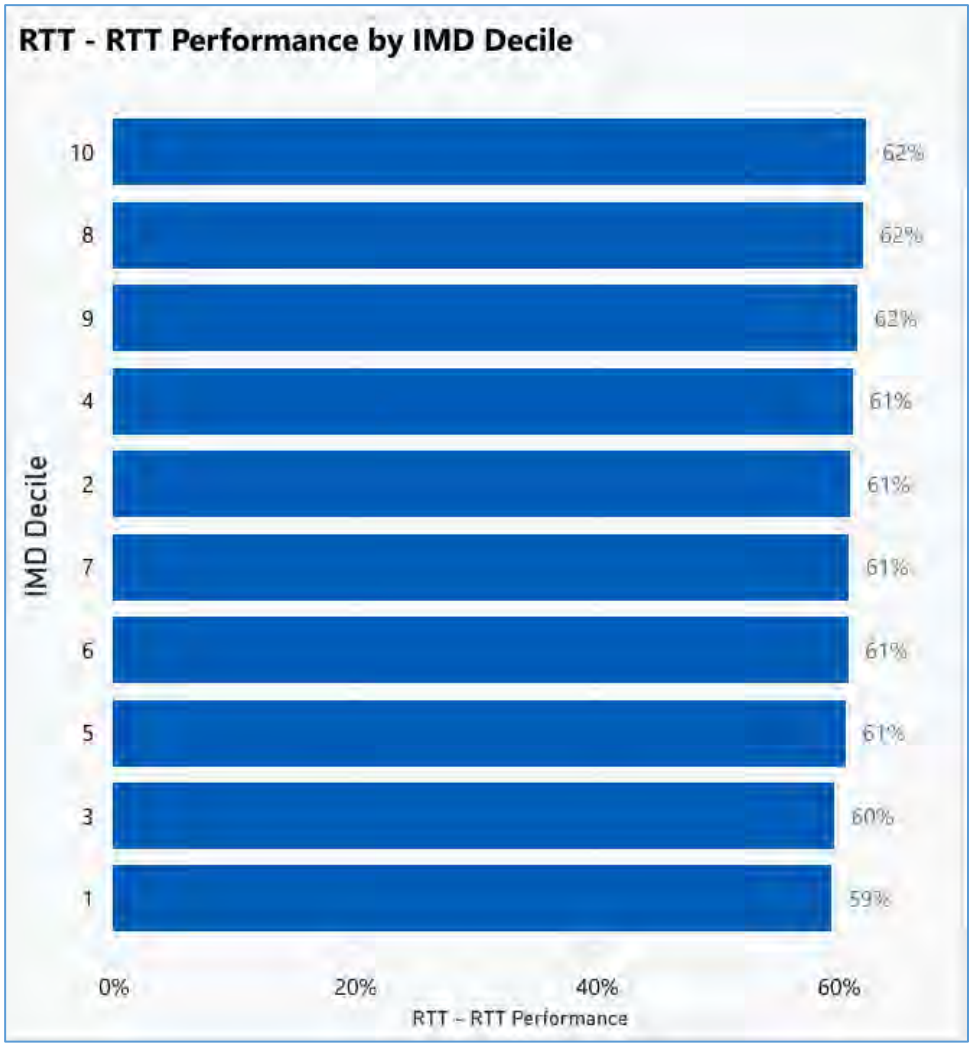
Ethnicity completeness is essential for identifying unwarranted variation across pathways. Across 2025/26, ethnicity not recorded ranged from 15 - 23%.

Even though completeness averages at national performance scores, the level of entries as ‘not stated’ or ‘unknown’ impairs the Trust’s ability to analyse inequalities in access, experience and outcomes, particularly given the local low volume of global majority groups.

Elective Care:

Referral to Treatment (RTT) Performance - 18-Week Standard

Graph 6: RTT performance shows a consistent and stable deprivation gradient from April 2025 to February 2026.

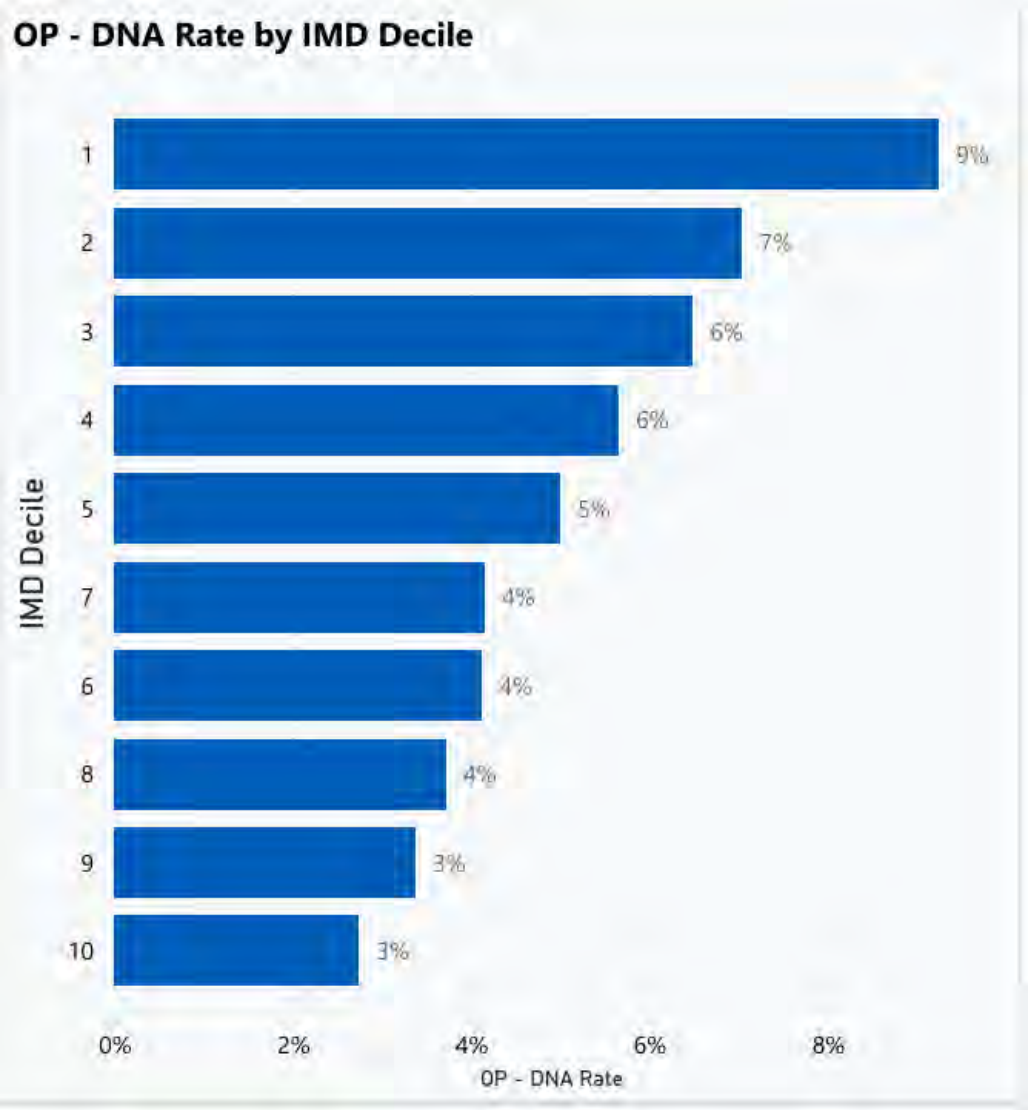


- IMD 1–2 groups consistently recorded the lowest RTT performance (57 - 61%).
- IMD 8–10 recorded the highest performance, reaching 66 - 68% by early 2026.

Although the gap is relatively small, it is persistent over time, indicating a socio-economic inequality in access to timely elective care. As outlined in Section 3.2, ethnicity analysis remains limited due to data completeness and cohort size.

Missed appointments (DNA/WNB)

Graph 7: Did not attend / Was not brought (DNA/WNB) data shows a strong and persistent deprivation gradient:



- IMD 1: 9-12%
- IMD 8-10: 3-4%

Patients in the most deprived deciles are three times more likely to miss appointments. This is a clear inequality, affecting access, waiting times, treatment progression and clinic utilisation. DNA data broken down by ethnicity is unreliable due to small numbers and suppression rules.

While ethnicity-based analysis is currently limited by completeness and low cohort size, deprivation-based inequalities are real, meaningful and a priority for action.

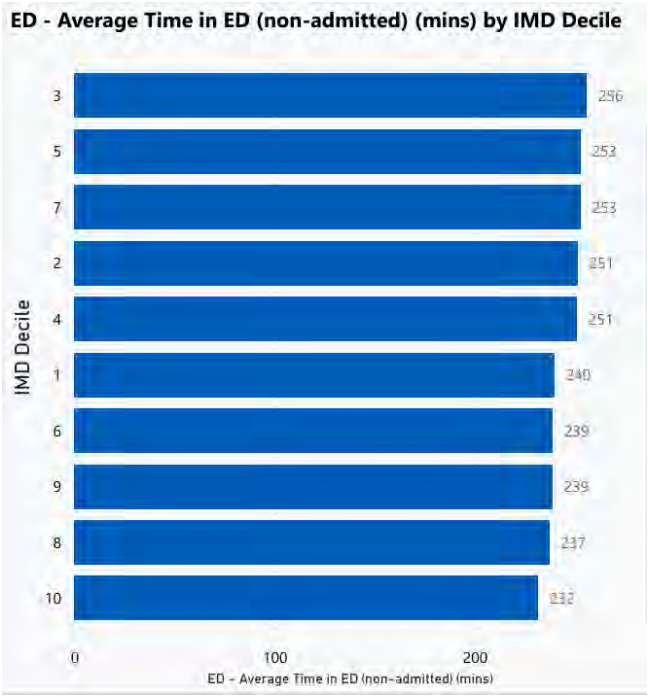
Urgent and Emergency Care

Admitted ED data shows a clear deprivation gradient. Patients from more deprived areas spend longer in the Emergency Department and are more likely to experience delays. The gradient is steeper in non-admitted- patients. This is likely to be influenced by a combination of higher clinical complexity, later presentation and wider social factors (Graphs 8 and 9).

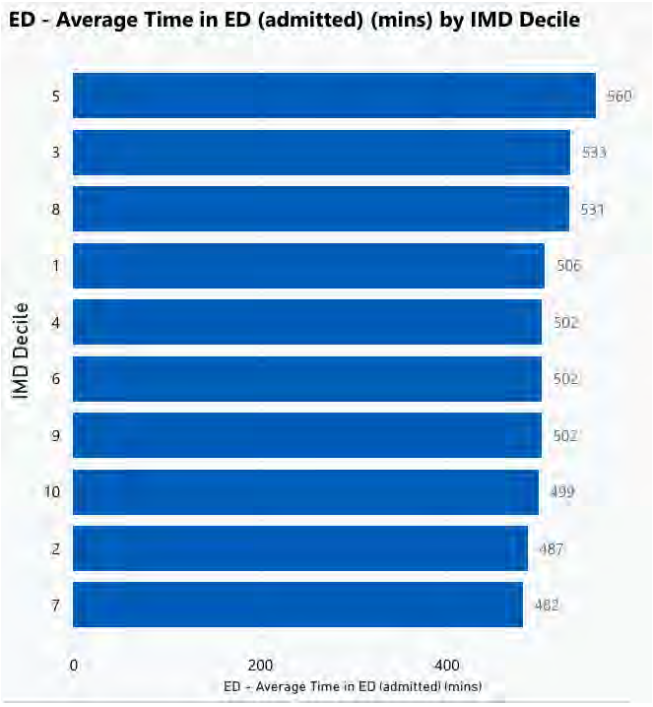
- IMD 1–2 patients consistently record longer stays.
- IMD 9–10 record shorter stays, including during winter pressures.

As outlined within the Health Inequalities report, ethnicity analysis remains limited due to data completeness and cohort size.

Graph 8: ED waiting time by IMD non-admitted.



Graph 9: ED waiting time by IMD admitted



In response to these findings, the Trust is collaborating and working in partnership with the University of Bath on a research pilot to analyse the Trust's emergency care activity data in greater depth. This work will explore patterns of demand, flow and outcomes across deprivation groups, identify emerging trends, and generate evidence to inform targeted actions to reduce inequalities in emergency care access and experience. The pilot will support the development of data-driven interventions aimed at addressing the underlying drivers of prolonged stays and delays for patients from more deprived communities.

Actions Taken

In response to the inequalities identified through routine analysis, the Trust has taken the following targeted actions during 2025/26. These actions focus on improving equity of access, reducing unwarranted variation, and strengthening the use of inequalities intelligence to inform service improvement.

Inequality Identified	Action Taken	Impact to Date	Next Steps (2026/27)
High smoking prevalence in IMD Deciles 1–2	Redesigned the Tobacco Dependence Service to ensure proactive identification and automatic referral of all inpatients who smoke, regardless of deprivation; embedded the service within admission pathways and delivered via trained Health Coaches using a holistic, person-centred model	Consistently high and equitable referral rates (94–100%) across all deprivation groups, ensuring those with greatest need are not disadvantaged; smoking cessation integrated with wider prevention and support	Strengthen recording of smoking status at admission and outcome tracking post-discharge; deepen analysis of quit outcomes by deprivation
Low ethnicity data completeness limiting inequalities analysis	Implemented enhanced dashboard functionality to highlight missing ethnicity data; introduced routine review of ethnicity recording at service and organisational level; participated in regional data quality improvement programmes	Increased organisational awareness of data quality gaps; clearer visibility of where recording is weakest, enabling targeted improvement	Align local processes with the NHS Ethnicity Recording Improvement Plan; deliver staff engagement and awareness activity to improve confidence in collecting self-reported ethnicity
Higher DNA/WNB rates and lower RTT performance in more deprived groups	Introduced targeted follow-up for patients who miss appointments, focusing on deprived cohorts; piloted mitigation measures to address barriers linked to digital exclusion following expanded digital communications	Early evidence of reduced unwarranted variation in selected pathways and improved understanding of non-attendance drivers in deprived populations	Expand targeted interventions across additional services; evaluate and refine approaches to reduce DNAs and improve equity of access
Longer ED waits for patients from more deprived areas	Initiated a research pilot with the University of Bath to analyse urgent and emergency care activity data by deprivation, focusing on demand, flow and outcomes	Improved analytical insight into deprivation-related variation in ED experience, informing future service redesign	Use findings to develop and test targeted interventions aimed at reducing prolonged stays and delays for patients from more deprived communities

These actions demonstrate the Trust's shift from identifying inequalities to actively responding to them through service redesign, targeted intervention and strengthened use of data. Progress is overseen through established governance structures, with actions informing priorities for 2026/27.

Risks, Challenges & Mitigations

Key challenges include incomplete ethnicity data and small population sizes for some groups which limit analytical capacity.

Making Health Inequalities Everybody's Business

The Trust's commitment to making health inequalities everybody's business is demonstrated through the design and delivery of its smoking cessation service. From the outset, the service was deliberately developed as a holistic, person-centred model, going beyond the treatment of tobacco dependence to address wider determinants of health. Given the higher prevalence of smoking in more deprived communities, this approach supports prevention and contributes to reducing inequalities that underpin poor health outcomes.

The service routinely considers the wider social and economic factors that affect a person's ability to engage with and sustain quit attempts, including housing insecurity, financial hardship, mental health needs and social isolation. Where additional needs are identified, individuals are actively supported and signposted to appropriate community, voluntary and statutory services, such as welfare and debt advice, housing support, mental health services and specialist community organisations.

By delivering smoking cessation as part of a wider prevention and personalised care offer, practitioners are able to support overall wellbeing while maintaining a clear focus on reducing tobacco dependence. The service is delivered by Health Coaches, whose skills-based approach helps individuals develop confidence, resilience and self-management capabilities that extend beyond smoking cessation and support longer-term behaviour change.

Mitigations are in place, including strengthened data processes and the routine consideration of health inequalities within operational and governance arrangements.

Priorities for 2026/27

- Improve ethnicity completeness.
- Deepen analysis of smoking and deprivation inequalities.
- Strengthen elective and UEC targeted interventions.
- Governance of Health Inequalities work.

Oversight of delivery and progress is provided through established Trust governance arrangements, with health inequalities routinely considered within divisional and corporate decision-making.

Overview of financial performance

Financial Performance for the Year

2025/26 was a challenging financial year for Royal United Hospitals Bath NHS Foundation Trust (the Trust). The Trust reported a Group financial deficit of £20.5 million, equivalent to 3.2 percent of income, compared with an NHS England (NHSE) operational planning requirement of breakeven. This position reflects the fully consolidated Group, including the Trust and its wholly owned subsidiary, Sulis.

The Trust's financial outturn contributed to being placed in Segment 4 of the NHS England Oversight Framework during the year.

During 2025/26, the Trust was financially performance-managed as part of the Bath, Swindon and Wiltshire (BSW) Integrated Care System, comprising the BSW Integrated Care Board and acute provider partners Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust. The BSW system reported a financial deficit of £25.0 million against its NHSE operational planning requirement, consistent with its agreed forecast position.

Whilst a challenging position, at mid-year the Trust had forecast an outturn of £32.0 million and significant improvement and recovery was undertaken in second half of the year. The final year-end position was in line with the forecast accepted and agreed by NHS England.

The table below describes the reconciliation from the Surplus/(deficit) shown in the Statement of Comprehensive Income in the Annual Accounts and the Surplus/(deficit) used for NHS Performance.

There is a major difference from the £76.5 million reported deficit and the £20.5 million deficit for NHS performance, this primarily arising due to a net asset impairment arising from impairment charge arising from revaluation of the Trust's land and buildings on a Modern Equivalent Asset basis, and a revaluation of bringing Sulis Orthopaedic Centre into economic use. These are large accounting movements but do not result in cash expenditure to the Trust, and do not form part of NHSE finance consolidation Department of Health & Social Care Revenue Departmental Expenditure Limits (RDEL), the primary measure used by HM Treasury to manage public expenditure:

Group Statement of Comprehensive Income (extract) Year ended 31 March 2026 £000s	**Trust**	**Sulis**	**Charity**	**Intracompany eliminations**	**Group total**
Operating income	599,421	54,506	2,378	(15,731)	640,574
Operating expenditure	(667,032)	(52,987)	(3,448)	15,052	(708,415)
Operating surplus/(deficit)	**(67,611)**	**1,519**	**(1,070)**	**(678)**	**(67,841)**
Net finance costs	(8,496)	(606)	124	308	(8,670)
Surplus/(deficit) for the period	**(76,106)**	**912**	**(946)**	**(370)**	**(76,511)**
Adjustments for NHS performance:					
Remove Charity surplus/(deficit)	-	-	946	-	946
Remove net asset impairments	63,425	-	-	-	63,425
Remove impact of donated assets	(8,359)	-	-	-	(8,359)
Surplus/(deficit) for the period for NHS performance	**(21,040)**	**912**	**-**	**(370)**	**(20,499)**

Key drivers of financial performance

The Trust set a challenging Cost Improvement Programme (CIP) target of £29.7 million for the year, following delivery of £32.2 million of savings in 2024/25 and a reduction in workforce costs in real terms. The 2025/26 target included year one of the national NHS productivity challenge, requiring delivery of efficiencies equivalent to approximately 2 percent per annum.

Over the year, the Trust delivered £15.0 million of recurrent savings. The resulting shortfall of £14.7 million against plan was the single largest contributor to the year-end deficit.

In addition to CIP under-delivery, the Trust experienced significant demand-led cost pressures that exceeded planning assumptions. These pressures reduced the scope to deliver savings and materially affected operational efficiency. Key factors included:

- Urgent and Emergency Care admissions were 12.8 percent higher than the prior year, compared with a planned increase of 3.4 percent. Demand accelerated in the second half of the year and was influenced, in part, by changes to ambulance handover time protocols.
- The Trust planned for a reduction in patients with No Criteria to Reside but ended the year with an average of 90 patients, around 50 higher than planned.
- High-cost drug expenditure exceeded plan by £2.1 million, driven by increased clinical demand.
- GP referrals were 2.9 percent higher than planned.
- Staff sickness absence increased by approximately 13 percent year-on-year, averaging 5.41 percent for the year and peaking at 6.29 percent in November. This created additional pressure on pay budgets through backfill costs.

The Trust did not request or receive Deficit Support Funding from NHS England during 2025/26.

Funding and system context

In 2025/26, the Trust received £19.2 million from the ICB Transitional Fund, representing a reduction of £8.8 million compared with 2024/25 funding, which comprised £22.7 million of ICB Transitional Fund and £5.3 million of NHS England Deficit Support Funding.

As part of a national programme to review historic block funding arrangements, an assessment indicated that, excluding Transitional Fund support, the Trust's income was materially below that implied under a national payment system model by £37.9m. National Cost Collection data published during the year indicated a Trust cost index of 98, compared with a national median of 100. In additional to the relative costly efficiency and income under-funding the Trust has also had to contribute to the Government's 2% productivity challenge faced by all NHS organisations.

This financial context meant that delivering further financial improvement in 2025/26 was particularly challenging.

In-year recovery actions

At the mid-point of the financial year, the Trust's straight-line forecast indicated a potential deficit of up to £32.0 million. In response, a formal financial recovery plan was implemented at Month 6 and refreshed at Month 9. The plan focused on strengthened grip and control, operational productivity, cost containment, and accelerated delivery of recovery actions.

As a result of these actions, the Trust delivered a final outturn of £20.5 million, representing a significant improvement against mid-year forecasts during a period of sustained operational pressure.

Key contributors to financial improvement included:

- Increased productivity and improved margins on planned care activity, including a focussed Quarter 4 elective recovery programme aligned to RTT improvement.
- Sulis Group surplus of £0.9 million, generated from core NHS and private activity, fully reinvested into NHS services.
- Continued reduction in premium staffing costs, with agency expenditure at 0.8 percent of total pay spend, limited to hard-to-recruit and highly specialised roles.
- Strengthened financial controls, including improved compliance with purchase order processes which increased to 90 percent of eligible expenditure.
- Delivery of transformation programmes, including outpatient modernisation, expansion of Same Day Emergency Care, and corporate services transformation.

Recognising the scale of the financial challenge, the Trust also commissioned external Financial Turnaround Support from November 2025, providing additional expertise and capacity. The governance, grip and control, and delivery disciplines established through this support are being embedded into business-as-usual arrangements.

Cash and liquidity

The income and expenditure deficit placed pressure on cash balances during the year. This was mitigated through the use of prior-year cash balances and a lower level of capital expenditure in line with the agreed BSW system capital plan. The Trust closed the year with a cash balance of £23.2 million, a reduction of £11.8 million. Active cash management remains a key priority for 2026/27.

Capital programme

The Trust invested £42.5 million in capital infrastructure during 2025/26. Funding sources comprised:

- Public Dividend Capital: £20.8 million
- Government decarbonisation grants: £9.1 million
- Charitable funds: £0.6 million
- Internally financed capital expenditure: £11.9 million

Major schemes delivered during the year included:

- Salix decarbonisation programme (£12.4 million)
- Electronic Patient Record programme (£5.2 million)
- Estates Safety Fund schemes (£6.2 million)
- Urgent and Emergency Care developments (£7.0 million)
- and MRI replacement (£2.3 million).

National approval processes and also re-phasing of the EPR programme meant that several schemes completed later than planned. Consequently, the majority of associated operational and financial benefits are expected to accrue in future years.

Forward look and financial sustainability

The Trust exited 2025/26 with an underlying deficit of £47.3 million (7.6 percent). This is adverse to the £20.5million in year deficit due primarily to the withdrawal £19.2m Transitional Support Income; a further loss of £4.8 million of nonrecurrent financial support from NHS England and other non-recurrent measures of £2.8m.

The key drivers include £37.9m funding shortfalls relating to historic block contract arrangements and cost pressures arising from demand growth and under-delivery of recurrent savings.

The Trust's three-year Medium-Term Financial Plan is stretching but considered deliverable. It requires delivery of £55.0 million of recurrent savings, supported by transformation investment in later years. The delivery profile is front-loaded, with significant risk concentration in 2026/27 ahead of the full impact of system demand management arrangements, clinical transformation, and digital and capital investments.

For 2026/27, the Trust is planning for a breakeven position, supported by £8.4m Transitional Funding and £4.2m NHSE funding support; £9.8m of block contract rebasing income and other tariff changes; and a planned Cost Improvement Programme of £37.6 million. Delivery of this plan is dependent on effective demand management, particularly in urgent and emergency care, high-cost drugs, and delayed discharges.

The Trust continues to work with BSW system partners to strengthen financial sustainability through service transformation, productivity improvement, and appropriate use of its subsidiary, Sulis Hospital.

Going Concern disclosure

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

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

For this reason, the Directors have adopted the going concern basis in preparing the accounts. The assessment considers a period of at least 12 months from the date of approval of the financial statements.

Details of overseas and subsidiary operations

The Trust has no branches or offices outside the UK.

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

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

Cara Charles-Barks
Chief Executive
26 June 2026

Accountability Report

Directors' report

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

Directors of the Royal United Hospitals Bath NHS Foundation Trust during 2025/26:

Non-Executive Directors		Appointed
Alison Ryan	Chair	1st April 2019 (until 30th June 2025)
Liam Coleman	Chair	1st July 2025
Nigel Stevens	Non-Executive Director	1st April 2018 (until 30th June 2025)
Sumita Hutchison	Non-Executive Director	1st September 2019
Antony Durbacz	Non-Executive Director	1st November 2020
Paul Fairhurst	Non-Executive Director	1st October 2022
Hannah Morley	Non-Executive Director	1st April 2023 (until 14th January 2026)
Paul Fox	Non-Executive Director	1st April 2023 (until 30th April 2025)
Simon Harrod	Non-Executive Director	1st October 2024
Joy Luxford	Non-Executive Director	1st May 2025

Executive Directors - voting	
Cara Charles-Barks	BSW Group Chief Executive
Andrew Hollowood	Interim Managing Director (until 31st August 2025) BSW Group Clinical Transformation Officer (from September 2025)
John Palmer	Managing Director (from 1st September 2025)
Kheelna Bavalia	Interim Chief Medical Officer
Simon Truelove	Interim Chief Finance Officer (until September 2025)
Simon Wade	Interim Chief Finance Officer (from 3rd September – 31st October 2025) BSW Group Chief Finance Officer (from 1st November 2025)
Antonia Lynch	Chief Nursing Officer and Interim Director of Estates and Facilities
Paran Govender	Chief Operating Officer (until July 2025)
Alfredo Thompson	Chief People Officer (until 9th January 2026)
Jocelyn Foster	Chief Strategic Officer (until January 2026)

Executive Directors – non-voting	
Christopher Brooks-Daw	Chief of Staff (until 31st July 2025)
Bernie Bluhm	Acting Chief Operating Officer (from 21st July 2025) Chief Operating Officer (from 5th November 2025)
Andrew Hollowood	BSW Group Clinical Transformation Officer (from September 2025)
Jude Gray	BSW Group Chief People Officer (from 1st November 2025)
Jonathan Hinchliffe	BSW Group Chief Transformation and Innovation Officer (from April 2025 until January 2026) BSW Group Chief Digital and Information Officer (Interim) (from 1st January 2026)
Mark Ellis	BSW Group Chief Risk Officer (from 26th January 2026)
Judy Dyos	BSW Group Chief Strategic Officer (Interim, part time) (from 2nd February 2026)

Note: Changes in Directors of the Royal United Hospitals Bath NHS Foundation Trust in 2025/26

- Paul Fox served as a Non-Executive Director from 1 April 2023 until 30 April 2025, when he stepped down from the Board during the year.
- Alison Ryan was Chair until 30 June 2025.
- Nigel Stevens was Vice-Chair and Senior Independent Director until his term of office ended on 30 June 2025.
- Liam Coleman became Chair on 1 July 2025, creating a joint Chair arrangement with Great Western Hospitals NHS Foundation Trust.
- Sumita Hutchison became Interim Vice-Chair from 1 July 2025.
- Paul Fairhurst became Senior Independent Director from 1 July 2025.
- Paran Govender held the role of Chief Operating Officer until July 2025.
- Bernie Bluhm became Acting Chief Operating Officer on 21 July 2025.
- Christopher Brooks-Daw left the Trust on 31 July 2025.
- Andrew Hollowood served as Interim Managing Director until 31 August 2025. From September 2025, Andrew Hollowood was appointed BSW Group Clinical Transformation Officer, reflecting the development of the BSW Hospitals Group operating model.
- Simon Truelove served as Interim Chief Finance Officer until September 2025.
- John Palmer was appointed Managing Director of the Trust with effect from 1 September 2025.
- Simon Wade served as Interim Chief Finance Officer from 3 September 2025 until 31 October 2025. Simon Wade was subsequently appointed BSW Group Chief Finance Officer with effect from 1 November 2025.
- There was a short period of overlap between the appointment of Jude Gray as Group Chief People Officer and the departure of Alfredo Thompson in January 2026. This occurred in the context of the BSW Hospitals Group's move to a single Group Chief People Officer role.

- During the year, Jonathan Hinchliffe's job title changed; however, there was no change to the substance, responsibilities, or scope of the role.
- Jocelyn Foster served as Chief Strategic Officer until January 2026, when she stepped down from the role.
- Hannah Morley served as a Non-Executive Director from 1 April 2023 until 14 January 2026, when she stepped down from the Board during the year.
- Mark Ellis was appointed BSW Group Chief Risk Officer with effect from 26 January 2026, representing a new Group level role introduced during the year.
- Judy Dyos was appointed Interim BSW Group Chief Strategic Officer, on a part time basis, with effect from 2 February 2026.

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

In accordance with the Foundation Trust Code of Governance, the Board has considered the independence of each Non-Executive Director, including length of service. While Sumita Hutchison has served on the Board for more than six years, the Board is satisfied that she remains independent in character and judgement. This conclusion has been informed by the comprehensive review undertaken by the Council of Governors. Following this review, Sumita Hutchison was reappointed for a further term and appointed as Vice Chair from 1 July 2025. The Board is satisfied that these roles do not impair her independence, but rather reflect her experience, performance and ability to provide constructive challenge in support of the Trust's developing group model.

Fit and Proper Persons Test

The Board is satisfied that appropriate processes are in place to ensure that Directors meet the requirements of the Fit and Proper Persons Test. Any Director who no longer meets these requirements would have their membership of the Board of Directors terminated. This did not apply to any Director during 2025/26.

The Board of Directors

Alison Ryan, Chair (until June 2025)
Alison Ryan served as Chair of the Royal United Hospitals Bath NHS Foundation Trust from 2019 until 30 June 2025. During her tenure, Alison chaired the Board of Directors, the Board of Directors' Nominations and Remuneration Committee and the Council of Governors and was also a member of the Charities Committee. She played a key role in supporting the Trust's governance, leadership and engagement with Governors. By way of interests, Alison was reappointed as South West Regional Chair for Organ Donation in March 2022 and also served as a mentor to the Chief Executive of Julian House during her time at the Trust.
Liam Coleman, Chair (from July 2025)
Liam Coleman was appointed as Interim Chair of the Royal United Hospitals Bath NHS Foundation Trust on 1 July 2025, alongside his role as Chair of Great Western Hospitals NHS Foundation Trust, providing shared leadership across the two organisations. As Chair, he leads the Board of Directors and Council of Governors and plays a key role in supporting the Trust's transition to the BSW Hospitals Group model. Liam brings significant senior leadership and governance experience from across the public and regulated sectors, with a strong focus on financial stewardship, organisational performance and system collaboration. By way of declared interests, Liam is Interim Chair of the Financial Ombudsman Service and Group Chair of London and Quadrant Housing Trust.
Nigel Stevens, Non-Executive Director (until June 2025)
Nigel Stevens served as a Non-Executive Director from April 2018 until June 2025 and held the roles of Vice Chair and Senior Independent Director during his tenure. He chaired the Quality Assurance Committee and was a member of the Audit and Risk, Finance and Performance, Subsidiary Oversight, and Nominations and Remuneration Committees. Nigel brought experience from senior leadership roles across the public and private sectors, providing constructive challenge and assurance to the Board. By way of interests, Nigel is the owner and sole trader of Raybarrow Consulting and was appointed Chair of Transport Focus, a publicly funded watchdog, in June 2022.
Sumita Hutchison, Non-Executive Director and Vice Chair (from July 2025)
Sumita Hutchison has served as a Non-Executive Director since September 2019 and was appointed Vice Chair from July 2025. She is Chair of the Non-Clinical Governance Committee and the Charities Committee and is a member of the People Committee, Audit and Risk Committee and the Nominations and Remuneration Committee. She is the Board lead for equality, diversity and inclusion and for health and wellbeing. Sumita brings strong governance and employment law expertise and has experience supporting public sector organisations at board level. In addition to her role at the Trust, Sumita holds a number of voluntary and trustee roles.
Antony Durbacz, Non-Executive Director
Antony Durbacz was appointed as a Non-Executive Director on 1 November 2020. On the Board, he has been Chair of the Finance and Performance Committee since October 2023 and Chair of the Subsidiary Oversight Committee since July 2026. By way of background, Antony is a chartered accountant and has held a number of senior finance roles, primarily in the manufacturing sector. Prior to joining the Trust, he served as a Non-Executive Director and Chair of the Audit Committee at Taunton and Somerset NHS Foundation Trust. By way of interests, Antony is a Governor at Bath Spa University and a Trustee of Wessex Learning Trust. His daughter is on rotation as a Registrar in Obstetrics and Gynaecology in the Severn region.

Paul Fairhurst, Non-Executive Director and Senior Independent Director (from July 2025)
Paul Fairhurst was appointed as a Non-Executive Director on 1st October 2022, he chairs the People Committee and has previously served on the Finance and Performance and Quality Assurance Committees. Paul is the Board lead for safeguarding, staff inequalities and the Improving Together programme. He brings a background in corporate law and strategic leadership from a range of public, private and charitable organisations. He is the Non-Executive Director lead for safeguarding, security, staff inequalities and Improving Together. By way of declared interests, Paul is a Trustee of Designability and Back Up Trust.
Hannah Morley, Non-Executive Director
Hannah Morley served as a Non-Executive Director from 1 April 2023 until 14 January 2026. During her tenure, she chaired the Quality Assurance Committee and was also a member of the Non-Clinical Governance and People Committees. By way of background, Hannah has a clinical and service development background within the healthcare sector and held senior planning and service development roles within the NHS during her time on the Board. By way of declared interests, Hannah is a member of the Chartered Society of Physiotherapists and the Health and Care Professions Council, along with a number of professional bodies related to physiotherapy and allied health professions.
Paul Fox, Non-Executive Director
Paul Fox served as a Non-Executive Director from 1 April 2023 until 30 April 2025. During his tenure, he chaired the Audit and Risk Committee from October 2023 and was also a member of the Finance and Performance and Subsidiary Oversight Committees. By way of background, Paul has a senior finance and operational background across the public sector, including leadership roles within local government, higher education and national research bodies. He was awarded an OBE in 2022 for services to scientific research. By way of declared interests, Paul is a member of the UKRI Financial Sustainability of Research Committee and the Chartered Institute of Public Finance and Accountancy. He is also a Governor at Wiltshire College and University Centre. His wife works at University Hospitals Bristol and Weston NHS Foundation Trust and is registered with the NHS staff bank.
Simon Harrod, Non-Executive Director
Simon Harrod was appointed as a Non-Executive Director in October 2024 and became Chair of the Quality Assurance Committee in January 2026. He is also a member of the Audit and Risk Committee, the Subsidiary Oversight Committee and the Nominations and Remuneration Committee and acts as the Board's Maternity Safety Champion. Simon brings experience in clinical leadership, patient safety and quality improvement, drawing on his background as a consultant anaesthetist and Medical Director within the NHS. By way of declared interests, Simon is a Trustee of Amesbury History Centre.
Joy Luxford, Non-Executive Director
Joy Luxford was appointed as a Non-Executive Director in May 2025. She is Chair of the Audit and Risk Committee and is also a member of the Charities, Finance and Performance, Non-Clinical Governance, Subsidiary Oversight, and Board of Directors' Nominations and Remuneration Committees. By way of background, Joy is a chartered accountant with experience in finance, risk and audit across a range of complex organisations, including senior leadership roles in the charitable and public sectors. By way of declared interests, Joy is a Non-Executive Director at Alliance Homes, where she also chairs the Audit and Risk Committee, and is a Director of Iconoclast Global Limited. She is a member of the Institute of Chartered Accountants in England and Wales (ICAEW). Her husband operates an IT cyber security business which provided services to the Trust in May 2025 on normal commercial terms, with no involvement or influence from Joy.

Executive Directors - Voting
Cara Charles-Barks, Chief Executive
Cara Charles-Barks has worked at board level within the NHS since 2008, holding senior executive roles including Chief Operating Officer and Deputy Chief Executive, and serving as Chief Executive at Salisbury NHS Foundation Trust between 2017 and 2020. Earlier in her career, she held senior healthcare management roles in Australia. In November 2024, having worked within the BSW system for eight years, Cara was appointed Chief Executive Officer of the BSW Hospitals Group. She holds undergraduate and postgraduate degrees in Nursing and an MBA from the University of Adelaide. By way of declared interests, Cara is a Visiting Professor at the University of the West of England, Chair of NHS Quest, Honorary Colonel of 243 Multi-Role Medical Regiment, and a Director of Chatham Row Management Company Ltd.
Andrew Hollowood, Interim Managing Director (until September 2025) **Group Clinical Transformation Officer (from September 2025 became Non-voting)**
Andy Hollowood was appointed as Chief Medical Officer on 15 September 2022. He served as Deputy Chief Executive from November 2023 until November 2024 and was subsequently appointed Interim Managing Director following the appointment of the BSW Hospitals Group Chief Executive Officer. He remained in the Interim Managing Director role until 31 August 2025. From September 2025, Andy was appointed as Group Clinical Transformation Officer. On appointment to this Group role, he became a non-voting member of the Board. By way of background, Andy is a consultant cancer surgeon specialising in gastric cancer and has held senior medical leadership roles within the NHS, including Deputy Medical Director at University Hospitals Bristol and Weston NHS Foundation Trust. He brings experience in patient safety, quality improvement and addressing health inequalities. By way of declared interests, Andy is a Trustee of Boomsatsuma, a specialist creative and digital education provider. Andy's wife is a General Practitioner at Hartcliffe Surgery in Bristol.
John Palmer, Managing Director (from September 2025)
John Palmer was appointed as Managing Director in September 2025. He brings nearly 30 years' experience in public service, including executive leadership roles across local government, the Senior Civil Service and the NHS. Immediately prior to joining, John was Chief Operating Officer at Royal Devon University Healthcare NHS Foundation Trust between 2021 and 2025, where he led a major reset and recovery programme focused on elective and cancer performance and urgent care flow. He has previously held senior leadership roles at King's College Hospital NHS Foundation Trust and Cwm Taf Morgannwg University Health Board. John has no declared interests.
Simon Truelove, Interim Chief Finance Officer (until September 2025)
Simon Truelove was appointed as Interim Chief Finance Officer in March 2025, joining on temporary secondment from Avon and Wiltshire Mental Health Partnership NHS Trust, where he had been in post since September 2016. By way of background, Simon has spent his entire career in the NHS and has held senior finance roles across a range of organisations, including commissioning bodies, ambulance trusts and integrated health and social care providers. Prior to joining AWP, he served as Chief Financial Officer and Deputy Accountable Officer at Wiltshire Clinical Commissioning Group. Simon left the Trust in September 2025. By way of declared interests, Simon's wife was the Chief Finance Officer and Deputy Chief Executive of Bristol, North Somerset and South Gloucestershire Integrated Care Board.
Simon Wade, Interim Chief Finance Officer (from 3rd September 2025 until 31st October 2025) **Group Chief Finance Officer (from 1st November 2025)**
Simon Wade was appointed as Interim Chief Finance Officer in September 2025, alongside his role as Chief Finance Officer at Great Western Hospitals NHS Foundation Trust. In November 2025, he was appointed as Group Chief Finance Officer for the BSW Hospitals Group. By way of background, Simon has extensive senior NHS finance experience. Prior to his appointment as Chief Finance Officer at Great Western Hospitals NHS Foundation Trust in 2020, he served as Deputy Director of Finance. Simon has no declared interests.

Paran Govender, Chief Operating Officer (until July 2025)

Paran Govender joined as Chief Operating Officer in October 2023, joining from Guy's and St Thomas' NHS Foundation Trust. She held the role until July 2025. By way of background, Paran has extensive clinical and operational leadership experience as an Occupational Therapist, Chief Therapist and Director of Operations and Partnerships, having worked across a number of NHS organisations, including King's College Hospital NHS Foundation Trust. She brings a strong focus on inclusion, equality and patient-centred care. Paran stepped away from the Chief Operating Officer role in July 2025 and left the Trust in November 2025. During her time at the Trust, Paran had no declared interests.

Jocelyn Foster, Chief Strategic Officer (until January 2026)

Jocelyn Foster served as Chief Strategic Officer until her retirement in January 2026. During her time at the Trust, she led strategic planning, transformation and business development activity. By way of background, Jocelyn has experience across the public and private sectors in strategy, planning and transformation, including senior roles within local government, the NHS and national organisations. She holds an MBA, a Doctorate and a Bachelor's degree in Biological Sciences. By way of declared interests during her tenure, Jocelyn held a financial interest in Veloscient Ltd and undertook work as a complaint's panellist for the Dental Complaints Service.

Kheelna Bavalia, Interim Chief Medical Officer

Kheelna Bavalia was appointed as Interim Chief Medical Officer in February 2025, joining on secondment from NHS England South West. By way of background, Kheelna is a General Practitioner by training and has held a range of senior medical leadership roles across the NHS, including Deputy Postgraduate Dean, Deputy Medical Director, and Medical Director for System Improvement and Professional Standards, as well as Responsible Officer for NHS England South West. She brings experience in medical leadership, quality improvement and system working. By way of declared interests, Kheelna has been a Trustee of Shooting Star Children's Hospices since February 2023.

Antonia (Toni) Lynch, Chief Nursing Officer and Interim Director of Estates and Facilities

Toni Lynch was appointed as Chief Nursing Officer in April 2021, joining from Guy's and St Thomas' NHS Foundation Trust, where she was Deputy Chief Nurse and Acting Chief Nurse, providing leadership to nursing and midwifery teams through the first two waves of the COVID-19 pandemic. Toni has held a range of senior clinical and operational leadership roles. She holds a Master's degree in Advanced Nursing Practice and has completed the Nye Bevan Executive Leadership programme. In addition to her Chief Nursing Officer role, Toni took on executive responsibility for facilities in February 2024 and assumed executive responsibility for estates from January 2025. By way of declared interests, Toni's spouse is a Matron at Great Western Hospitals NHS Foundation Trust.

Alfredo Thompson, Chief People Officer (until January 2026)

Alfredo Thompson was appointed as Chief People Officer at the end of January 2022, joining from North Middlesex University Hospital NHS Trust, where he led culture change and leadership development programmes. During his tenure, Alfredo held a number of senior people leadership responsibilities and brought a strong focus on organisational culture, staff experience and inclusion. He has held senior roles both within the NHS and in other sectors. Alfredo left the Trust in January 2026 following the appointment of a single Group Chief People Officer for the BSW Hospitals Group. By way of declared interests during his time at the Trust, Alfredo attended Locum's Nest special interest group meetings.

Executive Directors – Non-Voting
Christopher Brooks-Daw, Chief of Staff (until July 2025)
Christopher Brooks-Daw was appointed as Chief of Staff in January 2024, bringing over 30 years' experience across clinical and corporate roles within the NHS, overseas and the independent healthcare sector. During his tenure, Christopher held senior leadership responsibilities spanning nursing, governance and risk, organisational development and change. He brought a strong focus on continuous improvement, positive organisational culture and advocacy for both staff and patients. Christopher formally left the Trust in July 2025.
Bernie Bluhm, Acting Chief Operating Officer (from July 2025 until November 2025) **Chief Operating Officer (from November 2025)**
Bernie Bluhm joined in April 2025 as Director of Urgent Care Recovery. She was appointed Acting Chief Operating Officer in July 2025 and subsequently appointed Chief Operating Officer in November 2025. By way of background, Bernie has extensive NHS experience and began her career at the Trust, specialising in emergency care nursing. Following her departure in 2004, she held a number of executive Chief Operating Officer roles and worked with NHS England's national team as Director for Planned Care Recovery. Immediately prior to returning, she was Director of Transformation for Planned Care at Royal Devon University Healthcare NHS Foundation Trust. Bernie has no declared interests.
Jude Gray, Group Chief People Officer (from 1st November 2025)
Jude Gray was appointed as Group Chief People Officer of the BSW Hospitals Group on 1st November 2025. Prior to this, she served as Chief People Officer at Great Western Hospitals NHS Foundation Trust from 2019. By way of background, Jude has senior people leadership experience across the public sector, including previous roles with the BBC and His Majesty's Prison and Probation Service. In her Group role, she is responsible for workforce planning, sustainability, health and wellbeing across the BSW Hospitals Group. By way of declared interests, Jude is a Trustee of ICP Support and Gympanzees. Her son is employed as a Senior Manager at Deloitte.
Mark Ellis, Chief Risk Officer (from 26th January 2026)
Mark Ellis was appointed as Chief Risk Officer in January 2026. He brings over 20 years' senior leadership experience across finance, governance and risk. By way of background, Mark is a Chartered Management Accountant and holds a Master's degree in Engineering Science from the University of Oxford. Prior to his appointment, he served as Chief Finance Officer at Salisbury NHS Foundation Trust for three years. Mark brings a strong focus on organisational culture, capability development and the effective use of insight to support risk management and performance improvement across clinical and corporate teams. By way of declared interests, Mark is a Director of SLT, a wholly owned subsidiary of Salisbury NHS Foundation Trust.
Jonathan Hinchliffe, Group Chief Digital and Information Officer
Jonathan Hinchliffe joined the BSW Hospitals Group executive team in April 2025 and currently serves as Group Chief Digital and Information Officer. During 2025/26, the role title was refined to reflect its focus on digital enablement, information strategy and business intelligence, with no change to underlying responsibilities or governance arrangements. Jonathan provides strategic leadership for system-wide digital transformation and the implementation of a shared electronic patient record across the Group. By way of declared interests, Jonathan is Delivery Director at St Vincents Consultancy, a company that provides interim roles and consultancy support to the NHS. Jonathan is employed as Group Chief Digital and Information Officer via St Vincents Consultancy.

Judy Dyos, Interim Group Chief Strategic Officer (from February 2026)
Judy Dyos was appointed as Interim Group Chief Strategic Officer in February 2026 to support strategic leadership across the BSW Hospitals Group pending substantive recruitment. She undertakes the role on a part-time basis alongside her substantive role at Salisbury NHS Foundation Trust. In her interim capacity, she has supported system-level strategic planning and collaboration aligned to the Group operating model. Judy has no declared interests.

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.

Well-led Framework

The Trust has had regard to NHS England's well-led framework in arriving at its overall evaluation of the organisation's performance and in developing its approach to internal control, the Board Assurance Framework and the governance of quality.

During 2024/25, the Trust completed an externally-facilitated Well-led Developmental Review, undertaken as part of a system-wide procurement across the three BSW acute trusts. The findings of this review have informed ongoing work to strengthen leadership, governance and accountability arrangements. Actions arising from the review have been embedded within existing corporate and divisional work programmes and are overseen through established executive and Board governance structures.

Further detail on the Trust's governance, leadership and assurance arrangements is set out in the Annual Governance Statement.

Additional Directors' report disclosure

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 2025/26. This is the same as the year 2024/25.

Overseas operations

The Royal United Hospitals Bath NHS Foundation Trust has not had any overseas operations in 2025/26. This was the same in the 2024/25 year.

External Consultancy

During 2025/26, the Trust made limited use of external consultancy and specialist support to support financial recovery and system wide transformation activity. This included the engagement of Hunter Healthcare Resourcing Ltd, commissioned through an established national procurement framework, to provide time limited specialist financial recovery consultancy support. This engagement was subject to appropriate approval and oversight through NHSE and supported delivery of the Trust's financial recovery and improvement activity.

The Trust also utilised Teneo to provide time limited programme support to the Bath and North East Somerset, Swindon and Wiltshire Hospitals Group. This support focused on the development and transition of group governance, risk and assurance arrangements, supporting the safe implementation of the emerging Group model while maintaining full statutory accountability of individual Trust Boards.

In addition, the Trust used the services of Steve Webster, Financial Improvement Director, to provide senior financial improvement and recovery support as part of system planning arrangements across the BSW Hospitals Group. This provided additional expertise and capacity at a system level and supported consistent oversight and delivery of financial recovery activity while avoiding duplication of senior roles within individual Trusts.

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, Sulis Hospital and RUH Charitable Fund. Over the 12 months to 31 March 2026, the Group achieved the following performance:

	2025/26			2024/25	
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	85,640	428,353		83,456	377,287
Total bills paid within target	78,448	370,943		78,381	341,612
Percentage of bills paid within target	**91.60%**	**86.60%**		**93.90%**	**90.50%**
NHS					
Total bills paid in the year	1,882	26,587		1,739	29,114
Total bills paid within target	1,430	14,388		1,326	17,742
Percentage of bills paid within target	**76.00%**	**54.10%**		**76.30%**	**60.90%**
Total					
Total bills paid in the year	**87,522**	**454,940**		**85,195**	**406,401**
Total bills paid within target	**79,878**	**385,331**		**79,707**	**359,354**
Percentage of bills paid within target	**91.30%**	**84.70%**		**93.60%**	**88.40%**

Better Payment Practise Code includes all external creditors paid in year and therefore will not match to non-staff operating expenses included in the statement of financial position

Total interest paid to suppliers under the Late Payment of Commercial Debts Act 1998 was £3,719 (£0k in 2024/25).

Enhanced quality governance reporting

The Trust prepares a Quality Account in line with national guidance as a matter of good practice. The accuracy of the Quality Account, and assurance that it presents a balanced view of the controls in place to maintain and improve quality, is provided through internal review, stakeholder engagement and consultation, with the Board using this process alongside routine quality reporting to assure itself that quality governance arrangements are effective. The Trust's Quality Account for 2025/26 will be published on the Trust's website by 30 June 2026.

Quality is embedded within the Trust's overall strategy, *The people we care for*. Quality priorities and targets are aligned to clinical divisions, with performance monitored through the Trust-wide Integrated Performance Report (IPR). The IPR is reviewed monthly through the Trust's governance structure and escalated to the Board of Directors, supporting oversight and challenge and providing assurance on patient safety, clinical effectiveness and patient experience.

During the year, the Board received regular reports on key quality indicators and used this information to provide challenge and oversight and to support continuous improvement.

Quality Report 2025/26

Delivering high quality, safe and compassionate care remains the Trust's foremost priority. Throughout 2025/26, the Trust faced operational and financial pressures, particularly within urgent and emergency care and workforce capacity. Despite these challenges, our staff remained focused on patient safety, clinical effectiveness and improving the experience of those who use our services.

This Quality Report sets out our performance against nationally mandated and locally agreed quality priorities for 2025/26. It provides an assessment of where we have delivered good outcomes for patients and where improvement is still required. The report draws on assurance provided to the Board through the Integrated Performance Report and associated quality governance arrangements, including routine reporting on risks, performance trends and delivery of improvement actions.

The Board is committed to learning from safety events, listening to patients and carers, and supporting our workforce to deliver continual improvement, using this information to inform decision making and prioritisation throughout the year. The actions described in this report will continue into 2026/27 as part of our wider recovery and improvement programmes.

Overview of Quality Priorities for 2025/26

During 2025/26, the Trust's quality priorities were aligned to national NHS priorities and local risks identified through the risk register and Integrated Performance Report. The principal quality focus areas were:

- Reducing avoidable harm, including pressure ulcers and inpatient falls
- Improving patient safety incident response and learning through the Patient Safety Incident Response Framework (PSIRF)
- Maintaining safe staffing levels
- Improving access to timely diagnosis and treatment
- Strengthening patient and carer experience, particularly relating communication and complaints handling

The quality priorities we set out were:

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

Patient Safety

Patient Safety Incidents and Learning

The Trust manages patient safety incidents in accordance with national guidance. From April 2024, the Trust transitioned to the Patient Safety Incident Response Framework (PSIRF). This has supported a systems-based approach to learning and improvement, moving away from routine investigation towards proportionate learning responses. During 2025/26, a number of Patient Safety Incident Investigations (PSIIs) were commissioned in response to safety events. Learning from incidents was reviewed through divisional and Trust-wide quality governance structures, with themes, learning and assurance reports escalated to the Board via the Integrated Performance Report, and actions tracked through established improvement plans.

Pressure Ulcers

Pressure ulcer prevalence remained a key patient safety concern during the year. Monthly reporting demonstrated variation in the number of category 2 and category 3 hospital-acquired pressure ulcers, with particular increases observed during periods of heightened bed pressures and emergency care demand.

Themes identified through incident review included:

- Prolonged stays in Emergency Department and assessment areas due to bed pressures
- Unwarranted variation in skin checks and off-loading, particularly in the context of medical devices
- Increased vulnerability among patients with multiple co-morbidities or approaching end of life

Divisional improvement actions were implemented with oversight from specialist services, including tissue viability expertise. Reducing pressure ulcers remains a priority for 2026/27. Year-end aggregated pressure ulcer rates are not yet available and will be confirmed in future reporting.

Falls

Inpatient falls resulting in moderate harm were reported throughout 2025/26. While absolute numbers remained low, several incidents triggered further review. As a result, a Trust-wide patient safety incident investigation (PSII) into falls was commissioned, focusing on contributory factors and system learning. Learning was incorporated into falls prevention work plans, with progress and assurance reported through quality governance structures and escalated to the Board.

Infection Prevention and Control

The Trust continued active surveillance of healthcare associated infections during the year, including Clostridioides difficile, E. coli bacteraemia and other mandatory bloodstream infection metrics.

Clostridioides difficile cases were reported at the annual threshold, with a reduction of 28 cases compared with the previous year. However, thresholds were breached for E. coli bacteraemia, MRSA

bacteraemia and Klebsiella bloodstream infections, while performance for Pseudomonas aeruginosa remained below the annual threshold.

No consistent Trust-wide contributory system factors were identified; however, ongoing surveillance and thematic review remain in place to ensure any emerging patterns are identified and acted upon. For E. coli bacteraemia in particular, a contributory theme was an increase in the number of elderly and frail patients presenting with urinary tract infections. Seasonal pressures, including winter respiratory illness, also contributed to increased infection risk during periods of operational pressure.

Improvement actions focused on hydration, catheter management and environmental hygiene, with learning shared across clinical divisions through established infection prevention and control governance arrangements, and assurance provided to the Board on trends, contributory factors and mitigating actions.

Mortality Surveillance

Enhanced mortality surveillance arrangements and triangulation of safety events were strengthened during the year with outputs used to inform Board assurance on patient safety and quality of care. This work will continue in 2026/27 to strengthen assurance and learning.

Maternity and perinatal quality and safety

Quality and safety within maternity and neonatal services were supported through a comprehensive governance framework, providing assurance to the Board on clinical outcomes, patient safety and continuous improvement. Perinatal deaths and serious incidents were reviewed in line with national requirements using the Perinatal Mortality Review Tool (PMRT) and the Patient Safety Incident Response Framework, with learning identified, shared and tracked through multidisciplinary governance processes. A locally increased stillbirth rate was observed in 2024 and 2025 compared to previous years; detailed case cohort review did not identify consistent themes or specific areas of concern to inform targeted improvement activity, and ongoing surveillance continues. All eligible incidents were reported to the Maternity and Newborn Safety Investigations (MNSI) programme in line with national requirements.

The service maintained a strong focus on continuous improvement, informed through the triangulation of audit findings, incident review, workforce data and service user feedback. Key areas of focus included postnatal care, medicines management, foetal monitoring, neonatal hypoglycaemia pathways and obstetric ultrasound care pathways. These areas were identified through cumulative review of service insights and continue to inform improvement priorities. Progress has also been made in addressing maternity support worker workforce challenges, with targeted engagement, including staff focus groups, informing actions to improve retention and wellbeing.

Workforce remains a key determinant of quality and safety. Whilst overall stability improved, challenges remain in achieving postnatal staffing levels aligned to Birthrate Plus® acuity standards, with a reassessment planned in 2026/27 to support future workforce modelling. Neonatal services experienced periods of increased acuity associated with regional cot pressures, impacting workforce capacity. Risks relating to workforce capacity, system pressures and wider national challenges were identified, recorded on the Trust risk register and actively managed through established governance processes.

Throughout the year, patient and staff voice remained central to quality oversight, with insight from families, staff and the Maternity and Neonatal Voices Partnership informing service priorities. Overall, the Board received assurance that maternity and perinatal services remained safe, well governed and committed to continuous learning and improvement, with clear priorities identified for 2026/27.

Clinical Effectiveness

Access to Diagnosis and Treatment

Performance against national access standards remained challenging during 2025/26, reflecting system-wide demand pressures:

- **Diagnostics (DM01)** performance improved during the year but remained below the national standard, with recovery plans in place
- **Cancer standards** showed periods of both improvement and deterioration, particularly across the 28-day Faster Diagnosis and 62-day pathways
- **Referral to Treatment (RTT)** performance demonstrated gradual improvement, with the Trust successfully eliminating waits over 65 weeks by the end of the year

Recovery actions were supported by additional capacity, pathway redesign, and targeted improvement programmes. The Trust continues to work closely with system partners to address constraints beyond the acute setting.

Same Day Emergency Care (SDEC)

Same Day Emergency Care provision expanded during 2025/26, contributing to improved flow and reduced length of stay for selected patient cohorts. By mid-year, performance met or exceeded the national ambition of 40% of medical non-elective zero-day length of stay patients being managed through SDEC pathways.

Safe Staffing and Workforce Impact

Maintaining safe staffing levels was a significant challenge during 2025/26. Day shift fill rates for registered nurses and support staff frequently fell below target, driven by:

- Vacancies in high-pressure clinical areas
- Sustained sickness absence, particularly related to anxiety, stress and depression
- Seasonal illness and workforce availability pressures

Despite these challenges, mitigation measures were put in place, including escalation processes, targeted recruitment, use of temporary staffing, and enhanced senior oversight to maintain patient safety.

Patient Experience

Friends and Family Test and Feedback

Patients continued to report positively on the care received, with high levels of recommendation through the Friends and Family Test. Narrative feedback consistently highlighted compassionate care and professional staff interactions.

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?'* The Trust received ratings from over 30,000 patients who ranked their experience between 1 (very good) and 5 (very poor) of the hospital. Over 94% of our patients rated their experience as positive. The area that received most feedback was staff attitude. The less positive experiences related to staff attitude, waiting times and communication. The information is included in quarterly patient experience reports to the Patient

Experience Committee, with key themes, risks and assurance escalated to the Board where actions for improvement are identified.

Complaints and Concerns

The Trust notes a gradual increase in the volume of formal complaints during 2025/26. Key themes included:

- Concerns about clinical care relating to waiting times and appointments
- Communication and delays
- Experience within emergency and assessment areas

While the majority of concerns were acknowledged promptly, performance against complaint response time targets remained below the Trust standard across several months, however the Trust is working with families to agree achievable timescales.

Improvement actions included:

- Strengthening divisional oversight of complaints
- Supporting earlier resolution where appropriate
- Using complaint learning to inform service improvement

Improving complaint response timeliness remains a priority for 2026/27.

Improving Patient and Carer Experience

Improving patient and carer experience was a core quality objective throughout the year.

Key areas of focus included:

- Strengthening communication with patients and families, particularly during periods of prolonged waiting
- Improving clarity of information provided at discharge which continues into this year
- Enhancing support during maternity and perinatal services, including feedback from families

In maternity and neonatal services, patient feedback remained largely positive. Targeted improvements were progressed around antenatal education, postnatal information, and digital enhancements, including preparation for implementation of digital cardiotocography.

Learning from complaints, concerns and feedback continued to inform improvement actions, with themes reviewed through quality governance arrangements and routinely reported to the Board to support oversight and scrutiny.

Quality Governance and Assurance

Quality performance and improvement were overseen through established governance arrangements, with assurance provided to the Board via the Integrated Performance Report. Quality metrics were considered alongside operational and workforce information, enabling early identification of risk, triangulation of issues and targeted improvement.

The Board received routine updates on patient safety, clinical effectiveness and patient experience, including learning from harm, mortality surveillance, complaints and patient feedback. The Board used this information to provide effective challenge, to seek assurance on the adequacy of controls and

actions in place, and to monitor delivery of improvement plans, assuring itself that appropriate actions were taken to maintain and improve quality throughout the year.

Looking Ahead to 2026/27

The Trust recognises that maintaining and improving quality will continue to require sustained focus in the context of ongoing recovery. Key priorities for 2026/27 include:

- Further reduction in avoidable patient harm
- Strengthening safe staffing and workforce wellbeing
- Improving responsiveness to patient feedback and complaints
- Sustaining recovery in access and flow across care pathways

The Board remains committed to supporting continuous improvement and delivering safe, effective and compassionate care for all patients.

Stakeholder relations

Anchor organisations

The Trust continues to fulfil its role as an anchor organisation, working with system and civic partners to support population health, reduce inequalities and contribute to local economic and social development.

During 2025/26, the Trust's anchor activity focused on delivering the Health Inequalities Programme, supporting local economic strategies in Bath and North East Somerset and Wiltshire, strengthening community engagement, and increasing understanding of the Trust's role within the communities it serves. Delivery has been supported through partnership working with Bath and North East Somerset Council, the University of Bath and Bath Spa University.

Key activity during the year included progress on the Trust's heat decarbonisation programme, supported by a £21.6m government grant. This programme will replace ageing heating infrastructure with more energy-efficient systems, improving air quality for patients, staff and the local community and reducing carbon emissions under the Trust's direct control by an estimated 25% by 2030.

The Trust also continued to support local employment, skills development and supply chains through careers engagement, partnership working with educational institutions and local procurement initiatives. As a service provider, the Trust progressed work to reduce health inequalities, including initiatives to improve digital inclusion, support public health and move care closer to home. This included expanding outpatient provision at Frome Medical Practice to include chemotherapy services.

Strategic Partnerships

The Trust has continued to strengthen its strategic partnerships, particularly with Bath and North East Somerset Council, the University of Bath and Bath Spa University. These partnerships support joint working across research, innovation, workforce development and service improvement.

During 2025/26, collaboration with the University of Bath continued through shared research activity and exploration of future opportunities to support the Trust's strategic objectives, including student-led projects aligned to organisational priorities. In partnership with Bath Spa University, the Trust hosted a creative policy fellow and supported student activity focused on improving the use of data for strategic alignment. Regular partnership steering group meetings provide oversight and coordination, enabling partners to combine expertise and capability to support improvements for patients, staff, students and the wider community.

Voluntary, Community and Social Enterprise (VCSE) Sector

The Trust works closely with a range of Voluntary, Community and Social Enterprise (VCSE) partners to support patients, visitors, staff and the wider community. VCSE organisations based on or working closely with the Trust include ReMind, Designability and Bath Radio.

The Community Wellbeing Hub, located in the RUH Atrium, continues to provide access to a range of health and wellbeing services for patients, families, visitors and staff. Delivered in partnership with Bath and North East Somerset Council, Age UK, HCRG, the Trust and VCSE organisations across the community, the Hub offers support including smoking cessation services, housing, employment and income advice, and signposting to services that support safe and timely discharge from hospital.

The Trust is also supported by the Friends of the RUH, whose volunteers make a significant contribution to patient experience through activity on wards and the operation of the Friends Shop and Friends Café. Funds raised through these services are reinvested to support enhancements to patient care and the hospital environment.

Training and development

The Trust continues to play a significant role in education, training and workforce development. The RUH hosts the Bath Academy as a teaching hub for Bristol Medical School, supporting the education and training of nearly 400 undergraduate medical students, equating to approximately 9,000 student weeks each year. Teaching is delivered by around 25 Consultant Coordinators and Tutors, supported by eight Clinical Teaching Fellows, across both ward-based and classroom settings, including the Trust's Simulation Suite.

The Trust also continues to develop a flexible and sustainable workforce through non-medical roles, including Advanced Clinical Practitioners, Nurse Practitioners and Physician Associates. Multi-professional skills days and education programmes support integrated learning and development across clinical and professional groups.

Widening participation remains a priority, with initiatives designed to support access to employment and training opportunities. These include careers events, outreach work with local schools and colleges, virtual work experience, and the Project SEARCH supported internship programme for young people with a learning disability or autism.

The Trust's Clinical Skills programme and clinical practice facilitator role provide support to learners across clinical areas, ensuring consistent, high-quality skills training and practical competency assessment in clinical practice.

Primary care services

In 2024/25, the Trust took over the lease for nine consulting rooms and one minor operations theatre at Frome Medical Practice, with the aim of maximising the volume and diversity of outpatient services delivered locally and moving care closer to home for patients living in Frome, Shepton Mallet, Warminster and the surrounding area. In 2025, a Systemic Anti-Cancer Treatment Centre was opened at the site, providing chemotherapy, immunotherapy, hormonal therapy and targeted therapy.

Health Innovation West of England

The Trust hosts and works in partnership with Health Innovation West of England to support collaboration, innovation and the spread of best practice to improve patient safety, quality of care and population health outcomes across the South West. During 2025/26, clinical teams continued to participate in regional innovation programmes supporting service improvement, including work on preventing caesarean birth surgical site infections and improving non-invasive ventilation.

Engagement with patients, communities and partners

The Trust continued to engage with local communities and stakeholder organisations through a range of formal and informal mechanisms, including partnership forums, patient and public engagement activity and statutory meetings. Feedback from Healthwatch and local stakeholder groups continues to inform service improvement and patient experience work, alongside direct engagement with patients and families.

Statement as to disclose to the auditor

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

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

Income Disclosures

Income from the provision of goods and services for the purposes of health services in England is greater than the income from the provision of goods and services for any other purpose for Royal United Hospitals Bath NHS Foundation Trust. Income received from other sources include private patients, car parking and catering, details of these are provided in the accounts. Any net surplus generated from these additional activities serves to enhance patient care and maintaining the quality of the estate.

Joint ventures

The Trust did not hold any joint venture arrangements during 2025/26.

The Wiltshire Health and Care LLP contract, previously delivered as a joint venture with Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust, ceased on 1 April 2025 and the entity is no longer trading.

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. Kheelna Bavalia, the Trust's Chief Medical Officer, is a Director of Sulis Hospital Bath Ltd, and Simon Sethi participates in the governance and oversight of the subsidiary. The Directors have declared their respective interests to both boards.

The RUH Board has established a Subsidiary Oversight Committee to provide assurance that the Trust's objectives in acquiring Sulis Hospital are being achieved, and that the hospital is performing well, delivering safe, high-quality care, complying with regulatory requirements and managing its finances appropriately.

RUH Charitable Funds

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

Remuneration Report

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

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

The report sets out how the remuneration of senior managers is determined. A 'senior manager' is defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust. For the purposes of this report, this has been concluded to relate to all Executive and Non-Executive members of the Board of Directors, reflecting their responsibility for the leadership and oversight of the Trust and, where applicable, the Group as a whole.

Annual Statement on Remuneration

Chair of the Remuneration Committee's annual statement on remuneration

The Board of Directors has established a Nominations and Remuneration Committee with delegated responsibility for matters relating to the appointment, remuneration and terms of service of the Chief Executive and Executive Directors. The Committee is chaired by the Trust Chair and is comprised solely of Non-Executive Directors.

The Committee is responsible for setting and agreeing Executive Director remuneration, including salary, benefits, contractual terms and arrangements for termination of employment. The Committee also considers remuneration matters arising from senior leadership appointments and changes required to support operational continuity and delivery of the Trust's strategic objectives.

During 2025/26, the Committee reviewed the remuneration of Executive Directors, having regard to the Very Senior Managers pay award and guidance issued by NHS England. In line with the NHS Very Senior Managers Pay Framework, pay decisions were subject to local consideration, affordability and role eligibility. A 3.25 per cent pay award was approved for eligible Executive Directors and Very Senior Managers, backdated to 1 April 2025.

The Committee collaborated closely with the Chief Executive in reviewing Executive Director performance during the year, with performance considerations informing remuneration decisions where appropriate. In line with its Terms of Reference, the Chair advised the Committee on the performance of the Chief Executive. The Committee also considered a number of interim and substantive senior appointments to ensure leadership continuity during a period of organisational change.

In performing its duties, the Committee had regard to the Trust's Equality, Diversity and Inclusion Policy and sought to ensure that remuneration decisions were fair, transparent and proportionate. The Committee recognises the need to attract and retain experienced senior leaders while remaining mindful of public accountability, internal pay relativities and the wider financial environment in which the Trust operates.

Nominations and Remuneration Committee - Membership and Attendance during 2025/26:

This section provides details of the membership of the Nominations and Remuneration Committee and attendance during 2025/26, supporting transparency over the Committee's operation and oversight arrangements.

Name	Role	Committee Membership
Liam Coleman	Non-Executive Director (Chair)	Part year (from July 2025)
Sumita Hutchison	Non-Executive Director (Interim Vice-Chair)	Full year
Paul Fairhurst	Non-Executive Director	Full year
Joy Luxford	Non-Executive Director	Part year (from May 2025)
Simon Harrod	Non-Executive Director	Full year
Antony Durbacz	Non-Executive Director	Full year
Nigel Stevens	Senior Independent Director	Part year (to June 2025)
Alison Ryan	Non-Executive Director	Part year (to June 2025)
Paul Fox	Non-Executive Director	Part year (to April 2025)
Hannah Morley	Non-Executive Director	Part year (to January 2026)

The Committee met on seven occasions during the year. Individual attendance is shown below:

Name	Attended		Name	Attended
Liam Coleman	4/5		Antony Durbacz	5/7
Sumita Hutchison	5/7		Nigel Stevens	0/2
Paul Fairhurst	6/7		Alison Ryan	2/2
Joy Luxford	5/6		Paul Fox	1/1
Simon Harrod	6/7		Hannah Morley	2/6

The Committee was supported by the Chief Executive, Chief People Officer, Managing Director and Head of Corporate Governance. No external remuneration consultants were engaged during the year.

2025/26 decisions on remuneration

During the year, the Committee agreed the following:

- **3 April 2025** – The Committee approved a number of arrangements to support leadership capacity and delivery across the BSW Hospitals Group. This included the creation of the Group Transformation and Innovation Officer and Group Strategy Officer roles, the appointment of Simon Truelove as Interim Chief Finance Officer, and the appointment of Bernie Bluhm as Director of Urgent Care Recovery on a fixed-term basis noting that the post would be funded by BSW ICB.
- **4 June 2025** – The Committee approved the appointment of John Palmer as Managing Director of the Royal United Hospitals Bath NHS Foundation Trust, at Very Senior Manager level, in line with Trust policy.

- **2 July 2025** – Due to the resignation of the substantive Chief Operating Officer, the Committee approved the appointment of Bernie Bluhm as Interim Chief Operating Officer, as a non-voting member of the Board, for a maximum period of six months, on existing remuneration arrangements.
- **6 August 2025** – The Committee approved the application of the 2025/26 national Very Senior Manager pay award to eligible Executive Directors and Very Senior Managers.
- **3 September 2025** – The Committee approved the application of the national Very Senior Manager pay award to the Managing Director, ensuring parity with equivalent roles across the BSW Hospitals Group. The Committee also approved interim Chief Finance Officer arrangements for the Trust during the transition to a Group Chief Finance Officer model.
- **3 December 2025** – The Committee approved the recruitment of the Chief Medical Officer role on a substantive basis, including agreement to proceed with open external advertisement.
- **January 2026** (via correspondence) – The Committee approved the extension of the Chief Medical Officer secondment to enable completion of the substantive recruitment process.
- **4 February 2026** – Due to the resignation of the Chief Nursing Officer, the Committee approved the recruitment of the Chief Nursing Officer role on a substantive basis to support leadership continuity and operational stability.

Senior Managers' Remuneration Policy

The Trust's remuneration policy applies to senior managers, defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. This includes Executive and Non-Executive Directors.

With the exception of the Chief Executive and Executive Directors, employees of the Trust are remunerated in accordance with national NHS pay arrangements. Non-medical staff are paid in line with the NHS Agenda for Change pay structure. Medical staff are remunerated in accordance with national terms and conditions of service for doctors and dentists.

The Chief Medical Officer is employed under the national Consultant Contract and associated Medical Terms and Conditions. An additional management allowance is payable to reflect the additional responsibilities associated with the role of Chief Medical Officer.

Policy framework

The remuneration of the Chief Executive and Executive Directors is determined by the Board of Directors' Nominations and Remuneration Committee. In doing so, the Committee acts in accordance with the NHS Very Senior Managers Pay Framework and relevant guidance issued by NHS England.

Remuneration is set within the context of:

- the NHS Very Senior Managers Pay Framework (effective from 1 April 2025)
- the Trust's strategic objectives
- affordability and public accountability
- benchmarked pay ranges across comparable NHS organisations

The Committee considers role scope and complexity, market benchmark data, individual performance, affordability and internal pay relativities when determining remuneration. The Trust confirms that it complied with the NHS Very Senior Managers Pay Framework during 2025/26. Where required, appropriate approvals were sought and obtained. No departures from the Framework occurred during the year.

Key components of remuneration

Component	Description	Maximum payable
Salary	Executive Director salaries are determined by the Nominations and Remuneration Committee, having regard to role scope and complexity, delivery of the Trust's strategic objectives and individual performance. All Executive Director remuneration is subject to satisfactory performance in line with contractual terms, with the Chief Executive's performance reviewed annually by the Trust Chair.	No prescribed maximum. Salaries are set within the applicable NHS Very Senior Managers pay ranges, informed by market benchmarking.
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.	Variable
Performance-related pay	No such scheme operates at the Trust.	£0.
Pension	Standard pension arrangements are in place.	As per scheme rules

Application of the Policy in 2025/26

During the year:

- a 3.25% Very Senior Managers pay award was approved for eligible Executive Directors and Very Senior Managers, backdated to 1 April 2025.
- interim appointments and management allowances were approved to ensure continuity of leadership.
- certain senior managers exited the Trust through resignation or contract expiry.

No long-term or short-term performance-related bonus schemes operated during the year.

Appraisal and performance assessment of Executive Directors

All Executive Directors, including the Chief Executive, are subject to an annual appraisal process. The Chief Executive is appraised by the Chair, supported by Non-Executive Directors. Executive Directors are appraised by the Chief Executive and/or Managing Director. The Senior Independent Director leads the appraisal of the Chair.

Individual objectives are set annually and are aligned to the Trust's strategic priorities. Performance against objectives is reviewed during the year through established performance and governance processes.

The Board's Nominations and Remuneration Committee is responsible for determining the remuneration and terms and conditions of employment for Executive Directors and other Very Senior Managers. In reaching decisions, the Committee takes into account individual performance, affordability, any relevant national guidance, and external benchmarking information.

The Council of Governors is responsible for the appraisal and remuneration arrangements for Non-Executive Directors.

Chair and Non-Executive Directors remuneration 2025/26

The Council of Governors has established a Nominations and Remuneration Committee which is responsible for the appointment, appraisal and remuneration of the Trust Chair and Non-Executive Directors.

In June 2025, the Council of Governors approved the appointment of Liam Coleman as Interim Joint Chair of the Royal United Hospitals Bath NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust, commencing on 1 July 2025, on a time-limited basis. The role is shared across both organisations, with remuneration costs apportioned equally between the two trusts (50:50).

The Chair and Non-Executive Directors receive an annual fee, with additional responsibility payments for specific roles. Remuneration disclosed in this report reflects the arrangements in place and amounts paid by the Trust during 2025/26.

Chair

Name	Role	Period in post	Remuneration paid per annum by RUH (£)
Alison Ryan	Chair of the Trust Board and Council of Governors	1 April 2025 to 30 June 2025	*£49,950*
Liam Coleman	Interim Joint Chair of the Trust Board and Council of Governors	From 1 July 2025	*£40,000*

The Interim Joint Chair role is shared with another NHS foundation trust. Remuneration disclosed reflects the amount paid by the Royal United Hospitals Bath NHS Foundation Trust.

Non-Executive Directors and additional responsibility payments

Role	Annual Remuneration
Vice-chair	£24,500
Non-Executive Director	£13,000
Senior Independent Director additional payment	£1,500
Chair of Audit and Risk Committee additional payment	£1,500
Chair of other Board Committees additional payment (maximum one payment)	£1,000

Annual Report on Remuneration

Service Contracts obligations

With the exception of the Chief Operating Officer, who is employed on a fixed term contract until September 2026, the Chief Executive and Executive Directors are employed on permanent contracts, which may be terminated by either party subject to notice periods of six months. The Trust intends to undertake substantive recruitment to the Chief Operating Officer post during 2026/27.

Contracts are subject to normal employment legislation and the Trust's policies and procedures.

Disclosures in accordance with the Health and Social Care Act

Director and Governor expenses etc

Information regarding Director and Governor expenses during the reporting period are outlined below:

Directors' expenses

During the year, taxable expenses of £17,515.01 were paid to Executive Directors and £3,607.46 to Non-Executive Directors. These amounts relate to expenses incurred wholly, necessarily and exclusively in the performance of duties.

The remuneration tables within this report include all Executive and Non-Executive Directors who served during the year.

Governors' Expenses

Governors are not remunerated but may claim reasonable expenses incurred in the performance of their duties. Expenses of £1,034.36 were paid to Governors during the year ended 31 March 2026.

Senior Managers' Remuneration

The definition of 'Senior Managers' is those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Royal United Hospitals Bath NHS Foundation Trust. This includes Executive Directors and other Very Senior Managers who meet this definition, whether or not they are members of the Board.

BSW Remuneration Committee in Common

As part of the transition to a BSW Hospitals Group governance model, the Trusts agreed to establish Board Remuneration, Nominations and Appointments Committees in Common to support aligned decision making in relation to the appointment and remuneration of shared executive roles.

The Terms of Reference for the Committees in Common were approved by the BSW Hospitals Group Joint Committee in July 2025, at which point the arrangements were brought into effect. The Terms of Reference were subsequently updated in November 2025 to reflect minor amendments, including clarification of quoracy and chairing arrangements.

Each Trust's statutory Remuneration Committee retains independent accountability for its decisions, which are taken concurrently through the Committees in Common arrangements and recorded as decisions of the respective Trust committees.

Attendance at the Remuneration Committee in Common during 2025/26

Remuneration Committees in Common meeting attendance

Meeting date	RUH attendance	GWH attendance	SFT attendance	Comments
30 July 2025	Present	Present	Present	First formal meeting following establishment of the Committees-in-Common
29 September 2025	Present	Present	Present	Quorate for all Trusts
22 October 2025	Present	Present	Present	Quorate for all Trusts
17 December 2025	Present	Present	Present	Quorate for all Trusts
19 January 2026	Present	Present	Present	Quorate for all Trusts

Decisions taken by written circulation

Date	Nature of decision	RUH participation	GWH participation	SFT participation	Notes
January 2026	Appointment and remuneration of Group Chief Risk Officer	Confirmed by circulation	Confirmed by circulation	Confirmed by circulation	Circulation agreed at the January meeting. Quorum of responses received from all Trusts.
February 2026	Approval to recruit Group Chief Digital & Information Officer & associated remuneration	Confirmed by circulation	Confirmed by circulation	Confirmed by circulation	Quorum of responses received from all Trusts.

All formal meetings of the Remuneration Committees in Common during the year were quorate for each participating Trust. Where meetings could not be convened and a decision was time critical, the Committees agreed to take decisions by written circulation in accordance with the approved Terms of Reference. Decisions taken in this way were supported by full papers, confirmed by a quorum of members from each Trust, and subsequently noted to ensure a complete audit trail.

Remuneration decisions during 2025/26

During 2025/26, the Boards' statutory Remuneration Committees met in common to support aligned decision making in respect of the appointment and remuneration of shared executive roles across the BSW Hospitals Group. Each Trust's Remuneration Committee retained independent accountability for its decisions, which were taken concurrently through the Committees in Common arrangements and recorded as decisions of the respective Trust committees.

The Committees in Common met formally during the year, including meetings held in July, September, October and December 2025, and January 2026. Where appropriate, the Committees also agreed to take certain time critical decisions by written circulation between meetings, in line with the approved Terms of Reference.

Key decisions taken by the Boards' Remuneration Committees in Common during 2025/26 included the following.

- **30 July 2025** – The Committees approved the application of the 2025/26 national Very Senior Manager pay award to the Group Chief Executive Officer, in line with national guidance. The Committees also agreed that future pay awards for Group roles should be explicitly linked to appraisal outcomes and the setting of clear annual objectives.
- **30 July 2025** – The Committees considered the development of the Group executive leadership structure, approving revised job descriptions and remuneration frameworks for Group executive roles and noting the introduction of interim arrangements to support delivery of the Group operating model. This included initial review of executive portfolios and alignment to the national VSM framework.
- **29 September 2025** – The Committees approved the appointment and remuneration of the Group Strategic Clinical Transformation Director, following an internal recruitment process, and noted that the postholder would remain on existing contractual terms in line with agreed arrangements.
- **22 October 2025** – Following completion of consultation on the Group leadership model, the Committees approved the appointment and remuneration of the Group Chief Finance Officer and Group Chief People Officer, including confirmation of start dates. The Committees also approved associated changes to executive roles and responsibilities and approved revisions to job descriptions to reflect updated Group portfolios.
- **22 October 2025** – The Committees reviewed the structure and balance of Group executive roles and approved updates to executive job titles and portfolios, including clarification of responsibilities across strategy, transformation, digital, clinical transformation and people functions. These changes clarified responsibilities and strengthened the separation of assurance, delivery and leadership roles within the Group executive structure.
- **17 December 2025** – The Committees approved the establishment of a new Group Chief Risk Officer role, including the role purpose, recruitment approach and remuneration framework. At the same meeting, the Committees approved progression to open competition for the Group Chief Strategy Officer role following review of interim arrangements and approved further refinements to Group executive portfolios and role titles.
- **19 January 2026** – The Committees approved interim executive arrangements to support continuity of strategic leadership pending substantive recruitment, confirming the parameters and duration of interim cover in line with the approved governance framework.

Following the formal meeting held in January 2026, a meeting scheduled for February 2026 was postponed. In order to avoid delay to essential executive appointments, the Committees agreed that

specific decisions could be taken by written circulation in line with the approved Terms of Reference. These decisions included:

- **January 2026 (by circulation)** – approval of the appointment and remuneration of the Group Chief Risk Officer, following completion of the agreed interview process.
- **February 2026 (by circulation)** – approval to proceed with external recruitment for the Group Chief Digital and Information Officer role, including approval of the associated remuneration level, following prior approval of the role description.

All decisions taken by correspondence were supported by appropriate papers, confirmed by a quorum of members from each Trust, and subsequently noted to ensure a complete and transparent audit trail.

Collectively, these decisions supported the transition to a Group executive leadership model, including the review and refinement of roles, responsibilities and job titles, while maintaining transparency, proportionality and alignment with national pay guidance. No discretionary performance-related pay was awarded outside national frameworks during the year.

Group Director remuneration arrangements

Group Directors are employed under joint arrangements across the BSW Hospitals Group. Where an individual undertakes a Group-level role, their remuneration is apportioned and charged across the three participating foundation trusts in line with agreed cost-sharing arrangements. Each Trust discloses only the proportion of remuneration that relates to services provided to that Trust during the financial year. The total remuneration paid to each individual across the Group is determined in accordance with the NHS Very Senior Manager Pay Framework and relevant local approvals.

Senior Managers' Remuneration (subject to audit)

Remuneration for Senior Managers for 2025/26:	Salary and Fees (bands of £5,000)	All taxable benefits (total to the nearest £100)	Annual performance related bonuses (bands of £5,000)	Long-term performance related bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
Cara Charles-Barks Chief Executive**	95 - 100	700	-	-	165.0 - 167.5	260 - 265
Simon Wade Group Chief Financial Officer (from 3 November 2025) **	20 - 25	-	-	-	92.5 - 95	110 - 115
Andrew Hollowood Managing Director (Interim) (until 31 August 2025) Group Clinical Transformation Officer (from 1 September 2025) **	145 - 150	-	-	-	60 - 62.5	210 - 215
Jude Gray Group Chief People Officer (from 3 November 2025) **	20 - 25	-	-	-	40 – 42.5	60 - 65
Judy Dyos Group Chief Strategic Officer (Interim) (from 2 February 2026) **	0 - 5	-	-	-	50 - 52.5	55 - 60
Mark Ellis Group Chief Risk Officer (from 1 September 2025) **	10 - 15	100	-	-	50 - 52.5	65 - 70
Jonathan Hinchliffe Group Chief Digital and Information Officer (Interim) (from 7 April 2025) **	125 - 130	-	-	-	0 – 2.5	125 - 130
Simon Sethi Director of Elective Recovery (from 1 April 2025) **	50 - 55	-	-	-	47.5 - 50.0	100 - 105
John Palmer Managing Director (from 1 September 2025)	110 - 115	-	-	-	30 - 32.5	140 - 145
Kheelna Bavalia Chief Medical Officer (Interim)	210 - 215	-	-	-	192.5 - 195	400 - 405
Paran Govender Chief Operating Officer (until 2 November 2025)	100 - 105	-	-	-	32.5 - 35.0	135 - 140
Bernadette Bluhm Chief Operating Officer (Interim) (from 21 July 2025)	80 - 85	-	-	-	17.5 – 20	100 - 105
Antonia Lynch Chief Nursing Officer	175 - 180	-	-	-	215 - 217.5	390 - 395
Jocelyn Foster Chief Strategic Officer (until 23 January 2026)	125 - 130	-	-	-	57.5 - 60.0	180 - 185

Remuneration for Senior Managers for 2025/26:	Salary and Fees (bands of £5,000)	All taxable benefits (total to the nearest £100)	Annual performance related bonuses (bands of £5,000)	Long-term performance related bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
Alfredo Thompson Chief People Officer (until 8 January 2026)	115 - 120	-	-	-	37.5 - 40.0	155 - 160
Christopher Brooks-Daw Chief of Staff (until 31 July 2025)	40 - 45	-	-	-	0 - 2.5	40 - 45
Simon Truelove Chief Finance Officer (Interim) (until 17 September 2025)	70 - 75	900	-	-	47.5 - 50.0	120 - 125
Elisabeth Walters Chief Finance Officer (until 30 June 2025)	40 - 45	-	-	-	0 - 2.5	40 - 45
Alison Ryan Chair	10 - 15	-	-	-	-	10 - 15
Liam Coleman Chair (Interim)*	30 - 35	500	-	-	-	30 - 35
Antony Durbacz Non-Executive Director	10 - 15	-	-	-	-	10 - 15
Paul Fairhurst Non-Executive Director	10 - 15	-	-	-	-	10 - 15
Paul Fox Non-Executive Director (until 30 April 2025)	0 - 5	-	-	-	-	0 - 5
Sumita Hutchinson Non-Executive Director	20 - 25	-	-	-	-	20 - 25
Hannah Morley Non-Executive Director (until 14 January 2026)	10 - 15	-	-	-	-	10 - 15
Nigel Stevens Non-Executive Director (until 30 June 2025)	0 - 5	-	-	-	-	0 - 5
Simon Harrod Non-Executive Director	10 - 15	-	-	-	-	10 - 15
Joy Luxford Non-Executive Director (from 1 May 2025)	10 - 15	-	-	-	-	10 - 15

* Indicates shared role between RUH & GWH - 50% of cost applied
** indicates BSW Group Role - 35% of cost applied

The following group roles provide executive leadership across RUH, SFT and GWH under a shared leadership arrangement. In accordance with HM Treasury's Financial Reporting Manual and the NHS Group Accounting Manual, the apportioned cost of remuneration is disclosed in the table above. The apportionment of the total salary and taxable benefit is carried out on the following basis. RUH 35%, GWH 35%, SFT 30%. The salary (disclosed in bands of £5k) provided is the total for the period in post during the financial year.

- Chief Executive - Cara Charles-Barks - £270k - £275k
- Chief Financial Officer - Simon Wade - £60k - £65k

- Strategic Clinical Transformation Director - Andrew Hollowood - £130k - £135k
- Chief People Officer - Jude Gray £55k - £60k
- Chief Strategic Officer - Judy Dyos £10k - £15k
- Chief Risk Officer - Mark Ellis £35k - £40k
- Chief Transformation & Innovation Officer (Interim) - Jonathan Hinchcliffe £370k - £375k
- Director of Elective Recovery - Simon Sethi £145k - £150k

Remuneration 2024/25

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 (bands of £5,000)	Long-term performance-related bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
Cara Charles-Barks Chief Executive	180 - 185	100	-	-	142.5 – 145.0	325 -330
Libby Walters Chief Finance Officer	175 - 180	-	-	-	180.0 - 182.5	360 - 365
Andrew Hollowood Chief Medical Officer / Interim Managing Director	235 - 240	-	-	-	260.0 - 262.5	495 - 500
Jocelyn Foster Chief Strategic Officer	145 - 150	-	-	-	25.0 - 27.5	175 - 180
Antonia Lynch Chief Nursing Officer	165 - 170	-	-	-	15.0 - 17.5	180 - 185
Alfredo Thompson Chief People Officer	140 - 145	-	-	-	25.0 - 27.5	170 - 175
Paran Govender Chief Operating Officer	170 - 175	-	-	-	102.5 - 105.0	275 -280
Christopher Brooks-Daw Chief of Staff	125 - 130	-	-	-	32.5 - 35.0	160 -165
Sarah Richards Chief Medical Officer (Acting) (from 1 November 2024 – 2 February 2025)	50 - 55	-	-	-	17.5 - 20	70 -75
Jon Lund Chief Finance Officer (Interim) (from 1 May 2024 – 11 March 2025)	140 - 145	-	-	-	292.5 – 295.0	435 - 440
Simon Truelove Chief Finance Officer (Interim) (from 17 March 2025)	5 - 10	-	-	-	0 - 2.5	5 -10
Kheelna Bavalia Chief Medical Officer (Interim) (from 3 February 2025)	35-40	-	-	-	5 – 7.5	40 - 45

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 (bands of £5,000)	Long-term performance-related bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
Alison Ryan Chair	45 -50	-	-	-	-	45 -50
Nigel Stevens Non-Executive Director	15 - 20	-	-	-	-	15 -20
Sumita Hutchinson Non-Executive Director	10 - 15	-	-	-	-	10 -15
Ian Orpen Non-Executive Director	5 - 10	-	-	-	-	5 - 10
Antony Durbacz Non-Executive Director	10 - 15	-	-	-	-	10 - 15
Paul Fairhurst Non-Executive Director	10 - 15	-	-	-	-	10 - 15
Hannah Morley Non-Executive Director	10 - 15	-	-	-	-	10-15
Paul Fox Non-Executive Director	10 - 15	-	-	-	-	10-15
Simon Harrod Non-Executive Director	5 - 10	-	-	-	-	5-10

Pension Benefits

Pension for Senior Managers for 2025/26:	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 2026 (bands of £5,000)	Lump sum at pension age, related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025	Real increase in Cash Equivalent Value Transfer	Cash Equivalent Transfer Value at 31 March 2026	Employer's Contribution to Stakeholder Pension	Not in post for the full year (no. of days)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Cara Charles-Barks Chief Executive	7.5 - 10	12.5 - 15	67 - 70	140 - 145	1,239	165	1,439	0	
Simon Wade Group Chief Financial Officer*	5 - 7.5	5 - 7.5	60 - 65	145 - 150	1,185	95	1,300	0	
Andrew Hollowood Managing Director (Interim) / Group Clinical Transformation Officer	2.5 - 5	0 - 2.5	110 - 115	285 - 290	2,575	86	2,691	0	
Jude Gray Group Chief People Officer*	2.5 - 5	0 - 2.5	15 - 20	0 - 5	266	36	322	0	
Judy Dyos Group Chief Strategic Officer (Interim)*	2.5 - 5.0	0 - 2.5	50 - 55	120 - 125	1,038	54	1,110	0	
Mark Ellis Group Chief Risk Officer*	2.5 - 5.0	0 - 2.5	35 - 40	85 - 90	645	40	703	0	
Jonathan Hinchliffe Group Chief Digital and Information Officer (Interim)*	0 - 2.5	0 - 2.5	0 - 5	0 - 5	0	0	0	0	359/265
Simon Sethi Director of Elective Recovery (from 1 April 2025)	2.5 - 5	0 - 2.5	40 - 45	90 - 95	708	37	763	0	

Pension for Senior Managers for 2025/26:	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 2026 (bands of £5,000)	Lump sum at pension age, related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025	Real increase in Cash Equivalent Value Transfer	Cash Equivalent Transfer Value at 31 March 2026	Employer's Contribution to Stakeholder Pension	Not in post for the full year (no. of days)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
John Palmer Managing Director*	0 - 2.5	0 - 2.5	35 - 40	0 - 5	480	24	545	0	212/365
Kheelna Bavalia Chief Medical Officer (Interim)	10 - 12.5	17.5 - 20	35 - 40	75 - 80	582	188	797	0	
Paran Govender Chief Operating Officer*	0 - 2.5	0 - 2.5	55 - 60	125 - 130	1,101	31	1,174	0	216/365
Bernadette Bluhm Chief Operating Officer (Interim)*	0 - 2.5	0 - 2.5	0 - 5	0 - 5	0	16	38	0	254/365
Antonia Lynch Chief Nursing Officer	10 - 12.5	20 - 22.5	65 - 70	160 - 165	1,312	245	1,577	0	
Jocelyn Foster Chief Strategic Officer*	2.5 - 5	0 - 2.5	30 - 35	60 - 65	648	54	732	0	298/365
Alfredo Thompson Chief People Officer*	2.5 - 5	0 - 2.5	45 - 50	0 - 5	629	31	688	0	283/365
Christopher Brooks-Daw Chief of Staff*	0 - 2.5	0 - 2.5	25 - 30	35 - 40	531	3	555	0	122/365
Simon Truelove Chief Finance Officer (Interim)*	2.5 - 5	2.5 - 5	55 - 60	140 - 145	1,223	56	1,362	0	170/365
Elisabeth Walters Chief Finance Officer*	0 - 2.5	0 - 2.5	65 - 70	160 - 165	1,613	0	1,502	0	91/365

*Figures pro rata as not in post for the full year.

The employer's contribution to Stakeholder Pension is zero for all individuals because the NHS Pension is a defined benefit scheme rather than a stakeholder.

The following group roles, provide executive leadership across RUH, SFT and GWH under a shared leadership arrangement. Pension calculations have been shown in full for all group roles in RUH, GWH and SFT Annual Report. Pensions have not been apportioned.

- Chief Executive
- Chief Financial Officer
- Strategic Clinical Transformation Director
- Chief People Officer
- Chief Strategic Officer
- Chief Risk Officer
- Chief Transformation & Innovation Officer (Interim)

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 (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 following BSW group roles, Chief Executive, Chief Finance Officer, Strategic Clinical Transformation Director, Chief People Officer, Chief Strategic Officer, Chief Risk Officer, Chief Transformation & Innovation Officer (interim) and Director of Elective Recovery provide executive leadership across RUH, SFT and GWH under a shared leadership arrangement.

In accordance with HM Treasury's Financial Reporting Manual and the NHS Group Accounting Manual, the salaries for group roles have been apportioned in the following basis, RUH 35%, GWH, 35% and SFT 30%. This may mean group roles will not identify as the highest paid roles within the Trust reporting.

The banded remuneration for the highest paid Director in the Royal United Hospitals Bath NHS Foundation Trust for the financial year 2025-26 was £210,000 - £215,000 (2024-25 £230,000 - £235,000). This is a change between years of minus 8.6% (2024-25 0%).

Total remuneration includes salary, non-consolidated performance-related pay and benefits in kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The calculation only includes Trust and charity staff and excludes staff relating to bank, and any owned subsidiaries.

For employees of the Trust as a whole, the range of remuneration in 2025-26 was from £180 to £403,716 (2024-25 £255 to £425,338). 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 1.22%. 19 employees received remuneration more than the highest-paid director in 2025-26 (2024-25 8).

	2024/25	2025/26	%age difference
Midpoint of the salary remuneration of Highest paid director	£232,500.00	£212,500.00	-8.60
Total of annualised Pay excluding the highest paid director, divided by FTE total of employees minus 1 FTE for the highest pay director	£55,294.80	£55,968.67	1.22

Highest Paid Director Bonus

No Director bonus or performance payments were made in 2025/26.

The highest paid Director is disclosed in the midpoint of bands of £5k, in previous years this was actual salary.

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.

2024/25	25th Percentile	Median	75th Percentile
Salary component of pay	£28,850.84	£40,313.53	£52,809.00
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 (%)	8.23	5.89	4.50

2025/26	25th Percentile	Median	75th Percentile
Salary component of pay	£29,186.96	£40,832.00	£51,994.04
Total pay and benefits excluding pension benefits	£29,186.96	£40,832.00	£51,994.04
Pay and benefits excluding pension: pay ratio for highest paid Director (%)	7.28	5.21	4.09

In the prior year overtime and additional payments were not included in the salary component of pay. This has been updated in line with the guidance.

The movement in pay ratio is due to the salary of the highest paid director reducing. This is due to the previous year highest paid director moving into a BSW group role for the full year.

Payments for loss of office

There has been one payment of £86,667 made to a senior manager during 2025/26 for loss of office. This was a redundancy payment that was calculated in line with NHS Terms and Conditions. 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 2025/26.

Cara Charles-Barks
Chief Executive (Accounting Officer)
26 June 2026

Staff report

Analysis of staff numbers

An analysis of average 2024/25 and 2025/26 staff numbers for the group is outlined below:

This information is subject to audit:

Group						
	2025/26 Permanent number	2025/26 Other number	2025/26 total number	2024/25 Permanent Number	2024/25 Other Number	2024/25 total number
Medical and dental	791	23	**814**	774	17	**791**
Ambulance staff	4	1	**5**	4	1	**5**
Administration and estates	993	64	**1,057**	963	76	**1,039**
Healthcare assistants & other support staff	1,569	110	**1,679**	1,566	129	**1,695**
Nursing, midwifery & health visiting staff	1,779	106	**1,885**	1,803	125	**1,928**
Scientific, therapeutic, and technical staff	531	14	**545**	514	12	**526**
Healthcare science staff	165	4	**169**	165	2	**167**
Total average numbers	**5,832**	**322**	**6,154**	**5,789**	**362**	**6,151**
Of which: Number of employees (WTE) engaged on capital projects	29	-	**29**	18	-	18

Analysis of staff costs for 2024/25 and 2025/26

	2025/26 Permanent £000	2025/26 Other £000	2025/26 total £000	2024/25 Permanent £000	2024/25 Other £000	2024/25 total £000
Salaries and wages	314,953	1,882	316,835	298,852	1,308	300,160
Social security costs	40,307	-	40,307	31,307	-	31,307
Apprenticeship levy	1,464	-	1,464	1,413	-	1,413
Employer's contributions to NHS pension scheme	56,962	-	56,962	54,548	-	54,548
Pension cost - other	481	-	481	408	-	408
Other post-employment benefits	-	-	-	-	-	-
Other employment benefits	-	-	-	-	-	-
Termination benefits	-	-	-	-	-	-
Temporary staff	-	5,345	5,345	-	5,073	5,073
NHS charitable funds staff	730	-	730	777	-	777
Total gross staff costs	**414,897**	**7,227**	**422,124**	**387,305**	**6,381**	**393,686**
Recoveries in respect of seconded staff	-	-	-	-	-	**-**
Total staff costs	**414,897**	**7,227**	**422,124**	**387,305**	**6,381**	**393,686**
Of which: Costs capitalised as part of assets	2,978	-	**2,978**	2,111	-	**2,111**

Sickness absence data – national data – data will be available in May

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**
2025/26	5,938	69,579	11.7		2,167,192	112,873
2024/25	5,918	61,888	10.5		2,160,120	100,395

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

An RUH 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. Given the context (i.e. the RUH becoming part of BSW Hospitals Group), an interim People Plan focussing on change management was agreed in June 2025.

The RUH People Function continues to work in alignment with three main themes: Culture, Capability and Capacity, which are underpinned by an ongoing commitment to embed a restorative, just and learning culture, whilst improving civility and kindness across the board.

Significant time and effort were invested throughout 2025/26 in the collaborative, evidence-based design of Group People Services., The resulting coproduced function will deliver efficient, modern, and over time, digitally enabled people services to approximately 17,000 staff across the Group. During quarters 1 and 2 of 2026/27, a comprehensive Group People Plan in support of the Group Strategy will be developed to shape both Groupwide and Trust-specific programmes of intervention and development.

The people we work with

During 2025/26, turnover and staff vacancies remained low, while sickness absence continued to rise. These trends coincided with the organisation's increased focus on operational effectiveness and financial sustainability. The People We Work With Breakthrough Objective centred on the theme "this organisation values my work," seeking to strengthen alignment between staff experience—measured through the National Staff Survey and Pulse Surveys - and perceptions of organisational priorities. Although survey results did not show statistical improvement on this question, the work informed enhanced focus on appraisal, wellbeing, staff communications, and reward and recognition.

The following key achievements were delivered across the year.

Leadership Development

In August 2025 we relaunched our internal leadership programmes for Aspiring Leaders (aimed at colleagues who are brand new to leadership or interested in a future leadership role) and Developing & Excelling Leaders (designed to strengthen the capabilities of those who lead of teams or departments). The programmes have been completed by over 100 staff members. These programmes include a range of development interventions, from classroom learning with a strong focus on practical application, peer learning and reflective practice, to development opportunities such as Action Learning Sets, Coaching and access to Scope for Growth conversations.

As leaders we need to consider inclusion in our actions and decision making, therefore inclusion is woven throughout the programme. National NHS expectations and leadership competencies are shared too, as well as Improving Together training.

All participants are asked to complete an End Point Assessment, which consists of creating a Personal Development Plan, writing a reflective piece and giving a presentation to a panel of leaders from across the organisation on how the participants and their teams have benefitted from the programme.

Library Services

During the reporting period, the Academy Library met all 9 essential indicators at the Established level and 6 of the 7 essential indicators at the 'Good' level, demonstrating strong overall performance against NHS England quality standards. NHS England highlighted the following areas of good practice:

- The Academy Library is business-critical, supporting evidence-informed decision-making across the Trust, benefiting both clinical and non-clinical practice while saving staff time and costs and improving patient care.
- Excellent collaborative working across the BSW system.
- Strong leadership and partnership working, with the Library embedded in Trust-wide groups and actively influencing policy and leadership.
- Innovative support for learners, meeting the needs of staff and students.
- A broad range of services that positively support the patient experience.

This feedback reflects the Academy Library's strategic contribution to Trust priorities and system-wide working.

Safety and Inclusion

Our Violence Prevention and Reduction programme continued to strengthen support for colleagues - particularly frontline staff - in challenging and responding to offensive behaviour from members of the public. Work is currently focused on increasing utilisation of policy provisions across nursing, AHP, support workforce and patient safety teams. The Trust's positive action programme, Routes to Success, has progressed into its third cohort of 21 staff, with planning underway to expand delivery across the remaining two Trusts in the BSW Hospitals Group.

Our Anti-Racism Programme continued to embed across the organisation, supported by the REACH Network and reinforced by Board-level commitment to addressing racism in all forms. The RUH has taken a proactive role in promoting this agenda across the BSW Hospitals Group and within the NHS Southwest Chief People Officers Network. In 2026/27, the programme will expand to include an externally facing anti-racism approach for patients, visitors and the public, and work will begin to support the other two Trusts in developing a shared programme.

Five staff networks continued to operate with varying levels of activity, with an increasing focus on intersectionality. Four seasonal inclusion weeks provided targeted opportunities for staff engagement, education and celebration, helping to embed the wider inclusion agenda. Leadership and team development programmes were aligned to the Trust's change management priorities, with an emphasis on creating safe, healthy and inclusive workplaces. Implementation of the TED (Team Engagement and Development) platform in 2026/27 will provide leaders and teams with enhanced tools and resources to support team effectiveness.

Wellbeing

Staff wellbeing remained a priority. In December 2025, the Trust procured Perkbox as the new Employee Assistance Programme, aligning provision across the Group and offering a broader range of support services. This has enabled wellbeing staff to focus more directly on targeted in reach support, including stress and burnout interventions, trauma support, team debriefs and specialist supervision. Alongside these developments, Occupational Health and Wellbeing teams have been codesigning a new model of service delivery, scheduled for rollout in 2026/27.

Electronic Rostering

The Trust also achieved Level of Attainment 4 against the E-Rostering Meaningful Use Standards in 2026 - an achievement secured by only around 10% of trusts nationally and validated by the NHSE Workforce team. This milestone reflects strong collaborative working across teams, supported by education workshops and the introduction of monthly prospective and retrospective roster reviews.

We have now signed contracts with Health Rota to support the rollout of the new rostering system for medical staff. A detailed project plan is in place and will be reviewed regularly to ensure alignment with service needs and to maximise the benefits of implementation across specialties.

Anaesthetics and ITU are currently in the process of transferring onto the new rostering system, with a planned go-live date of 27 April 2026.

Job Planning

We successfully achieved the required NHS England 95% sign-off rate for consultant job plans during 2025/2026. All departments completed consistency checks, and each job plan was fully validated against contractual pay requirements.

Indefinite Leave to Remain (ILR) Hardship Fund

The Trust introduced an ILR Hardship Fund as part of a wider support package for internationally educated nurses approaching eligibility to apply for Indefinite Leave to Remain after five years in the UK, The support offer includes structured ILR workshops, provided by Bevan Brittan, guidance through the application process, and signposting to external advice and financial support, including Royal College of Nursing immigration services.

The cost of an ILR application is £3,226 per individual, rising to £12,904 for a family of four, presenting a significant financial barrier for some colleagues. The hardship fund provides targeted, repayable assistance after other options such as savings or loans have been explored. Repayments are made through salary deductions over a 12-month period. By supporting colleagues to secure ILR where possible, the scheme also helps mitigate ongoing visa sponsorship costs for the Trust, while promoting workforce stability, inclusion and retention.

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 2026

	Female	Male	Total
Directors	3	2	**5**
Other Senior Managers (band 8A+)	85	50	**135**
Employees	4,753	1,690	**6,443**
Total	4,841	1,742	**6,583**

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.

NHS Staff Survey 2025 – 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 2025 and we saw a slightly reduced response rate from last year of 52%.

NHS People Promise Indicators – Scores Over Time

RUH scores against People Promise themes		2021	2022	2023	2024	2025
PP1	We are compassionate and inclusive	7.4	7.3	7.4	7.4	**7.4**
PP2	We are recognised and rewarded	6.0	5.9	6.1	6.0	**6.0**
PP3	We each have a voice that counts	6.8	6.7	6.8	6.7	**6.6**
PP4	We are safe and healthy	5.8	5.7	6.0	6.0	**6.1**
PP5	We are always learning	5.3	5.4	5.6	5.6	**5.5**
PP6	We work flexibly	6.1	6.1	6.3	6.2	**6.3**
PP7	We are a team	6.7	6.7	6.9	6.8	**6.8**
E_4	Staff Engagement	7.0	6.9	7.1	6.9	**6.8**
M_4	Morale	5.8	5.7	6.0	5.9	**5.9**

How to read the graphic overleaf

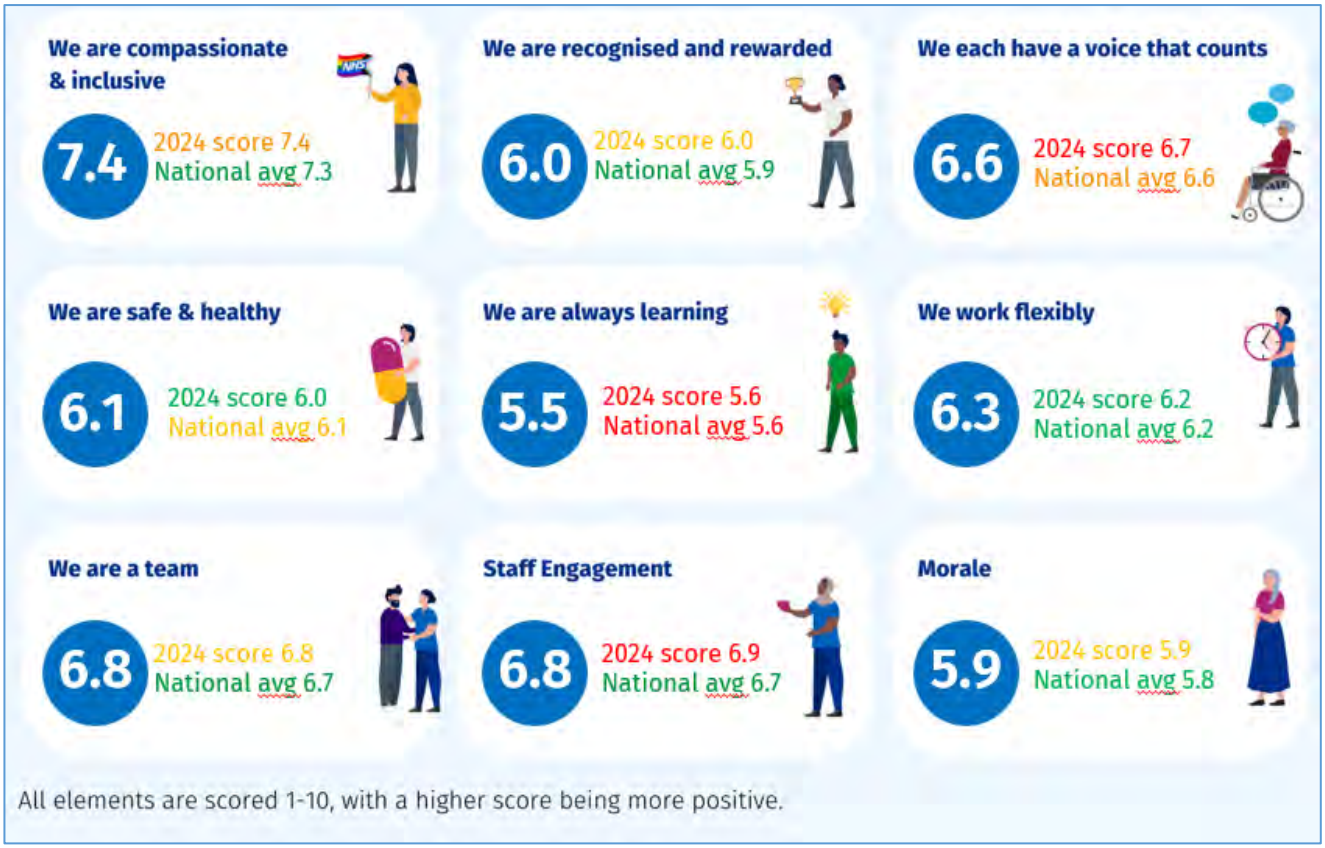
The graphic overleaf shows how we benchmark against the national average. The figure shown in the blue circle represents the Trust's 2025 People Promise score for each theme. This is presented alongside the 2024 score and the 2025 national average for comparison.

Performance against the prior year is indicated using colour coding:

- green where the 2025 score has improved on 2024
- amber where the score is unchanged
- red where the score has declined

The same colour coding is used to show comparison with the national average, indicating where the Trust's score is higher, the same, or lower than the national benchmark.

All elements are scored on a scale of 1 to 10, with higher scores indicating a more positive response.



Staff Survey 2025: Key Findings

Overall trends:

The 2025 Staff Survey indicates that staff continue to feel the impact of sustained operational and financial pressures, alongside a limited external labour market. These pressures are reflected in perceptions of understaffing, high levels of burnout and sickness absence, constrained development opportunities, and persistently low turnover.

Working together:

Most staff report positive working relationships, citing kindness, respect and feeling valued by colleagues (73–83%). RUH's sustained focus on Civility and Kindness is frequently highlighted as impactful. Managers are generally perceived as supportive, listening to staff concerns and showing interest in wellbeing (63–75%). Sixty per cent of respondents would recommend RUH as a place to work, placing the organisation above average.

Sense of purpose:

Despite ongoing pressures, staff maintain a strong sense of purpose. Eighty-eight per cent feel their role makes a difference to patients, and 70% believe patient care remains the organisation's top priority. Confidence in the standard of care remains above the Picker benchmark.

Safety, inclusion and reporting:

Around 90% of staff report not experiencing violence, harassment or discrimination from managers or colleagues. However, workforce data (including WRES/WDES) indicates that staff with protected characteristics are more likely to experience negative behaviours, including from patients and visitors.

Seventy-eight per cent of disabled staff report receiving reasonable adjustments, above peer benchmarks, though consistency remains an issue.

Staff report increased likelihood of reporting incidents compared to 2024, potentially reflecting improvements in reporting mechanisms and psychological safety. Continued focus is required to ensure equitable access to reporting and effective action following incidents.

Engagement and work-life balance:

Although staffing concerns persist, respondents report fewer unpaid hours and slightly improved work-life balance. Nearly 75% feel able to suggest improvements within their team or department, reflecting increasing engagement through improvement initiatives such as Improving Together.

Areas for Improvement

Career development:

Opportunities for development and training have declined, largely due to financial constraints and limited ability to release staff. Turnover has remained at a low level while sickness absence increased from August 2025, likely further limiting progression opportunities. Perceptions of fairness in career progression remain a challenge.

Workload, staffing and reward:

Only 23% of staff report manageable time pressures, 29% feel staffing levels are adequate, and 43% feel able to manage competing demands. Thirty-one per cent are satisfied with their pay. While turnover remains low, retention risk persists; only 43% do not think about leaving, and just 53% are unlikely to actively seek alternative employment.

Wellbeing:

Staff health and wellbeing remain a significant concern. Survey results align with internal and external data showing the cumulative impact of prolonged pressure. Twenty-four per cent report emotional exhaustion and 30% burnout, with stress-related issues widespread. While managers are generally perceived as supportive, the wider working environment is seen as challenging for maintaining good health.

A sickness reduction programme has been in place since December 2025, and improving staff wellbeing and reducing absence will be a core Breakthrough Objective for 2026/27.

Off payroll engagements

In accordance with HM Treasury and NHS annual reporting requirements, the Trust is required to disclose information on off-payroll working arrangements where individuals are engaged at a rate of £245 per day or greater. This includes details of off-payroll engagements in place at 31 March 2026, all off-payroll workers engaged at any point during the year ended 31 March 2026, and any off-payroll engagements involving Board members or senior officials with significant financial responsibility.

Since April 2017, public sector bodies have been responsible for determining the employment status of off-payroll workers and for ensuring that the correct income tax and national insurance contributions are deducted and paid where required. As a result, all off-payroll engagements, regardless of value, are assessed to ensure compliance with off-payroll working and tax legislation.

The required statutory disclosures are set out in Tables [1] to [3]. Exit package disclosures are reported separately in line with national guidance.

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

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

1 April 2025 to 31 March 2026	Trust	Charity	Sulis	Total
Number of existing engagements as of 31 March 2026	10	0	172	**182**
Of which, the number that have existed for:				
Less than one year at time of reporting.	5	0	17	**22**
Between one and two years at time of reporting.	2	0	16	18
Between two and three years at time of reporting.	1	0	16	17
Between three and four years at time of reporting.	2	0	8	10
Four or more years at time of reporting.	0	0	115	115

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

1 April 2024 to 31 March 2025	Trust	Charity	Sulis	Total
Number of off-payroll workers engaged during the year ended 31 March 2025	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

1 April 2025 to 31 March 2026	Trust	Charity	Sulis	Total
Number of off-payroll workers engaged during the year ended 31 March 2026	12	0	172	**12**
Of which:				
Number - not subject to off-payroll legislation *	4	0	0	**4**
Number - not subject to off-payroll legislation and determined as in-scope of IR35 *	0	0	0	**0**
Subject to off-payroll legislation and determined as out of scope of IR35 *	8	0	172	**8**
Number of engagements reassessed for compliance or assurance purposes during the year	0	0	12	**0**
Of which: number of engagements that saw a change to IR35 status following review	0	0	0	**0**

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

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

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility:

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**

1 April 2025 and 31 March 2026	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.	22	4	4	30

*Within the Trust figures one individual is the Chief Transformation & Innovation Officer (Interim) for the BSW Group who has been contracted by the RUH. Trust Board and Senior Managers include joint roles across BSW Hospitals Group.

** Members of the Charities Committee are also Trust Board members.

Staff Exit Packages (figures subject to audit)

Staff exit packages within the scope of this disclosure include, but are not limited to, those made under nationally agreed arrangements or local arrangements for which DHSC / HM Treasury approval was required. This does not include retirements due to ill health. Figures for 2024/25 and 2025/26 are included in these tables.

2024/25	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band			
<£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**

2025/26	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band			
<£10,000	-	19	19
£10,000 - £25,000	-	8	8
£25,001 - 50,000	-	1	1
£50,001 - £100,000	1	1	2
£100,001 - £150,000	-	-	0
>£150,001	-	-	0
Total number of exit packages by type	**1**	**29**	**30**
Total cost (£)	**£87,000**	**£309,000**	**£396,000**

Exit packages: other (non-compulsory) departure payments

	2024 – 2025		2025 - 2026	
	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	13	£235,000
Early retirements in the efficiency of the service contractual costs.	0	0	0	0
Contractual payments in lieu of notice.	19	£128,000	16	£74,000
Exit payments following Employment Tribunals or court orders.	0	0	0	0
Non-contractual payments requiring HMT / DHSC approval. *	0	0	0	0
Total	**19**	**£128,000**	**29**	**£309,000**
Non-contractual payments requiring HMT / DHSC approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

The Remuneration Report provides details of exit payments payable to individuals named in that Report.

Payments for loss of office	£86,667
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 and three intermittent support groups:

- REACH (Race, Ethnicity and Cultural Heritage)
- LGBTQ+ (lesbian, gay, bisexual, and transgender)
- Enable (staff with disabilities and long-term health conditions)
- Women's Network
- Men's Network
- Armed Forces Network
- Menopause Support Group
- Neurodiversity Support Group
- Menstrual Health Support Group

In 2025/26 we have facilitated quarterly inter-sectional inclusion weeks, in which all networks come together for a series of activities related to inclusion and diversity. This is supported by a regular EDI newsletter and (more recently) inclusion-focussed staff engagement opportunities led by the RUH Managing Director.

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.

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.

Pay gap analysis

The analysis below summarises the Trust's gender and ethnicity pay gaps, highlighting current position, year-on-year movement and the factors influencing differences in pay across staff groups.

Gender:

For Agenda for Change (AfC) staff, both the median pay gap (£2.31) and the mean pay gap (87p) are in favour of females and have widened in the past year. The distribution of males and females across staff groups and AfC Bands continues to be a key factor in this.

For Medical & Dental staff, both the median and mean gaps have widened in favour of males in monetary terms. However, as the increase in the gap is not as great as the increase in the male mean, the mean percentage gap has slightly reduced. Time in grade and Clinical Excellence Awards remain key factors.

Ethnicity:

Our overall median pay gap between Global Majority and white staff has reduced to 44p in favour of Global Majority colleagues, whereas the overall mean pay gap is £1.49 in favour of white staff.

The difference between these reflects 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.

We have an ethnicity pay gap within our medical and dental workforce, which has widened slightly (to £10.20 median and £4.74 mean). Analysis is being undertaken to establish recruitment, retention and progression strategies to level this up, whilst also recognising that progress here has been slower in 2024/25 due to reduced recruitment activity.

Work will begin in 2026/27 to understand the factors influencing medical and dental ethnicity pay gaps across the BSW Hospitals Group.

Male Median Pay (all staff): £19.49

Agenda for Change Staff: £16.93
Medical and Dental Staff: £52.10

Female Median Pay (all staff): £20.10

Agenda for Change Staff: £19.24
Medical and Dental Staff: £36.27

Median Pay Gap (all staff): -3.12%
Agenda for Change staff: -13.62% Medical and Dental Staff: 30.38%

Male Mean Pay (all staff): £25.39

Agenda for Change Staff: £19.07
Medical and Dental Staff: £49.70

Female Mean Pay (all staff): £21.72

Agenda for Change Staff: £19.94
Medical and Dental Staff: £41.86

Mean Pay Gap (all staff): 14.45%
Agenda for Change staff: -4.55% Medical and Dental Staff: 15.78%

Global Majority Median Pay (all staff): £20.26

Agenda for Change Staff: £19.80
Medical and Dental Staff: £35.99

White Median Pay (all staff): £19.82

Agenda for Change Staff: £18.66
Medical and Dental Staff: £46.19

Median Pay Gap (all staff): -2.30%
Agenda for Change staff: -6.13% Medical and Dental Staff: 22.07%

Global Majority Mean Pay (all staff): £21.61

Agenda for Change Staff: £19.57
Medical and Dental Staff: £42.03

White Mean Pay (all staff): £23.10

Agenda for Change Staff: £19.83
Medical and Dental Staff: £46.77

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Mean Pay Gap (all staff): 6.43%
Agenda for Change staff: 1.29% Medical and Dental Staff: 10.14%

Governance of the Trust

Role of the Board of Directors

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

The Board of Directors is responsible for:

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

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

Board of Directors' focus

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

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

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

The Board of Directors has timely access to all relevant operational, financial, regulatory, and quality information. Upon appointment to the Board of Directors, all Directors (Executive and Non-Executive) are

fully briefed about their roles and responsibilities. Ongoing development is provided collectively through Board Seminars which take place bi-monthly and Away Days as required. Individual training needs are assessed through the appraisal process, and all Directors are able to attend regional and national events.

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

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)

Non-Executive Directors 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 Non-Executive Directors also fulfil their responsibility for determining appropriate levels of remuneration for Executive Directors.

NEDs are appointed on a three-year term of office and 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 NEDs 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. Sumita Hutchison 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. Sumita brings a wealth of knowledge and experience that would benefit the Trust as it develops 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 and Chair Appointments

The Council of Governors' Nomination and Remuneration Committee is a committee of the Council of Governors and is responsible for overseeing Non-Executive Director and Chair appointment processes, including interview panel membership, and for making recommendations to the Council of Governors.

One new Non-Executive Director, Joy Luxford, joined the Trust on 1 May 2025. Her appointment was approved by the Council of Governors in April 2025.

In June 2025, following a review by the Nomination and Remuneration Committee, the Council of Governors approved the reappointment of Paul Fairhurst as a Non-Executive Director for a further three-year term from 1 October 2025 to 30 September 2028. At the same time, the Council endorsed his appointment as Senior Independent Director and approved the appointment of Sumita Hutchison as Interim Vice Chair for a period of up to 18 months, reflecting the increased responsibilities associated with the role during a period of organisational transition.

Also in June 2025, the Council of Governors approved the appointment of Liam Coleman as Interim Chair of the Trust, creating an interim joint Chair role with Great Western Hospitals NHS Foundation Trust for a period of up to 18 months to provide stability during the transition to group governance arrangements.

In March 2026, the Council of Governors approved the appointment of Paul van der Hyde as Interim Group Chair of the BSW Hospitals Group, following a pause in the substantive Group Chair recruitment process and to support continuity of leadership during the establishment of the Group Board.

Board evaluation and development

Evaluation of the Chair's performance is led by the Senior Independent Director under the auspices of the Council of Governors' Nominations and Remuneration Committee, which is also responsible for evaluating the performance of the Non-Executive Directors. The Chief Executive's performance is evaluated by the Chair. The Chief Executive is responsible for undertaking an evaluation of the performance of individual Executive Directors, the outcome of which is reported to the Board of Directors' Nominations and Remuneration Committee. Each Committee of the Board of Directors undertakes an annual self-assessment and reports the outcome to the Board of Directors.

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

Management Executive Committee (MEC)

The Management Executive Committee (MEC) is a committee of the Board of Directors and is the Trust's executive and operational decision-making forum.

Chaired by the Managing Director, MEC operates under delegated authority from the Board to oversee the day-to-day management of the Trust and delivery of agreed strategic and operational objectives. It provides executive leadership across performance, quality, workforce, finance and risk, and supports timely decision-making in relation to clinical and operational delivery.

MEC is accountable to the Board through the Managing Director and provides regular reporting on performance, risk and progress against objectives.

Board Committees

The Board of Directors delegates specific responsibilities to its committees to support effective oversight of the Trust's activities. Each committee is chaired by a Non-Executive Director and provides regular reports to the Board on areas of responsibility, assurance and risk. A summary of each committee's role is set out below.

Audit and Risk Committee

Provides independent assurance to the Board on the effectiveness of governance, risk management and internal control arrangements. Oversees internal and external audit, financial reporting, and compliance with statutory and regulatory requirements.

Finance and Performance Committee (FPC)

Provides assurance on the Trust's financial and operational performance, including delivery of the Trust's financial plans, operational standards and improvement programmes.

Non-Clinical Governance Committee (NCGC)

Oversees non-clinical risk and governance arrangements, including estates, digital, health and safety, and business continuity, and provides assurance on compliance with relevant requirements.

Quality Assurance Committee (QAC)

Provides assurance to the Board on the quality of clinical services, including patient safety, clinical effectiveness and patient experience, and oversight of quality governance arrangements.

People Committee

Provides assurance on workforce strategy, culture and capability, including delivery of the People Plan and management of workforce-related risks.

Subsidiary Oversight Committee

Provides assurance on the governance, performance and risk management of subsidiary entities, including alignment with the Trust's strategic objectives.

Board of Directors' Nominations and Remuneration Committee

Responsible for the appointment and terms and conditions of employment of the Chief Executive and Executive Directors.

The Charities Committee

Acts on behalf of the Board in its role as Corporate Trustee, providing assurance on the governance and management of charitable funds.

Other Committees of the Board

Joint Committee

As part of the transition to a Group operating model, a joint committee was established at the beginning of 2025, comprising representatives from each of the constituent Trust Boards. The committee operates under formally agreed terms of reference and exercises specified functions delegated to it by each Board, while ultimate accountability continues to rest with the individual statutory Boards. The purpose of the joint committee is to support greater alignment, consistency and collaboration across the Group in areas where collective decision-making adds value, while preserving the sovereignty of each Trust and ensuring compliance with constitutional, statutory and regulatory requirements. The joint committee provides a monthly report to each Trust Board, ensuring transparency, oversight and effective assurance. The delegated arrangements are kept under regular review to ensure that the governance framework remains effective, proportionate and fit for purpose as the Group model continues to evolve.

Board and Committee attendance

	Appointment Date		Board of Directors' (6 Meetings)	BSW Hospitals Group Joint Committee (8 meetings)	BSW Hospitals Group Nominations and Remuneration Committee in Common (5 meetings)	Audit and Risk Committee (4 Meetings)	Charities Committee (4 Meetings)	Finance and Performance Committee (11 meetings)	Non-Clinical Governance Committee (5 meetings)	Nominations and Remuneration Committee (7 Meetings)	People Committee (6 Meetings)	Quality Assurance Committee (6 Meetings)	Subsidiary Oversight Committee (3 Meetings)
	From	To											
Non-Executive Directors													
Alison Ryan, Chair	01/04/19	30/06/25	**1 (1)**	**1 (1)**	**0 (0)**	**-**	**1 (1)**	**3 (3)**	**-**	**2 (2)**	**-**	**-**	**1 (1)**
Liam Coleman, Chair	01/07/25	30/06/26	**4 (5)**	**7 (7)**	**5 (5)**	**-**	**-**	**-**	**-**	**4 (5)**	**-**	**-**	**2 (2)**
Nigel Stevens	01/04/18	30/06/25	**0 (1)**	**-**	**0 (0)**	**-**	**-**	**2 (3)**	**-**	**0 (2)**	**-**	**-**	**1 (1)**
Antony Durbacz	01/11/20	31/10/26	**5 (6)**	**6 (8)**	**4 (5)**	**-**	**-**	**9 (11)**	**-**	**5 (7)**	**-**	**2 (2)**	**2 (3)**
Hannah Morley	01/04/23	14/01/26	**3 (5)**	**-**	**2 (4)**	**-**	**-**	**-**	**3 (4)**	**2 (6)**	**3 (5)**	**4 (5)**	**-**
Paul Fairhurst	01/10/22	30/09/28	**5 (6)**	**8 (8)**	**5 (5)**	**-**	**-**	**1 (1)**	**-**	**6 (7)**	**6 (6)**	**-**	**-**
Paul Fox	01/04/23	30/04/25	**0 (0)**	**-**	**0 (0)**	**-**	**-**	**1 (1)**	**1 (1)**	**1 (1)**	**-**	**-**	**-**
Sumita Hutchison	04/09/19	30/06/26	**6 (6)**	**7 (8)**	**3 (5)**	**3 (4)**	**4 (4)**	**-**	**5 (5)**	**5 (7)**	**5 (6)**	**1 (3)**	**-**
Simon Harrod	01/10/24	30/09/27	**6 (6)**	**6 (8)**	**3 (5)**	**3 (4)**	**-**	**6 (7)**	**2 (2)**	**6 (7)**	**-**	**6 (6)**	**3 (3)**
Joy Luxford	01/05/25	30/04/28	**5 (6)**	**-**	**5 (5)**	**4 (4)**	**3 (3)**	**8 (10)**	**4 (4)**	**5 (6)**	**-**	**-**	**3 (3)**
Executive Directors (voting)													
Cara Charles-Barks Group Chief Executive	01/11/24	-	**5 (6)**	**8 (8)**	**4 (0)**	**-**	**-**	**-**	**-**	**6 (0)**	**-**	**-**	**-**
Andrew Hollowood Managing Director (Interim)	01/11/24	31/08/26	**2 (2)**	**2 (2)**	**-**	**-**	**-**	**3 (0)**	**-**	**1 (0)**	**-**	**-**	**-**
John Palmer Managing Director	01/09/25	-	**3 (4)**	**5 (6)**	**-**	**-**	**-**	**6 (0)**	**-**	**2 (0)**	**-**	**-**	**-**
Kheelna Bavalia Chief Medical Officer (Interim)	03/02/25	-	**4 (6)**	**-**	**-**	**0 (4)**	**-**	**7 (11)**	**-**	**-**	**5 (6)**	**6 (6)**	**0 (3)**
Antonia Lynch Chief Nursing Officer	01/04/21	30/06/26	**6 (6)**	**4 (8)**	**-**	**0 (4)**	**1 (4)**	**1 (0)**	**4 (5)**	**-**	**4 (6)**	**5 (6)**	**3 (3)**
Paran Govender Chief Operating Officer	02/10/23	20/07/25	**0 (2)**	**-**	**-**	**-**	**-**	**0 (3)**	**-**	**-**	**0 (2)**	**0 (2)**	**0 (1)**

	Appointment Date		Board of Directors' (6 Meetings)	BSW Hospitals Group Joint Committee (8 meetings)	BSW Hospitals Group Nominations and Remuneration Committee in Common (5 meetings)	Audit and Risk Committee (4 Meetings)	Charities Committee (4 Meetings)	Finance and Performance Committee (11 meetings)	Non-Clinical Governance Committee (5 meetings)	Nominations and Remuneration Committee (7 Meetings)	People Committee (6 Meetings)	Quality Assurance Committee (6 Meetings)	Subsidiary Oversight Committee (3 Meetings)
	From	To											
Executive Directors (voting continued)													
Simon Truelove Chief Finance Officer (Interim)	17/03/25	11/09/25	**3 (3)**	**-**	**-**	**1 (1)**	**1 (1)**	**5 (5)**	**1 (2)**	**-**	**-**	**-**	**1 (1)**
Simon Wade Chief Finance Officer (Interim)	12/09/25	04/11/25	**0 (0)**	**1 (1)**	**-**	**1 (1)**	**0 (1)**	**2 (2)**	**-**	**-**	**-**	**-**	**-**
Simon Wade Group Chief Finance Officer	05/11/25	-	**3 (3)**	**5 (5)**	**-**	**1 (2)**	**0 (2)**	**2 (4)**	**-**	**-**	**-**	**-**	**1 (2)**
Joss Foster Chief Strategic Officer	01/07/12	23/01/26	**4 (5)**	**4 (6)**	**-**	**-**	**3 (3)**	**-**	**2 (4)**	**-**	**3 (5)**	**-**	**0 (2)**
Alfredo Thompson Chief People Officer	31/01/22	08/01/26	**3 (4)**	**1 (0)**	**-**	**-**	**-**	**-**	**-**	**4 (0)**	**3 (5)**	**-**	**-**
Executive Directors (non-voting)													
Christopher Brooks-Daw Chief of Staff	05/01/24	31/07/25	**0 (2)**	**-**	**-**	**1 (0)**	**-**	**1 (0)**	**-**	**-**	**-**	**-**	**-**
Bernie Bluhm Chief Operating Officer (Interim)	21/07/25	-	**2 (4)**	**-**	**-**	**-**	**-**	**6 (8)**	**-**	**-**	**0 (3)**	**2 (3)**	**1 (2)**
Jude Gray Group Chief People Officer	01/11/25	-	**3 (3)**	**5 (5)**	**2 (0)**	**-**	**-**	**-**	**-**	**2 (0)**	**0 (2)**	**-**	**-**

	Appointment Date		Board of Directors' (6 Meetings)	BSW Hospitals Group Joint Committee (8 meetings)	BSW Hospitals Group Nominations and Remuneration Committee in Common (5 meetings)	Audit and Risk Committee (4 Meetings)	Charities Committee (4 Meetings)	Finance and Performance Committee (11 meetings)	Non-Clinical Governance Committee (5 meetings)	Nominations and Remuneration Committee (7 Meetings)	People Committee (6 Meetings)	Quality Assurance Committee (6 Meetings)	Subsidiary Oversight Committee (3 Meetings)
	From	To											
Executive Directors (non-voting continued)													
Jonathan Hinchliffe Group Chief Digital and Information Officer (Interim)	14/04/25	-	**5 (6)**	**8 (8)**	**-**	**-**	**-**	**-**	**3 (4)**	**-**	**-**	**-**	**-**
Andrew Hollowood Group Clinical Transformation Officer	01/09/25	-	**4 (4)**	**6 (6)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Mark Ellis Group Chief Risk Officer	26/01/26	-	**1 (1)**	**1 (2)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Judy Dyos Group Chief Strategic Officer (Interim)	02/02/26	-	**0 (1)**	**1 (2)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

** 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 Royal United Hospitals Bath NHS Foundation Trust is accountable to its members through 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 (City of Bath, North East Somerset, Mendip, North Wiltshire, South Wiltshire and Rest of England and Wales)
- 5 Staff Governors, elected by staff members
- 5 Stakeholder Governors, appointed by partner organisations

The Council of Governors is chaired by the Trust Chair, Liam Coleman. Governors provide a vital link between the Trust and its members and play a key role in representing the interests of members, the local community and other stakeholders. The Council has a statutory right to be consulted on the Trust's forward plans and on matters that may have a significant impact on the Trust or the services it provides.

The roles and responsibilities of the Council of Governors are set out in legislation and are defined in the Trust's Constitution. These include both statutory duties and additional non-statutory responsibilities. When preparing the NHS Foundation Trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors.

In March 2025, the Council of Governors approved the establishment of a temporary Committees-in-Common Council of Governors Nominations and Remuneration Committee across the BSW Hospitals Group, for the specific purpose of recruiting a Group Chair. In March 2026, the Committee's Terms of Reference were revised to oversee the recruitment of the first cohort of Group Non-Executive Directors. Each Trust retained its own local Council of Governors Nominations and Remuneration Committee to oversee Trust-specific matters. The work of these Committees is referred to elsewhere in this report.

During most of 2025/26, the Council of Governors also operated a number of working groups aligned broadly to Board Committees. These included:

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

Non-Executive Directors regularly attended working group meetings to support engagement and respond to Governor questions.

In December 2025, the Council of Governors established a Task and Finish Group to review its working group structure. Following consideration of a number of options, a more streamlined model was agreed, comprising a Nominations and Remuneration Committee, a Membership and Outreach Working Group, and a Governor and Non-Executive Director Forum. This revised structure was approved by the Council of Governors in February 2026 and will become operational in 2026/27, supporting closer alignment with emerging Group governance arrangements and Governors' statutory responsibilities.

The Lead and Deputy Lead Governors meet regularly with the Trust Chair, providing an additional mechanism for communication between the Board of Directors and the wider Council of Governors. The Trust also maintains a comprehensive Governor induction and ongoing development programme, supported by external organisations including NHS Providers.

2025/26 Governor Elections

During 2025/26, the Trust held a constituency-wide election to elect two Staff Governors and six Public Governors across five public constituencies. Following validation of election results, Governors were successfully elected in all constituencies except Mendip.

All constituencies with vacancies were contested elections. The full election report is available from the Membership Office at ruhmembership@nhs.net.

Following the election, it was identified that the address of the successful Mendip candidate fell outside the required constituency boundary. In line with the Trust's election rules, the position was offered to the next highest polling candidate, who was unable to accept the role due to a change in personal circumstances.

As a result, the Mendip Public Governor position remains vacant. In addition, the Trust has one Stakeholder Governor vacancy. Work will be undertaken during 2026/27 to fill both vacancies.

Governors by constituency – 1 April 2025 to 31 March 2026

The Governor's terms of appointment can be seen in the table below. There are 21 Governor Positions in total. As at 31 March 2026, there were 20 Governors in post (11 public, 5 staff and 4 appointed) and 1 vacancy.

Public Governors	Constituency	Term of Appointment
Viv Harpwood (Lead Governor from November 2023)	City of Bath	01/11/2022 – 31/10/2025
Sue Toland	City of Bath	17/07/2024 – 31/01/2025
Ming Keng Teoh	City of Bath	03/11/2025 – 31/10/2028
Rachel Walker	City of Bath	03/11/2025 – 31/10/2028
Anna Beria	North East Somerset	01/11/2022 – 31/10/2025 03/11/2026 – 31/10/2028
Vic Pritchard	North East Somerset	01/11/2023 – 31/10/2026
Kate Cozens	Somerset (Mendip)	01/11/2023 – 31/10/2026
Chris Norman	Somerset (Mendip)	27/06/2024 – 31/10/2025
Nick Gamble	North Wiltshire	01/03/2023 – 31/10/2025
Paul Newman	North Wiltshire	01/11/2023 – 31/10/2026
Christopher Leadbeater	North Wiltshire	03/11/2025 – 31/10/2028
Di Benham	South Wiltshire	01/11/2022 – 31/10/2025
Ian Lafferty	South Wiltshire	01/11/2023 – 31/10/2026
Adam Cooksey	South Wiltshire	03/11/2025 – 31/10/2028
Anne-Marie Walker	Rest of England & Wales	01/11/2023 – 31/10/2026

Staff Governors	Constituency	Term of Appointment
Narinder Tegally	Staff	01/11/2019 – 31/10/2022 01/11/2022 – 31/10/2025
Craig Jones	Staff	01/11/2023 – 31/10/2026
Gary Chamberlain	Staff	01/11/2023 – 31/10/2026
Craig Sanders	Staff	03/03/2025 – stood down 19/01/2026
Fi Abbey	Staff	03/11/2025 – 31/10/2028
Anthony Green	Staff	03/11/2025 – 31/10/2028
Fiona Marfleet	Staff	21/01/2026 – 31/10/2026

Stakeholder Governors	Organisation	Term of Appointment
Cllr Alison Born	BaNES Council	20/05/2021
Cllr Johnny Kidney	Wiltshire Council	01/10/2017 – 02/05/2025
Cllr Ian Thorn	Wiltshire Council	04/12/2025
Prof Deborah Wilson	University of Bath	01/11/2024 – 31/10/2026
Lucy Baker	BSW ICS (BaNES)	16/09/2024
Vacancy	BSW ICS (Wiltshire)	-

Council of Governor Meetings

The Council of Governors met formally on six occasions during 2025/26. Attendance is detailed in the table overleaf. These meetings provided Governors with regular updates on Trust performance and developments within the local health system, and opportunities to question members of the Board of Directors. The Chief Executive and Managing Director provided written and verbal updates as standing agenda items, with other Executive Directors attending as required.

During 2025/26, most Council of Governors meetings were held in person at venues across Bath. Details of each meeting were published on the Trust's website to enable public attendance and observation.

Key decisions taken by the Council of Governors during the year included the following.

April 2025

- Approved the appointment of Joy Luxford as Non-Executive Director for the period 1 May 2025 to 30 April 2028.

June 2025

- Approved the re-appointment of Paul Fairhurst as Non-Executive Director for the period 1 October 2025 to 30 September 2028.
- Endorsed the appointment and remuneration of Paul Fairhurst as Senior Independent Director.
- Approved the appointment and remuneration of Sumita Hutchison as Interim Vice-Chair for a period of up to 18 months.

- Approved the appointment and remuneration of Liam Coleman as Interim Chair of the Trust, establishing an Interim Joint Chair arrangement with Great Western Hospitals NHS Foundation Trust for a period of up to 18 months.

September 2025

- Approved amendments to the Trust's Constitution.

December 2025

- Appointed Kate Cozens, Public Governor, as Lead Governor.
- Approved the establishment of a Task and Finish Group to review and simplify the Council of Governors' working group structure.

February 2026

- Approved the appointment of an Interim Group Chair across the BSW Hospitals Group for a period of up to 18 months, following a decision to pause substantive recruitment due to a lack of competition.
- Approved amendments to the Group Chair job description to reflect its interim status.
- Confirmed that the Interim Group Chair appointment process would be overseen by the Joint Council of Governors Nominations and Remuneration Committee.
- Endorsed the appointment of Craig Jones, Staff Governor, as Deputy Lead Governor.
- Approved a streamlined Council of Governors working group structure, including the dissolution of the Strategy and Business Planning, Quality and People Working Groups, and the establishment of a quarterly Governor and Non-Executive Director Forum, including its Terms of Reference.

March 2026

- Approved the appointment of Paul von der Heyde as Interim BSW Hospitals Group Chair for an initial period of up to 18 months from 1 April 2026, subject to Fit and Proper Person checks and national confirmation.
- Approved a new Non-Executive Director model for the future BSW Hospitals Group Board.
- Approved revised Terms of Reference for a temporary Councils of Governors Committee-in-Common Nominations and Remuneration Committee to oversee recruitment of the first cohort of Group Non-Executive Directors.
- Delegated responsibility to the Committees-in-Common Nominations and Remuneration Committee to oversee Group Non-Executive Director recruitment.
- Approved an end-of-term date of 30 June 2026 for the existing RUH Chair, supporting an orderly transition to Group governance arrangements.

Governors are required to declare any material interests at each Council of Governors meeting. A register of Governors' interests is available to members of the public on request via the Membership Office.

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 821262

Membership and attendance at Council of Governors meetings 2025/26

The table below sets out Governor attendance at Council of Governors meetings between 1 April 2025 and 31 March 2026. Figures in brackets indicate the number of meetings each Governor was eligible to attend, with zero indicating where an individual was not a member or attendance was not required.

Council of Governor meeting attendance				
Governor name			**Non-Executive Directors**	
Anna Beria	4/6		Alison Ryan (Chair)	1/1
Adam Cooksey	0/4		Liam Coleman (Chair)	5/5
Anne-Marie Walker	4/6		Nigel Stevens	0 (0)
Anthony Green	3/4		Antony Durbacz	2 (0)
Chris Norman	1/2		Hannah Morley	0 (0)
Christopher Leadbeater	2/4		Paul Fairhurst	4 (0)
Cllr Alison Born	1/6		Paul Fox	0 (0)
Cllr Ian Thorn	1/4		Sumita Hutchison	4 (0)
Cllr Johnny Kidney	0/0		Simon Harrod	4 (0)
Craig Jones	5/6		Joy Luxford	4 (0)
Craig Sanders	0/3			
Di Benham	1/2		**Executive Directors**	
Fi Abbey	4/6		Cara Charles-Barks	2 (0)
Fiona Marfleet	1/3		Andrew Hollowood	1 (0)
Gary Chamberlain	3/6		Bernie Bluhm	1 (0)
Ian Lafferty	4/6		John Palmer	2 (0)
John Drake	0/3			
Kate Cozens	6/6			
Lucy Baker	0/6			
Ming Keng Teoh	2/4			
Narinder Tegally	0/2			
Nick Craw	0/3			
Nick Gamble	1/2			
Paul Newman	6/6			
Prof Deborah Wilson	3/6			
Rachel Walker	3/4			
Sue Toland	2/2			
Vic Pritchard	5/6			
Viv Harpwood	2/2			

Foundation Trust Membership

The Royal United Hospitals Bath NHS Foundation Trust membership is made up of public and staff members. Membership is free and people can become a member by completing a short application form which is available on the Trust's website (https://secure.membra.co.uk/RoyalBathApplicationForm/) or in a printed form found around the hospital. Public members receive updates from the Trust and are invited to 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 Trust's membership is representative of the local communities it serves. The Council of Governors' Membership and Outreach Working Group reviews membership data annually and, at its most recent review, was satisfied that the Trust's membership reflected the population using Trust services.

The Trust has a Membership Development and Engagement Strategy, which is reviewed and updated annually with support from the Governors' Membership and Outreach Working Group. During 2025/26, work to revise the strategy was paused and will recommence in 2026/27 to align with the emerging BSW Hospitals Group approach.

The strategy sets out how the Trust will develop an engaged and representative membership, with the aim of ensuring that the public remains at the heart of everything the Trust does. It also considers how engagement is monitored, including through surveys and participation in Governor meetings and member events.

As at 31 March 2026, the Trust had a total of 17,229 members, comprising 10,604 public members (patients, carers and members of the public) and 6,625 staff members. The Trust uses a range of channels to engage and communicate with its members, including:

- Members' e-communications
- Online surveys
- Governor meetings
- The Annual Members' Meeting
- Staff tri-weekly newsletters, monthly virtual staff briefs and weekly Q&A sessions.

Ongoing operational pressures continued to limit the scale and scope of engagement activity during 2025/26, although some progress was made in resuming face-to-face engagement. Governors attended local Patient Participation Group meetings and RUH Careers Fairs, providing opportunities for members of the public to meet Governors, learn more about the role and understand how they could become involved in supporting the Trust.

The Trust held its combined Annual General Meeting and Annual Members' Meeting on 25 September 2025 via Microsoft Teams. While recruitment activity remained limited by capacity, a small number of new members were recruited during the year through Governor engagement activities and the Trust's online application process.

Membership size and movements 2025/26:

Public constituency	Members		Staff constituency	Members
As at 1st April 2025	10,613		As at 1st April 2025	6,627
As at 31st March 2026	10,604		As at 31st March 2026	6,625

Analysis of current membership			
	Public constituency	**Number of members**	**Eligible Membership**
Age (years):	0-16	1	151,864
	17-21	41	51,785
	22+	9,766	642,177
Ethnicity:	White	8,926	772,058
	Mixed	91	15,635
	Asian or Asian British	207	18,539
	Black or Black British	125	7,977
	Other	40	5,590
Socio-economic groupings*	AB	3,209	88,630
	C1	3,119	105,102
	C2	2,115	75,775
	DE	2,137	76,389
Gender Analysis	Male	3,559	415,978
	Female	6,891	429,847
The analysis section of this report excludes: 796 public members with no dates of birth, 1215 members with no stated ethnicity and 154 members with no stated gender.			

Compliance with the Code of Governance for NHS Provider Trusts

The Code of Governance for NHS provider trusts was published in October 2022 and has applied to NHS provider trusts, including foundation trusts, since 1 April 2023.

The Royal United Hospitals Bath NHS Foundation Trust applies the principles and provisions of the Code on a comply or explain basis.

The Board considers that, for the year ended 31 March 2026, the Trust has complied with the provisions of the Code in full.

The Trust is committed to maintaining high standards of corporate governance. Compliance with the Code is supported through the Trust's governance framework, which is subject to regular review by the Board and its committees. Key elements of this framework include:

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

The Trust considers that it meets the disclosure requirements set out in the Code of Governance for NHS provider trusts and the NHS Foundation Trust Annual Reporting Manual.

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

Code section	Code Provision	Annual Report and Accounts Section
	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.	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 • 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.	Directors' report
B 2.13	The annual report should give the number of times the board and its committees met, and individual Director attendance.	Governance of the Trust
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	Directors' report and Council of Governors

Code section	Code Provision	Annual Report and Accounts Section
	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.	
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	Remuneration report

Code section	Code Provision	Annual Report and Accounts Section
	• the gender balance of senior management and their direct reports.	
C 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Directors' Report - Council of Governors
D 2.4	The annual report should include: • 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 • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Financial Performance
D 2.6	The Directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced, and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Accountability Report – Directors Report
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	Annual Governance Statement (complied)

Code section	Code Provision	Annual Report and Accounts Section
	controls. The board should report on internal control through the annual governance statement in the annual report.	
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.	This power has not been exercised

Code section	Code Provision	Annual Report and Accounts Section
	* 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)	

NHS System Oversight Framework

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high-performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

a) Its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity).
b) considering financial override which may limit a segment to be no better than 3.
c) contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality). And;
d) capability assessments which consider the organisation's leadership and governance.

Segmentation

Based on the most up-to-date information available at the time of preparing this Annual Report, the Trust was assessed by NHS England as Segment 4 under the NHS Oversight Framework as at 1 April 2026.

During the year, the Trust was subject to enhanced national oversight and improvement support from NHS England for specific priority areas through national Tier 1 performance arrangements. These arrangements provide structured engagement with NHS England national teams, alongside system partners, to support recovery, provide additional scrutiny, and monitor delivery against agreed performance trajectories.

The Trust continued to work closely with NHS England and system partners to address the areas identified for improvement. Further detail on the actions taken, arrangements for oversight and assurance, and assessment of leadership and governance capability is set out in the Annual Governance Statement.

This segmentation information is the Trust's position as at 1 April 2026. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website: https://www.england.nhs.uk/nhs-oversight-framework/segmentation and-league-tables/. The Trust is included on the acute Trust dashboard.

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's Group Accounting Manual and in particular to:

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

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

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

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

Signed:

Cara Charles-Barks, Chief Executive **Date: 26 June 2026**

Annual Governance Statement 2025/26

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Group'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, and 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 organisation's policies, aims and objectives, 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 for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accounting Officer, I have overall responsibility for ensuring that effective arrangements are in place to identify, assess and manage risk, including health and safety risks, and for providing the organisation with appropriate structures and resources to support the effective implementation of risk management policies and actions, within available resources.

The Board of Directors retains ultimate responsibility and accountability for the quality and safety of services provided. The Board has approved the Strategic Framework for Risk Management, which provides a clear and systematic approach to the identification, assessment and management of risk, ensuring that risk management is embedded within clinical, managerial and financial processes across the organisation. The Framework sets out the roles of the Board of Directors, Trust Management Executive, Divisional leadership teams and Board committees, together with the individual responsibilities of Executive Directors and staff in relation to risk management.

Operationally, the Trust uses a web-enabled electronic risk management system (Datix) to record, manage and monitor risks on the Trust-wide Risk Register. Significant risks, as determined by the agreed risk scoring methodology, are reviewed monthly by the Trust Management Executive, which provides executive oversight and ensures appropriate escalation and assurance is in place until risks are managed to an acceptable level.

The Board of Directors reviews the most significant operational and strategic risks on a quarterly basis through the Board Assurance Framework (BAF). The BAF comprises a limited number of high-level risks which, if not effectively managed, could prevent the organisation from achieving its strategic objectives. In addition, regular performance and finance reports presented to the Board highlight emerging and key risks, and Board reports include explicit consideration of risk and assurance.

The Risk and Control Framework

The organisation has an established Strategic Framework for Risk Management, approved by the Board of Directors, which defines the approach to identifying, assessing, managing and monitoring risk. The Framework sets out the organisation's risk appetite and clarifies individual and collective responsibilities

for risk management across the organisation, ensuring that risk management is embedded within clinical, operational and financial decision-making.

Risks are assessed using a consistent risk assessment methodology based on national guidance, applying a 5x5 (impact and likelihood) risk matrix to support the prioritisation of risks. All risks are recorded and monitored through the Trust-wide electronic risk management system (Datix), providing visibility and reporting across operational, executive and Board levels.

Significant risks are reviewed routinely through executive and Board-level governance arrangements, with the most critical risks escalated for oversight through the Board Assurance Framework (BAF). The BAF comprises a limited number of high-level risks which, if not effectively managed, could prevent the organisation from achieving its strategic objectives. The Board reviews progress against mitigating actions and the sufficiency of assurance on a regular basis.

Quality governance arrangements support the identification and management of clinical and patient safety risks, including learning from patient safety incidents, complaints and investigations. From April 2024, the organisation transitioned to the Patient Safety Incident Response Framework (PSIRF), in line with national requirements. Risk, quality and performance information is brought together through integrated reporting to the Board, supporting effective oversight, challenge and assurance.

Board Assurance Framework

The Trust has an established Board Assurance Framework (BAF), which provides the principal means by which the Board assures itself that the organisation's strategic objectives are supported by appropriate controls and that the key risks to their delivery are being effectively managed.

The BAF is reviewed by the Board on a quarterly basis at private meetings of the Board of Directors, and an update summary is subsequently presented at the next available public meeting. Each principal risk is assigned a lead Executive Director and is supported by assurance from the relevant Board committee. Committees provide oversight, scrutiny and assurance in respect of their allocated risks and report to the Board on the effectiveness of controls and mitigating actions.

The Framework is refreshed annually, with the Board holding a dedicated workshop to agree the principal risks and areas of focus for the year ahead.

Responsibilities of the Board of Directors

The Board of Directors is collectively responsible for the effective leadership, governance and control of the Trust, and for ensuring that robust systems of internal control, risk management and assurance are in place. The Board retains ultimate accountability for the achievement of the Trust's statutory and strategic objectives, the stewardship of public funds, compliance with all regulatory and legal requirements, and the safety and quality of services provided. Day-to-day management is delegated to the Chief Executive and Executive Directors, supported by a clear scheme of reservation and delegation, while the Board obtains assurance through a structured committee framework and regular performance, risk and compliance reporting.

The Board discharges its responsibilities through a number of standing Board assurance committees, each operating under formally approved Terms of Reference. These committees scrutinise key areas of risk and performance on behalf of the Board and provide assurance through regular upward reporting, recommendations for action, and escalation of matters requiring Board decision. The Board remains accountable for all decisions taken and for the effectiveness of the internal control environment, supported by the work of its committees.

Roles and Responsibilities of Board Committees

The Board has established a structure of standing committees to provide assurance on the effectiveness of the system of internal control and the management of principal risks. The roles and responsibilities of these committees are set out below.

The Audit and Risk Committee is the Board's primary source of independent assurance over the effectiveness of the Trust's systems of governance, risk management and internal control. The Committee supports the Board and the Accounting Officer by reviewing the adequacy, accuracy and robustness of the assurances that underpin the Board Assurance Framework and the Annual Governance Statement, and by providing assurance that principal risks are being appropriately identified, managed and controlled.

The Committee oversees the Trust's risk management arrangements, including the effectiveness of the Board Assurance Framework, risk appetite and supporting risk registers, and assesses the extent to which assurance is embedded and integrated across the organisation. It reviews the Trust's compliance with key governance requirements, including the NHS Provider Licence, the NHS Code of Governance, the Fit and Proper Persons requirements, and arrangements for managing conflicts of interest, gifts and hospitality, and counter fraud.

The Audit and Risk Committee has oversight of both internal and external audit. It approves the internal audit strategy and annual plan, reviews internal audit reports and ensures that agreed actions are implemented within appropriate timescales. The Committee also considers the work and findings of the external auditor, reviews the Annual Report and Accounts prior to submission to the Board, and considers the implications of audit findings and management responses. In addition, the Committee receives assurance on counter fraud arrangements, data quality, information governance and the effectiveness of systems that enable staff to raise concerns safely.

The Committee works closely with the Board's other assurance committees, drawing on their detailed scrutiny of quality, finance, people and non-clinical risks, while retaining an overarching view of the effectiveness of the Trust's governance and control framework. Through regular reporting and an annual effectiveness review, the Audit and Risk Committee provide the Board with assurance that the Trust's systems of internal control are operating effectively and support the delivery of its strategic and statutory objectives.

The Quality Assurance Committee is the Board's principal assurance committee for quality, patient safety, clinical effectiveness, patient experience and safeguarding. It provides assurance to the Board that quality and safety risks are appropriately identified, mitigated and managed, that regulatory requirements including Care Quality Commission standards are met, and that learning from incidents, complaints, claims and mortality reviews is embedded. The Committee maintains oversight of quality governance systems and sub-committees and ensures that the Trust can evidence compliance and continuous improvement in the delivery of safe, high-quality care.

The Finance and Performance Committee provides assurance on the Trust's financial sustainability, operational performance and delivery of the annual business plan. Its responsibilities include scrutiny of financial planning and control, capital investment, productivity and improvement programmes, and performance against national and local operational standards. The Committee oversees statutory and reputational risks relating to finance and performance, monitors recovery and improvement actions, and escalates material risks or issues of non-delivery to the Board.

The People Committee provides assurance on workforce strategy, delivery of the Trust's People Plan, and the management of workforce-related risks. It oversees performance against key people metrics, staff experience and engagement, equality, diversity and inclusion, and workforce transformation. The Committee assures the Board that robust systems are in place to manage statutory, regulatory and

reputational risks relating to the workforce and that appropriate action is taken where concerns are identified.

The Non-Clinical Governance Committee provides assurance on the governance and management of non-clinical risks and services, including estates and facilities, health and safety, digital systems, cyber security, information governance, environmental sustainability and business continuity. It reviews controls and assurances against relevant Board Assurance Framework risks, considers internal and external assurance reports, and supports the Board in forming the Annual Governance Statement by assuring the effectiveness of non-clinical risk management systems.

The Subsidiary Oversight Committee provides assurance to the Board on the governance, performance and risk management of the Trust's wholly owned subsidiary and related entities. It ensures that appropriate governance arrangements, regulatory compliance and reporting frameworks are in place, and that subsidiary activities support the Trust's strategic objectives. The Committee maintains oversight of financial, operational, quality and reputational risks associated with subsidiaries and escalates matters requiring Board attention.

Charitable Funds and Corporate Trustee Responsibilities

The Board of Directors acts as Corporate Trustee for the Royal United Hospitals Charitable Fund and retains collective responsibility for ensuring that charitable funds are managed, safeguarded and applied in accordance with charity law, donor intent and regulatory requirements. The Board has delegated day-to-day oversight of its corporate trustee responsibilities to the Charities Committee, which operates as an agent of the Trustees under formally approved Terms of Reference, while the Board remains accountable for the proper stewardship of charitable assets.

The Charities Committee provides assurance to the Board that charitable funds are governed and administered appropriately. Its responsibilities include oversight of fund objectives and spending plans, assurance that income and expenditure are correctly allocated and accounted for, scrutiny of investment arrangements and performance, review of audit reports relating to charitable funds, and recommendation of the charitable accounts to the Board for approval. The Committee also assures itself that risks relating to fraud, financial control and regulatory compliance are effectively managed, and that appropriate governance and reporting arrangements are in place to support the delivery of the charity's strategy in line with donor intentions.

After each Committee 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.

Non-Executive Directors

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

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

Joint Committee

As part of the transition to a Group operating model, a joint committee was established at the beginning of 2025, comprising representatives from each of the constituent Trust Boards. The committee operates under formally agreed terms of reference and exercises specified functions delegated to it by each Board, while ultimate accountability continues to rest with the individual statutory Boards. The purpose of the joint committee is to support greater alignment, consistency and collaboration across the Group in areas where collective decision-making adds value, while preserving the sovereignty of each Trust and ensuring compliance with constitutional, statutory and regulatory requirements. The joint committee provides a monthly report to each Trust Board, ensuring transparency, oversight and effective assurance. The delegated arrangements are kept under regular review to ensure that the governance framework remains effective, proportionate and fit for purpose as the Group model continues to evolve.

Executive Directors

As Accounting Officer, the Chief Executive has overall responsibility for maintaining a sound system of internal control and for ensuring effective risk management arrangements are in place across all organisational, financial and clinical activities throughout the Trust.

The Executive Team supports the Accounting Officer by exercising collective responsibility for managing risk within their respective areas. Day-to-day executive oversight of the Trust's risk management framework is delegated to the Chief Nursing Officer, who is responsible for the strategic development and implementation of organisational risk management systems and processes. This includes ensuring that appropriate arrangements are in place to monitor compliance with statutory and regulatory requirements, including Care Quality Commission registration and conditions. The Chief Nursing Officer also holds executive responsibility for patient safety, patient experience and medico-legal matters (jointly with the Chief Medical Officer (CMO).

The Chief Finance Officer is responsible for the operation of the Trust's financial control framework, including the adoption and maintenance of the Standing Financial Instructions covering budgetary control, procurement, banking, losses, and controls over income and expenditure. The Chief Finance Officer is the executive lead for counter fraud and provides assurance to the Audit, Risk and Assurance Committee through engagement with internal audit, external audit and counter fraud services, which deliver risk-based programmes of work to support the Board's assurance requirements.

The Managing Director chairs the Trust Management Executive Committee, which provides executive oversight of the adequacy and effectiveness of arrangements for managing the principal risks facing the organisation. Operational responsibility for identifying, assessing and managing risks sits with divisional and corporate managers, who are required to ensure that risks are proactively reviewed within their areas of responsibility and that appropriate mitigating actions are implemented.

Risks that cannot be adequately managed at local level, or where delivery of agreed mitigations is challenged, are escalated through Executive Performance Reviews, governance groups and relevant Board committees as appropriate. Divisional Governance Committees support this framework by strengthening oversight of local governance and risk management arrangements and ensuring consistency of approach across the Trust.

The risk management system and associated internal control processes are supported operationally by the Head of Risk and Assurance, who is responsible for maintaining the Trust's risk management framework and for ensuring that staff are trained and supported to manage risk effectively in accordance with the Strategic Framework for Risk Management. These arrangements enable the Board to obtain assurance on the effectiveness of the system of internal control throughout the year.

Quality Governance

The Board of Directors has overall responsibility for the quality and safety of care provided by the Trust and for ensuring that appropriate systems of quality governance and internal control are in place. The Board sets the tone and culture for quality through its strategic objectives and oversight arrangements, supported by the Senior Management Team.

The Trust operates a clear quality governance framework, described within the Integrated Governance and Accountability Framework, which is reviewed annually. This framework sets out how the Board directs and controls the organisation to identify, manage and monitor quality risks and supports delivery of the Trust's strategic objectives.

The Quality Assurance Committee acts on behalf of the Board to provide focused oversight and assurance on the quality and safety of services, including compliance with Care Quality Commission standards. The Committee reviews monthly quality performance information, receives assurance on patient safety, patient experience and clinical effectiveness, and monitors progress against quality priorities. Matters requiring further action or attention are escalated to the Board through formal committee reporting.

The Chief Executive, as Accounting Officer, is accountable for quality governance. Executive responsibility for quality is clearly defined, with the Chief Medical Officer leading on clinical effectiveness and the Chief Nursing Officer leading on patient safety and patient experience. Each strategic objective has an identified Executive Director lead, ensuring accountability for delivery and assurance.

Quality governance is embedded within the Trust's overall system of risk management. Quality risks are identified and assessed at divisional and corporate level and are recorded on risk registers. These risks are reviewed through divisional governance arrangements and escalated where necessary through the Trust Management Executive Committee and relevant Board committees. The Board receives assurance on principal quality risks through the Board Assurance Framework, including the application of the Board-approved risk appetite and tolerances.

The Board monitors quality and safety performance through a range of assurance mechanisms, including the monthly Integrated Performance Report, which provides ward-to-board visibility of key quality, patient safety and patient experience indicators. Oversight of mortality, learning from deaths, patient safety incidents, complaints, claims and inquests forms a core part of the Board's assurance framework.

The Trust has a Freedom to Speak Up Guardian (FTSUG) who acts in an independent and impartial capacity to support staff who raise concerns. The FTSUG has direct access to the Chief Executive and the Trust's nominated Non-Executive Director for Freedom to Speak Up, providing an additional route of escalation and assurance to the Board.

The Trust has implemented the Patient Safety Incident Response Framework, which underpins a learning-focused approach to responding to patient safety events. Oversight of patient safety events, themes and learning is maintained through established governance groups, ensuring that improvement actions are identified, monitored and aligned to patient safety priorities.

The Trust promotes an open and transparent culture that supports the reporting of incidents and concerns. The Freedom to Speak Up Guardian provides independent and impartial support to staff raising concerns and has direct access to the Chief Executive and a nominated Non-Executive Director. Patient and public voice is incorporated into quality governance through patient stories at public Board meetings, patient feedback reporting, engagement activity and governor involvement.

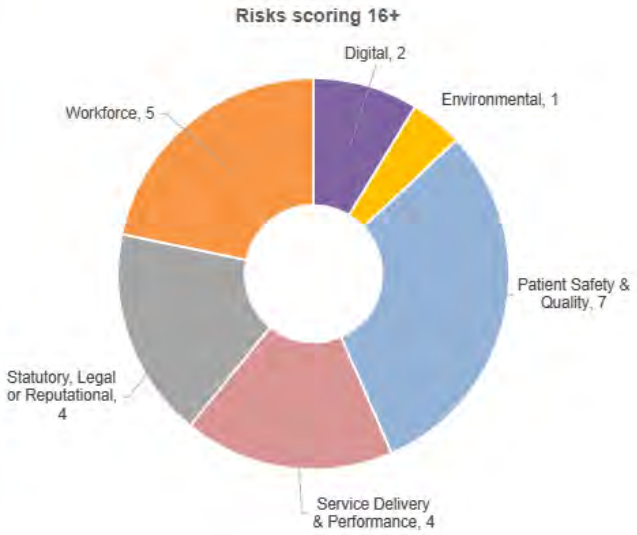
The Council of Governors engages with the quality agenda through established working arrangements, including attendance by a nominated Governor observer at the Quality Assurance Committee. These arrangements further support the Board's oversight of quality governance.

During the year, the Board has reviewed the effectiveness of the Trust's quality governance and risk management arrangements as part of the Annual Governance Statement process and is satisfied that appropriate systems of internal control have been in place to manage risks to the quality and safety of care.

Risks on the risk register

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

Risks scoring 16+



Datix ID	Assessment relating to
Digital	
1885	FacNet bespoke unsupported system - cyber risk
3022	End of life dictation system with backlog of clinic letters with potential for Lost to Treatment (delay) or Lost to Follow Up
Environmental	
2398	Variable cleaning standards in clinical and non-clinical areas - infection risk
Patient Safety & Quality	
2557	Maintaining a safe environment in line with IPC standards for isolating patients
2683	Emergency department unable to meet the NHS England target of four hour waiting times
2973	Insufficient medical palliative care provision
3224	Potential clinical harm to patients on outpatient pathways
3230	Insufficient Patient Safety, Risk, Audit and Quality Improvement Resource
3242	Delays in typing and sending clinical letters
Service Delivery & Performance	
1999	Respiratory Outpatient Capacity
2110	Business interruption as a result of backlog maintenance, or critical infrastructure risks
2385	Weight Management Service - Insufficient Capacity
2988	Non-replacement of medical equipment
Statutory, Legal or Reputational	
2806	Digital Clinical Safety
3165	Delivery of Annual Financial Plan
3198	Inconsistent Consent Form 4 Documentation
Workforce	
2075	Medical and nursing workforce gaps in ED
2124	Oncology/Haematology Workforce and Service Delivery
2764	Nursing, Allied Health and Midwifery workforce cost reduction
3025	Insufficient capacity within Pathology IT team
3067	Speech & Language Therapy Inpatient Provision

Board assurance framework:

The Trust maintains a Board Assurance Framework which brings together the principal risks that could threaten the achievement of the Trust's corporate objectives. During the year, the Board Assurance Framework comprised 13 principal risks.

Each risk is aligned to a corporate objective and has a named Executive Director lead responsible for ensuring appropriate controls and mitigating actions are in place. The principal risks are reviewed regularly by Executive Directors and are considered by the relevant Board committees prior to escalation to the Board. This provides assurance that risks are being actively managed and that actions are monitored and challenged.

The Board uses the Board Assurance Framework as a key component of its system of internal control, supported by the application of the Board-approved risk appetite and tolerances. Assurance is drawn from a range of sources including performance reporting, internal and external audit, regulatory feedback and committee oversight.

The principal risks facing the Trust during 2025/26 are consistent with those described in the Performance Report and relate to demand and capacity pressures across urgent and emergency care, delivery of elective recovery trajectories, workforce capacity, and financial sustainability. These risks have had a direct impact on the delivery of the Trust's objectives during the year and continue to represent the most significant challenges to performance.

The Board receives regular assurance on these risks through the Board Assurance Framework, which sets out the key controls in place, sources of assurance, and any gaps in control or assurance. The effectiveness of these arrangements is reviewed throughout the year by the Board and its committees.

The Trust has established governance and control processes to identify, assess and manage these risks, including routine performance reporting, risk escalation processes, and oversight through Board committees. These arrangements are designed to ensure that risks to the delivery of objectives are appropriately managed and mitigated. The principal risks included within the Board Assurance Framework relate to the following areas:

- Risk that failure to meet internally and externally set standards of quality and safety could result in harm to patients and care being delivered below expected standards.
- Risk that increasing demand for urgent and emergency care may exceed the Trust's capacity, impacting the timely assessment, treatment and admission of patients and delivery of national performance standards.
- Risk that planned care demand exceeds available clinical and diagnostic capacity, resulting in increasing waiting times, potential patient harm, reduced experience and breaches of national referral to treatment standards.
- Risk that failure to foster an inclusive culture and address potential discrimination could adversely affect staff recruitment and retention, expose the Trust to financial and reputational risk, and impact patient care.
- Risk that insufficient leadership capacity, capability and succession planning could limit the Trust's ability to transform services, sustain improvement and maintain a positive organisational culture.
- Risk that failure to deliver the financial plan and ensure financial accountability could affect the Trust's financial sustainability and ability to provide safe, effective and high-quality care.
- Risk that failure of Sulis Hospital to deliver its financial plan could have a direct adverse impact on the Trust's financial position.
- Risk that failure to address unwarranted variation and inequity of care could result in some populations not receiving appropriate levels of care.
- Risk arising from an ageing estate and increasing backlog maintenance, which could lead to service disruption, compromised patient safety, regulatory non-compliance and reduced experience for patients and staff.
- Risk that climate change and its associated impacts may affect the health of patients, staff and the wider community, and threaten the Trust's sustainability and ability to deliver services.
- Risk that insufficient digital capability may hinder the Trust's ability to improve patient and staff experience, optimise efficiency and enhance care delivery.
- Risk of cyber-security incidents, whether malicious or inadvertent, leading to loss of data, disruption to digital services and potential harm to patients.
- Risk that delayed or sub-optimal deployment of the joint Electronic Patient Record could result in expected clinical, operational and financial benefits not being realised and impact delivery of the Trust's future operating model.

Controls and mitigations include:

The Trust has an established framework for the identification, management and mitigation of its principal risks. Each risk within the Board Assurance Framework is supported by clearly defined controls, mitigating actions and sources of assurance, enabling the Board to understand both the current level of risk and the effectiveness of the arrangements in place to manage it.

Responsibility for each principal risk is assigned to a named Executive Director, with oversight provided through the relevant Board committees in line with their terms of reference. This ensures that risks are reviewed, challenged and escalated appropriately, and that assurance is provided to the Board on a regular basis. The Board receives routine updates on the Board Assurance Framework as part of its governance cycle.

Over the past two years, internal audit work has identified areas requiring improvement alongside positive assurance in a number of reviews, supporting the Board's understanding of the robustness of the Trust's governance, risk management and internal control arrangements.

Risks are managed through a combination of controls, mitigation actions and monitoring arrangements, with assurance obtained through executive oversight, committee review and Board reporting.

The Trust has assessed its compliance with NHS provider licence condition 4 (governance) and has concluded that effective systems and processes are in place to support compliance.

The Trust Management Executive manages the day-to-day operation of the organisation under delegated authority from the Board, with appropriate matters escalated through committees or directly to the Board where required. Committee terms of reference are regularly reviewed to ensure continued alignment with statutory and regulatory requirements, and committee Chairs provide assurance reports to the Board summarising key issues and risks.

The Board reviews the Integrated Performance Report at each meeting, providing assurance across quality, performance, finance and workforce and supporting effective scrutiny and challenge as part of the Trust's system of internal control.

Risks to compliance with the NHS provider licence (Condition 4 – Governance)

The Trust has considered the principal risks to compliance with the governance requirements set out in Condition 4 of the NHS provider licence. These risks relate primarily to the effectiveness of the Trust's governance arrangements, including the clarity of responsibilities between the Board of Directors, its committees and the executive team, and the effectiveness of reporting lines and accountabilities across the organisation.

Risks to compliance may arise where governance structures are not operating as intended, where information provided to the Board and its committees is not timely, accurate or sufficiently comprehensive to support effective decision-making, or where the level of oversight and challenge applied to performance and risk is insufficient.

The Trust has established a governance framework designed to mitigate these risks, including clearly defined roles and responsibilities, formal terms of reference for the Board and its committees, and established reporting and escalation processes. The Board receives regular, integrated reports on quality, performance, workforce and finance, supported by internal and external audit, to provide assurance on the effectiveness of governance arrangements.

During 2025/26, no material issues were identified that indicate a failure in the Trust's governance arrangements. The Board is satisfied that the systems in place to support compliance with Condition 4 are operating effectively and continues to keep these arrangements under regular review.

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.

The Care Quality Commission (CQC) undertook an unannounced inspection of the Urgent and Emergency Care (UEC) core service on 21-22 October 2025. The CQC visited the Emergency Department and Urgent Treatment.

The inspection covered the 5 key questions under the CQC's Single Assessment Framework (Safe, Caring, Effective, Responsive, Well-led). The Trust is awaiting publication of the final CQC inspection report. Once the report is received, the Trust will develop an improvement plan to address any recommendations for improvement identified within the report. Progress in implementing the improvement plan will be monitored through the Insights and Improvement Committee 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

In 2024/25, Aqua were commissioned to undertake Well-Led Developmental Reviews across Royal United Hospitals NHS Foundation Trust, Salisbury NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust. The reviews identified a number of key themes, including the need to maintain strategic alignment during organisational change, strengthen governance and risk arrangements, and further develop divisional accountability and visibility to the Board.

Rather than establishing a standalone Well-Led Improvement Programme, the Trust aligned the identified areas for improvement to existing corporate and quality governance programmes of work, ensuring ongoing oversight through established executive and Board governance arrangements. A number of the actions arising from the review were also progressed through a wider BSW corporate governance workstream, supporting the transition to the Group operating model.

During 2025/26, the Board received assurance on relevant aspects of governance, risk management and quality through its established reporting mechanisms; however, progress against the Well-Led review themes was not overseen through a resolute or formally tracked programme.

Looking ahead, the Trust intends to commission a further Aqua review during 2026/27, with a specific focus on the effectiveness and maturity of Group governance arrangements. This will provide external assurance to the Board on the operation of the developing Group model and help identify any further areas for improvement.

Developing workforce safeguards

The Trust has established workforce planning and assurance arrangements to support the delivery of safe, sustainable and effective services. Short, medium and long-term workforce strategies are set through the Trust's People Plan and strategic workforce planning processes, which are aligned to

operational and financial planning. Workforce risks are identified and monitored through divisional risk registers and the Board Assurance Framework, with assurance provided to the Board via the People Committee and routine integrated performance reporting. Clinical staffing levels and skill mix are subject to executive scrutiny in line with national guidance, and the Board receives assurance that appropriate arrangements are in place to maintain safe staffing and respond to workforce risks in accordance with the Developing Workforce Safeguards recommendations.

Mandatory Statements

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

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure that all employer obligations contained within the Scheme regulations are complied with, including the accurate processing of contributions and maintenance of pension records.

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

The Trust has undertaken risk assessments relating to the effects of climate change and severe weather and has developed a Green Plan in line with the Greener NHS programme. The Trust continues to have regard to its obligations under the Climate Change Act and associated adaptation reporting requirements.

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

The Board of Directors receives regular assurance on the economy, efficiency and effectiveness of the use of resources through routine financial, operational and performance reporting. Performance against agreed plans is reviewed through established Board and committee oversight arrangements, with investment decisions subject to robust business case approval and review of outcomes.

The Audit and Risk Committee provide independent assurance to the Board on matters of probity, regularity and value for money, drawing on the work of internal audit, external audit and counter fraud arrangements. Internal audit reviews relevant systems and processes during the year and provides assurance opinions and recommendations, which are monitored through Board committees to ensure timely management action.

External audit undertakes annual review of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The Trust also uses a range of benchmarking and system-level intelligence to support informed decision-making and identify opportunities for improvement.

Delivery of departmental cost improvement programmes is monitored through the Directorate Performance Review process. The Trust's overall financial position is overseen by the Finance and Performance Committee at its monthly meetings. Performance against key operational, workforce and quality metrics is routinely scrutinised by the Board and the Trust Management Executive through the monthly Integrated Performance Report.

Information governance and data security

The Trust completed its annual Data Security and Protection Toolkit submission for the 2025–26 reporting period and achieved a status of 'Standards Met', providing assurance that data protection and cyber security risks are being effectively managed within the Board-approved risk appetite.

Information governance is supported by a structured risk management framework, including the use of data protection impact assessments, supplier assurance processes, vulnerability management, and

internal and external assurance activity. Technical and organisational controls are risk-based, proportionate to service criticality, and subject to routine oversight through established information governance forums. Incident response and recovery arrangements are integrated with the Trust's wider emergency preparedness, resilience and business continuity frameworks and are subject to regular testing and organisational learning.

The Trust continues to recognise a number of ongoing challenges, including legacy technology, supplier dependencies, cyber monitoring capability and workforce capacity pressures. These risks are identified, reported and managed through agreed mitigation and improvement plans under senior management oversight and with appropriate Senior Information Risk Owner oversight. None of these matters undermine the Trust's overall information governance assurance position.

There were no serious information governance incidents, including no personal data breaches notified via the Data Security Incident Reporting Tool to the Information Commissioner's Office or the Department of Health and Social Care, during the 2025–26 reporting period. No regulatory action was therefore required or taken.

Independent assurance over the Trust's information governance arrangements was also provided through a DSPT audit undertaken by KPMG, which confirmed an improving control environment. This assurance will continue to be strengthened as the Information Governance service supports the development of the BSW Hospital Group model of working.

Data quality and governance

There is corporate leadership for data quality, with executive responsibility for information and data security held by the Chief Digital and Information Officer in their capacity as Senior Information Risk Owner (SIRO). The Board receives regular assurance on the quality and accuracy of performance data, including elective waiting time information, through routine Board and committee reporting.

The Trust operates an established data quality governance framework, supported by an agreed Data Quality Policy and formal oversight arrangements. An established data quality management approach, including specialist analytical support, enables the review, investigation and correction of data quality issues. Data quality is subject to independent scrutiny through internal audit, including reviews of elective waiting time reporting.

The Trust recognises that risks to the accuracy and quality of elective waiting time data arise from the complexity and volume of patient pathways, reliance on timely validation processes and the need for manual intervention. These risks are mitigated through ongoing validation, monitoring and escalation through established governance arrangements as part of the Trust's wider assurance framework.

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 internal audit, 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 results of my review of the effectiveness of the system of internal control by the Board, and its Audit and Risk Committee, with input from the Quality Assurance Committee and other relevant Board committees. Arrangements are in place to address identified weaknesses and to ensure continuous improvement of the system of internal control.

The Board of Directors has overseen the effectiveness of governance, risk management and internal control through regular meetings and the work of its committees. The Board and its committees receive

the Integrated Performance Report on a monthly basis, providing assurance on delivery against national priorities, regulatory requirements and locally agreed objectives, with detailed exception reporting where performance or control issues arise.

The Audit and Risk Committee provide independent assurance to the Board on the adequacy and effectiveness of the Trust's arrangements for governance, risk management and internal control. During the year, the Committee received reports from both internal and external audit, reviewed the Board Assurance Framework and the Risk Register, and oversaw counter fraud arrangements. The Committee agrees an annual risk-based internal audit plan and receives reports on the outcomes of reviews of the system of internal control during the course of the financial year. These assurances support the Board's assessment of the Trust's overall control environment.

Internal Audit delivered a risk-based programme of work aligned to the Trust's principal risks and areas of material importance. The Head of Internal Audit provided an annual opinion on the adequacy and effectiveness of the Trust's framework of governance, risk management and internal control, informed by work undertaken during the year. Internal audit findings and agreed management actions are monitored through the Audit and Risk Committee to ensure timely implementation and sustained improvement.

Where Internal Audit identified gaps in control or areas requiring improvement, management action plans were agreed to strengthen governance, risk management and internal control arrangements. Actions taken or underway during the year have focused on improving the consistency and effectiveness of oversight, enhancing the quality and use of management information, formalising policies and procedures, and strengthening the tracking and escalation of actions and learning. Progress against internal audit recommendations is monitored through the Audit and Risk Committee, with responsible executive leads providing assurance on delivery.

The Head of Internal Audit's annual conclusion for the period 1 April 2025 to 31 March 2026 reflects the requirements of the Global Internal Audit Standards, under which assurance is provided across four areas: governance, risk management, financial reporting and data quality. Internal Audit concluded that arrangements for risk management and financial reporting were operating with some improvements required, with both areas receiving an amber-green rating. Governance and data quality were assessed as amber-red, reflecting areas where the design or operation of controls requires improvement.

The Audit and Risk Committee directs the internal audit programme to review a range of areas, including both systems that are well established and those where improvement is required.

The governance assessment reflects the ongoing maturity of control processes across the organisation. Areas identified for improvement included:

- The timeliness and consistency of implementation of internal audit actions; and
- Governance arrangements supporting the Patient Safety Incident Response Framework, including clarity of oversight and effectiveness of supporting controls.

The data quality assessment reflects findings from a targeted review of discharge processes, which identified:

- Weaknesses in the completeness of key data fields;
- Inconsistencies in data accuracy when compared to underlying records; and
- Reliance on manual processes and data input, limiting the effectiveness of assurance reporting.

During the year, management implemented a total of 100 internal audit actions. All high priority actions raised in the year have been completed, with none outstanding at year end.

Notwithstanding these findings, Internal Audit reported that sufficient coverage had been completed during the year to support its overall conclusion and to contribute to the Board's assurance on the effectiveness of the system of internal control.

Clinical Audit forms a key part of the Trust's quality governance framework and is used to assess and improve the quality and safety of patient care. The clinical audit programme includes national and locally prioritised audits and is overseen through the Trust's quality governance structures, with learning used to support quality improvement and assurance to the Board.

My review of effectiveness is also informed by other external assurance activity, including inspections and reviews conducted by the Care Quality Commission and other regulators. Taking all sources of assurance into account, I am satisfied that the Trust has maintained effective arrangements for governance, risk management and internal control during the year, and that appropriate actions are in place to address areas for improvement. These arrangements provide reasonable assurance that the Trust's policies, aims and objectives are being achieved.

During 2025/26, the Trust has faced significant financial challenges, including a £20.5 million deficit and a shortfall in the delivery of the Cost Improvement Programme (CIP) of £14.7 million against plan. This reflects the scale and complexity of the financial environment and the ongoing pressures relating to demand, capacity and workforce.

The under-delivery of CIP and resultant deficit indicate that, despite established financial governance and budgetary control processes, there are areas where the effectiveness of financial planning, cost improvement delivery and performance management arrangements require strengthening. This is consistent with the findings of external audit in relation to value for money.

In response, the Trust has implemented a number of actions to strengthen financial control and oversight, including enhanced scrutiny through the Finance and Performance Committee, strengthened financial recovery arrangements, tighter controls on expenditure, and improved grip on CIP delivery, monitoring and escalation.

These actions are expected to improve the robustness of financial governance and support delivery of a more sustainable financial position in future periods. The Board will continue to monitor progress closely through its governance arrangements.

Conclusion

My review confirms that the Royal United Hospitals Bath NHS Foundation Trust has generally sound systems of internal control that support the achievement of its policies, aims and objectives.

The significant internal control issue relating to financial performance and delivery of the cost improvement programme is described above. Actions are in place to address this and strengthen financial control arrangements.

Signed:

Cara Charles-Barks
Chief Executive (Accounting Officer)
26 June 2026

Other Statutory and Regulatory Disclosures

Modern Slavery Act 2015 – Annual Statement 2025–26

The Group is committed to preventing modern slavery and human trafficking in all its activities and within its supply chains. We recognise our responsibility to operate ethically and with integrity, and we take a zero-tolerance approach to any form of slavery or human trafficking.

During the financial year ended 31 March 2026, the Group continued to apply its safeguarding, workforce and procurement policies to identify and mitigate the risk of modern slavery. We expect all suppliers and contractors to adhere to the same ethical standards and to comply with applicable legislation when providing goods or services on our behalf.

Modern slavery risks are considered as part of procurement and contract management processes, and staff are encouraged to raise concerns where exploitation is suspected, in line with whistleblowing and safeguarding arrangements.

This statement is made pursuant to section 54 of the Modern Slavery Act 2015 and has been approved by the Board. It will be reviewed and updated annually.

Independent Auditor's Report

Independent auditor's report to the Council 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 2026 and of the Group's and Foundation Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the Group statement of comprehensive income;
- the Group and Foundation Trust statements of financial position;
- the Group and Foundation Trust statements of changes in taxpayers' equity;
- the Group and Foundation Trust statements of cash flows; and
- the related notes 1 to 40.

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 property valuations, and IT regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

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

- determination of whether an expenditure is capital in nature, and for major projects the value of work completed at 31 March 2026, are 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.
- the judgemental nature of key assumptions used in the modern equivalent asset (MEA) property valuations: we engaged property valuations specialists to assess the assumptions and methodology used to value the estate; and performed sensitivity analysis on the key assumptions.

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.

In our audit report dated 27 June 2025, we reported to the Foundation Trust, a significant weakness in arrangements in respect of financial sustainability (how the Trust plans and manages its resources to ensure it can continue to deliver its services), specifically in how the Trust would achieve its planned savings and breakeven position.

This weakness has not yet been addressed as we noted that the Trust has reported an adjusted deficit of £20.5 million in FY 25/26 and has delivered £19 million efficiency savings, representing 57% of its planned savings of £34 million despite the acknowledged impact of the underfunding by the Integrated Care Board (ICB).

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.

On 17 June 2026, we reported to the Foundation Trust, a significant weakness in arrangements in respect of governance identified in the findings of the Care Quality Commission's (CQC) inspection report issued in May 2026. The report identified that the Trust's urgent and emergency services "Requires Improvement" across safe, caring, responsive, and well-led domains. The Trust was also found to be in breach of Regulation 17 (good governance), Regulation 18 (staffing), and Regulation 12

(safe care and treatment). We also note that the Trust's oversight framework segmentation is rated as 4 (Low performing). We recommended that the Trust governance team should develop and monitor a detailed action plan to address the findings of the CQC report with specific actions, owners and clear timelines and to review monitoring controls in place to identify issues in the future.

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 2026. 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 yet completed our work in respect of the Trust's consolidation returns for the year ended 31 March 2026 and 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 2026 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 Hospitals Bath NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Edward Bell (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Bristol, UK
26 June 2026

Royal United Hospitals Bath NHS Foundation Trust

Annual accounts for the year ended 31 March 2026

Foreword to the accounts

Royal United Hospitals Bath NHS Foundation Trust

These accounts, for the year ended 31 March 2026, 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 2026**

Consolidated Statement of Comprehensive Income

		Group	
		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	579,571	561,694
Other operating income	4	61,003	57,196
Operating expenses	6,8	(708,415)	(614,485)
Operating (deficit) / surplus from continuing operations		**(67,841)**	**4,405**
Finance income	10	1,751	2,321
Finance expenses	11	(2,084)	(1,873)
PDC dividend expenses		(8,348)	(8,149)
Net finance costs		**(8,681)**	**(7,701)**
Other gains	12	11	14
Deficit for the year		**(76,511)**	**(3,282)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(12,902)	(2,117)
Revaluations	20	15,281	2,959
Other reserve movements		-	(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	25	119	80
Total comprehensive expense for the period		**(74,013)**	**(2,361)**

Statements of Financial Position

		Group		Trust	
		31 March 2026	31 March 2025	31 March 2026	31 March 2025
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	14,15	12,554	8,070	11,458	7,097
Property, plant and equipment	17,18	289,355	334,216	282,792	330,247
Right of use assets	23,24	50,979	50,584	50,237	49,730
Other investments / financial assets	25	4,117	3,953	3,941	3,941
Receivables	28	1,859	1,947	7,383	5,184
Total non-current assets		**358,864**	**398,770**	**355,811**	**396,199**
Current assets					
Inventories	27	8,621	8,836	6,306	6,782
Receivables	28	44,488	36,722	37,048	30,747
Cash and cash equivalents	30	28,304	40,024	23,239	36,648
Total current assets		**81,413**	**85,582**	**66,593**	**74,177**
Current liabilities					
Trade and other payables	31	(73,036)	(67,670)	(63,321)	(61,625)
Borrowings	33	(2,659)	(2,662)	(2,349)	(2,530)
Provisions	34	(430)	(932)	(430)	(1,072)
Other liabilities	32	(13,612)	(10,857)	(10,761)	(8,634)
Total current liabilities		**(89,737)**	**(82,121)**	**(76,861)**	**(73,861)**
Total assets less current liabilities		**350,540**	**402,231**	**345,543**	**396,515**
Non-current liabilities					
Borrowings	33	(53,660)	(55,227)	(53,623)	(54,896)
Provisions	34	(4,310)	(1,315)	(4,310)	(1,175)
Total non-current liabilities		**(57,970)**	**(56,542)**	**(57,933)**	**(56,071)**
Total assets employed		**292,570**	**345,689**	**287,610**	**340,444**
Financed by					
Public dividend capital	SOCIE	306,600	285,706	306,600	285,706
Revaluation reserve	20	42,144	41,080	42,144	41,080
Income and expenditure reserve	SOCIE	(62,983)	11,267	(61,134)	13,658
Charitable fund reserves	26	6,809	7,636	-	-
Total taxpayers' equity		**292,570**	**345,689**	**287,610**	**340,444**

The notes on pages 158 to 220 form part of these accounts.

Name Cara Charles-Barks
Position Chief Executive
Date **26 June 2026**

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

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 2025 - brought forward		**285,706**	**41,080**	**11,267**	**7,635**	**345,689**
Deficit for the year		-	-	(76,714)	203	**(76,511)**
Total comprehensive expense		**-**	**-**	**(76,714)**	**203**	**(76,511)**
Other transfers between reserves		-	(1,315)	1,315	-	**-**
Impairments	7	-	(12,902)	-	-	**(12,902)**
Revaluations	20	-	15,281	-	-	**15,281**
Fair value gains on financial assets mandated at fair value through OCI		-	-	-	119	**119**
Public dividend capital received	Cashflow	20,894	-	-	-	**20,894**
Other reserve movements		-	-	1,149	(1,149)	**-**
Taxpayers' and others' equity at 31 March 2026		**306,600**	**42,144**	**(62,983)**	**6,808**	**292,570**

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group		Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
		£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward		**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	7	-	(1,324)	1,324	-	**-**
Impairments	20	-	(2,117)	-	-	**(2,117)**
Revaluations		-	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**	**7,635**	**345,689**

Statement of Changes in Equity for the year ended 31 March 2026

Trust	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward		**285,706**	**41,080**	**13,658**	**340,444**
Deficit for the year		-	-	(76,106)	**(76,106)**
Total comprehensive expense		**-**	**-**	**(76,106)**	**(76,106)**
Other transfers between reserves		-	(1,315)	1,315	**-**
Impairments	7	-	(12,902)	-	**(12,902)**
Revaluations	20	-	15,281	-	**15,281**
Public dividend capital received	Cashflow	20,894	-	-	**20,894**
Other reserve movements		-	-	(1)	**(1)**
Taxpayers' and others' equity at 31 March 2026		**306,600**	**42,144**	**(61,134)**	**287,610**

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**

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 26.

Statements of Cash Flows

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating (deficit) / surplus		(67,841)	4,404	(67,611)	5,840
Non-cash income and expense:					
Depreciation and amortisation	6	23,752	22,019	22,190	21,035
Net impairments	7	63,425	10,400	63,425	10,400
Income recognised in respect of capital donations	4	(9,409)	(10,956)	(9,409)	(13,078)
Increase in receivables and other assets		(12,036)	(444)	(8,457)	(4,325)
Decrease / (increase) in inventories		215	(552)	476	(524)
Increase in payables and other liabilities		11,964	4,056	2,987	8,719
(Decrease) / increase in provisions		(625)	171	(476)	423
Movements in charitable fund working capital		1,217	(1,324)	-	-
NHS charitable funds: other movements in operating cash flows		(309)	(222)	-	-
Net cash flows from operating activities		**10,353**	**27,552**	**3,125**	**28,490**
Cash flows from investing activities					
Interest received		1,627	2,063	1,627	2,063
Purchase of intangible assets		(5,897)	(3,344)	(5,789)	(3,528)
Purchase of Property, plant and equipment		(39,174)	(51,017)	(33,814)	(57,008)
Sales of property, plant and equipment		32	44	32	41
Receipt of cash donations to purchase assets		12,596	6,130	12,596	13,078
Finance lease receipts (principal and interest)		-	-	-	471
NHS charitable funds: other movements in operating cash flows		80	1,212	-	-
Net cash flows used in investing activities		**(30,736)**	**(44,912)**	**(25,348)**	**(44,883)**
Cash flows from financing activities					
Public dividend capital received		20,894	32,171	20,894	32,171
Movement on loans from DHSC		(313)	(313)	(313)	(313)
Capital element of lease liability repayments		(2,029)	(2,705)	(1,901)	(2,585)
Interest on loans		(113)	(120)	(113)	(120)
Other interest		(4)	-	-	-
Interest paid on lease liability repayments		(1,821)	(1,740)	(1,802)	(1,717)
PDC dividend (paid) / refunded		(7,951)	(8,435)	(7,951)	(8,435)
Cash flows from (used in) other financing activities		-	-	-	175
Net cash flows from financing activities		**8,663**	**18,858**	**8,814**	**19,176**
(Decrease) / increase in cash and cash equivalents		**(11,720)**	**1,498**	**(13,409)**	**2,783**
Cash and cash equivalents at 1 April - brought forward		**40,024**	**38,526**	**36,648**	**33,865**
Cash and cash equivalents at 31 March	30	**28,304**	**40,024**	**23,239**	**36,648**

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 International Financial Reporting Standards as adapted by the Department of Health and Social Care Group Accounting Manual (GAM). 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 circumstances of the Trust for the purpose of giving a true and fair view has been selected. The 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 right-of-use assets, where required by the Group Accounting Manual. Inventory are stated at the lower of cost and net realisable value. Financial assets and financial liabilities are measured at amortised cost or fair value, as appropriate, in accordance with IFRS 9 and IFRS 13.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Consolidation

NHS Charitable Funds

The Trust is the corporate trustee to the RUH Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the Charitable Fund and has the ability to affect those returns and other benefits through its power over the fund.

The Charitable Fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the Charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Other subsidiaries

The Trust has a subsidiary Sulis Hospital 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.

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 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 the Best Practice Tariff (BPT) schemes. Delivery under this scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead, they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the Trust is eligible for prescribed specialised services payments, additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £1.5m), 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.

The Trust's principal contracts with customers relate to the provision of NHS healthcare services. Payment is typically received monthly in arrears in line with agreed commissioning arrangements. The contracts do not contain a significant financing component as the period between the transfer of services and payment is short and reflects standard NHS payment practices. Consideration under NHS contracts includes variable elements, primarily relating to activity-based income and performance-related adjustments. Variable consideration is estimated using expected activity levels and is constrained in accordance with IFRS 15 paragraphs 56–58 to the extent that it is highly probable that a significant reversal of recognised revenue will not occur.

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 of receiving the income, this should be included within the provision for impairment of receivables. For 2025-26, this figure is 24.62 % (2024-25: 24.5%). Therefore, 24.62% of accrued ICR revenue within the provision for impairment of receivables.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure, it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Government grants and donations relating to the acquisition of property, plant and equipment are presented in the statement of financial position as deferred income within liabilities. The grants are released to income over the useful lives of the related assets in line with the depreciation charge. Grants are not deducted from the carrying amount of the related assets.

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 Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front-line services or back-office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use 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. 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 during 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.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged, and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

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	10	62
Dwellings	30	46
Plant & machinery	2	25
Information technology	2	7
Furniture & fittings	2	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, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset 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 can operate in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value, an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

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 Statement of Financial Position.

When the Trust first acquires control of an entity, the Group is required to measure goodwill at the acquisition date which is the extent to which the fair value of the consideration transferred exceeds the net recognised amount (typically at fair value) of all the identifiable assets acquired and liabilities assumed.

Goodwill is recognised as an intangible asset in the Consolidated Balance Sheet. It includes non-identified intangible assets including business processes and workforce-related industry-specific knowledge and technical skills. Goodwill has an indefinite expected useful life and is not amortised but is tested annually for impairment.

Costs related to the acquisition, are expensed as incurred.

On closure or disposal of an acquired business, goodwill would be taken into account in determining the profit or loss on closure or disposal.

Note 1.11 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.

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, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income depending upon type.

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure.

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.

Note 1.14 Business Combinations and Goodwill (continued)

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

The Trust has irrevocably elected to measure the following equity instruments at fair value through other comprehensive income. All gains and losses arising from investment funds held by the RUH Charity Fund will be measured at fair value through Other Comprehensive Income. The investment fund does not meet the criteria set out in the accounting standards to be recognised as a gain or loss through income and expenditure.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are determined by reference to 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 considered and the more overdue a receivable becomes, the higher the value of expected credit loss.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Prior to 1 January 2026, financial liabilities are de-recognised when the obligation is discharged, cancelled or expires. From 1 January 2026, financial liability may be derecognised before the settlement date if the liability is settled in cash through an electronic payment system at the point in time that all the following criteria are met:

- the entity has no practical ability to withdraw, stop or cancel the payment instruction ensuring the liability is on derecognised when the entity has irrevocably committed the funds
- No practical ability to access the cash to be used for settlement.
- Insignificant settlement risk associated with the system.

Note 1.15 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.
The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

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 34.2 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 claims are charged to operating expenses when the liability arises.

Note 1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets but are disclosed in Note 35 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised but are disclosed in Note 35.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.19 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.20 Corporation tax

Under current legislation, Foundation Trusts are not liable for corporation tax.

The Trust's subsidiary company files a separate tax return to the Trust. The subsidiary is not expected to pay any corporation tax in this financial period due to accumulated tax losses.

Deferred taxes are provided for on temporary differences and carry forwards. This is in line with the expected corporation tax rate increase, and the deferred tax assets not expected to be realised before this time. The rate change may affect future tax charges. In addition, the utilisation of any tax losses and temporary differences for which no deferred tax asset has been recognised may also affect future tax charges. Deferred taxes at the balance sheet date have been measured using these enacted tax rates and reflected in these financial statements.

Note 1.21 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.22 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.23 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.24 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

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

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.

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 several 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. 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 the intervening years
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis.

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 the intervening years.
•Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern 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 £340m as at 31 March 2026 (2025: £331m).

The Trust property valuation was done using an alternative site in Chippenham as at 31 March 2026.

Note 1.28 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are 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 based on 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 to replace the current assets. In determining the MEA for the current site, the Trust is required to base its assessment on assumptions that are practically achievable; however, these assumptions are purely for valuation purposes and do not imply that the Trust intends or plans to implement 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 considered when deciding on an appropriate alternative site.

For 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. The Trust has not included unused space, unused land, underutilised space and any space not used for healthcare purposes or required to directly support the delivery of healthcare, in the calculation of modern equivalent asset.

Classification of the Sulis Hospital Lease
The Trust has performed a review of IAS40 "Investment Property" and considered the classification of the Trust's external lease of the Sulis hospital site which is sub leased to the wholly owned subsidiary. As a result of this review, it has been concluded that this does not meet the definition of an investment property within the Trust only balance sheet. The Hospital lease has been classified as right to use asset under IFRS16.

Note 1.29 Key sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Land and buildings are included in the statement of financial position at a carrying amount of approximately £289 million at 31 March 2026 (2025: £334 million). These balances are subject to estimation uncertainty arising from the use of modern equivalent asset assumptions and construction cost indices applied within the valuation process.

In 2025/26, the level of estimation uncertainty has increased due to the full revaluation of the Trust's estate, which incorporated detailed estate modelling and resulted in the classification of the estate on a clinical, non-clinical and residential basis. This introduced additional judgement in determining the appropriate valuation basis and assumptions for different parts of the estate.

Note 1.29 Key sources of estimation uncertainty (continued)

Key sources of estimation uncertainty include:

•the classification of assets between clinical, non-clinical and residential categories, which affects the valuation methodology applied;
•assumptions regarding market-based yields, particularly for assets not directly used in service delivery;
•cost per square metre benchmarks and construction cost assumptions used within the valuation models;
•the assessment of functional and economic obsolescence, including the impact of asset condition, configuration and suitability for modern healthcare delivery; and
•compliance and backlog maintenance adjustments, which can significantly affect asset values.

The valuation of land and buildings is particularly sensitive to changes in key assumptions, especially those relating to asset classification, obsolescence and valuation inputs such as yield rates and cost benchmarks.

A reasonably possible change in these assumptions, when applied across the Trust's estate, could result in a material movement in the carrying value of land and buildings, particularly within the clinical estate due to its scale and specialised nature. However, due to the interrelationship of these assumptions, it is not practicable to quantify the impact of changes in individual inputs in isolation.

The Trust mitigates this uncertainty through the use of independent RICS-qualified valuers, detailed estate modelling, and regular valuation reviews in line with the Trust's accounting policies and the requirements of the DHSC Group Accounting Manual.

Sensitivity analysis for MEA key estimation

The valuation of land and buildings is sensitive to changes in key assumptions, particularly those relating to yields, cost benchmarks and assessments of obsolescence.

This sensitivity reflects a reasonably possible movement in a key assumption, rather than a stress scenario. A larger movement would no longer meet the IAS 1 definition of reasonably possible, particularly given the full revaluation and material impairment recognised in-year.

A reasonably possible change in valuation assumptions, such as a movement of approximately 0.25% in yields or equivalent valuation inputs, would result in a change in the carrying value of land and buildings of approximately £6.6 million.

This sensitivity represents an illustrative, single-assumption movement. In practice, valuation inputs are interdependent and changes would occur in isolation.

Note 2 Operating Segments

Operating segments are identified based on the internal financial reports that are regularly reviewed by the Trust Board, which is the Chief Operating Decision Maker. The Trust's activities are organised and managed by legal entity, with financial performance and position reported separately for the core NHS Trust operations, the Sulis Hospital subsidiary and the NHS Charitable Fund.

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. The Trust's Charity is consolidated into group accounts at month 9 and as at year-end. The financial position of Sulis and the Charity has been shown in the segmental analysis below.

Management has applied judgement in determining that the Trust's operating activities should be presented as a single reportable NHS Trust segment. In making this assessment, management considered that the services provided share similar economic characteristics, including the nature of services delivered, funding mechanisms, regulatory environment, cost structures and long-term financial performance. The Sulis Hospital subsidiary and the NHS Charitable Fund are reported separately due to their different objectives, funding sources and risk profiles.

Segment profit or loss, assets and liabilities are measured on the same basis as those used in the Trust's primary financial statements. Segment results are prepared in accordance with the Trust's accounting policies as set out in Note 1 and include allocations of centrally incurred costs where these are directly attributable. No differences exist between the measurement of segment information and the amounts reported in the primary statements.

The Trust derives the majority of its revenue from NHS commissioners. During the year, revenue from NHS England and Integrated Care Boards individually accounted for more than 10% of the Trust's total revenue. This revenue relates entirely to the Trust operating segment.

Revenue from transactions with NHS England amounted to approximately £65 million, representing more than 10% of the Trust's total revenue. Revenue from Integrated Care Boards amounted to approximately £463 million, also representing more than 10% of total revenue. All such revenue relates to the Trust operating segment.

Income and Expenditure analysis by Segment

2025/26	**Trust**	**Sulis**	**Charity**	**Adjustments for intracompany eliminations**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Operating income	599,421	54,506	2,378	(15,731)	**640,574**
Operating expenditure	(667,032)	(52,987)	(3,448)	15,052	**(708,415)**
Operating surplus/(deficit)	**(67,611)**	**1,519**	**(1,070)**	**(679)**	**(67,841)**
Net finance costs	(8,496)	(606)	124	308	**(8,670)**
Surplus/(deficit) for the period	**(76,107)**	**913**	**(946)**	**(371)**	**(76,511)**
Impairments	(12,902)	-	-	-	**(12,902)**
Revaluations	15,281	-	-	-	**15,281**
Fair value gains on financial assets mandated at fair value through OCI	-	-	119	-	**119**
Total comphrensive (expense) / income for the period	**(73,728)**	**913**	**(827)**	**(371)**	**(74,013)**

Note 2 Operating Segments continued

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	-	-	80	-	**80**
Total comphrensive (expense) /	**(1,107)**	**156**	**(842)**	**(568)**	**(2,361)**

Statement of Financial Position analysis by Segment

2025/26

	Trust	Sulis	Charity	Adjustments for intracompany eliminations	Total
	£000	£000	£000	£000	£000
Non-Current Assets	355,811	13,358	4,167	(14,472)	**358,864**
Current Assets	66,593	13,158	3,570	(1,907)	**81,414**
Current Liabilities	(76,861)	(16,006)	(959)	4,089	**(89,737)**
Total assets less current liabilities	**345,543**	**10,510**	**6,778**	**(12,290)**	**350,541**
Non-current liabilities	(57,933)	(11,510)	-	11,472	**(57,971)**
Total net assets employed	**287,610**	**(1,000)**	**6,778**	**(817)**	**292,570**

Statement of Financial Position by Segment

2024/25

	Trust	Sulis	Charity	Adjustments for intracompany eliminations	Total
	£000	£000	£000	£000	£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**

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)	**2025/26**	**2024/25**
	£000	**£000**
Income from commissioners under API contracts - variable element*	166,813	54,676
Income from commissioners under API contracts - fixed element*	296,671	418,210
High cost drugs income from commissioners	59,239	37,022
Other NHS clinical income	5,692	5,270
Private patient income	15,965	15,428
National pay award central funding***	-	1,184
Additional pension contribution central funding**	22,489	21,595
Other clinical income****	12,702	8,309
Total income from activities	**579,571**	**561,694**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

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 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 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**	**2025/26**	**2024/25**
	£000	**£000**
Clinical income	5,276	3,072
Patient care	4,542	2,919
Slam income	1,547	1,533
Overseas visitors	356	369
Prescriptions	99	1,202
RTA compensation	445	-
Intercompany adjustments	(1,523)	(787)
	10,742	**8,309**

Note 3.2 Income from patient care activities (by source)

	2025/26	**2024/25**
Income from patient care activities received from:	**£000**	**£000**
NHS England	64,771	109,050
Integrated care boards	491,731	429,161
Other NHS providers	2,243	2,808
NHS other	552	717
Local authorities	1,258	1,318
Non-NHS: private patients	15,965	15,428
Non-NHS: overseas patients (chargeable to patient)	356	369
Injury cost recovery scheme	445	634
Non NHS: other	2,250	2,209
Total income from activities	**579,571**	**561,694**
Of which:		
Related to continuing operations	579,571	561,694
Related to discontinued operations	-	-

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

	2025/26	2024/25
	£000	£000
Income recognised this year	356	369
Cash payments received in-year	258	203
Amounts written off in-year	221	57

Note 4 Other operating income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	4,080	-	**4,080**	4,804	-	**4,804**
Education and training	19,481	1,009	**20,490**	18,722	1,249	**19,971**
Non-patient care services to other bodies	12,510	-	**12,510**	8,315	-	**8,315**
Income in respect of employee benefits accounted on a gross basis	5,344	-	**5,344**	3,875	-	**3,875**
Receipt of capital grants and donations	-	9,409	**9,409**	-	10,956	**10,956**
Charitable and other contributions to expenditure	-	321	**321**	-	-	**-**
Revenue from operating leases	-	49	**49**	-	469	**469**
Charitable fund incoming resources	-	2,378	**2,378**	-	2,942	**2,942**
Other income	6,422	-	**6,422**	6,058	(194)	**5,864**
Total other operating income	**47,837**	**13,166**	**61,003**	**41,774**	**15,422**	**57,196**
Of which:						
Related to continuing operations			61,003			57,196
Related to discontinued operations			-			-

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

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end*	10,857	13,298

*This was incorrectly disclosed in the prior year and has now been corrected.

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:

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	579,571	561,694
Income from services not designated as commissioner requested services	61,003	57,196
Total	**640,574**	**618,890**

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.

	2025/26	2024/25
	£000	£000
Income	4,522	3,879
Full cost	(3,200)	(3,009)
Surplus	**1,322**	**870**

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)

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	49	469
Total in-year operating lease income	**49**	**469**

Note 5.2 Future lease receipts (Trust)

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	4,022	2,456
- later than one year and not later than two years	4,050	2,506
- later than two years and not later than three years	4,080	2,339
- later than three years and not later than four years	1,024	2,823
- later than four years and not later than five years	-	661
Total	**13,176**	**10,785**

The Trust has multiple lease arrangements with Sulis Hospital which are accounted for under IFRS 16 and IAS 16.

The most significant of the leases are the Hospital lease and the Sulis Orthopaedic Centre. Total income that the Trust received for operating leases from Sulis in 2025/26 was £3.5 million (2024/25: £2.4 million).

The operating lease is a sub lease of a Right of Use asset of the Trust rather than a lease of its own land and buildings.

The income received covered the cost of the leases, the Trust did not make any profit from the leasing arrangements in place.

The Hospital lease and Sulis orthopaedic centre are classified as an operating lease within the Trust accounts, and as such retains the rights over the asset. The remaining lease arrangements are not material to the accounts.

Note 6 Operating expenses (Group)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	152	2
Purchase of healthcare from non-NHS and non-DHSC bodies	3,110	3,678
Staff and executive directors costs	414,520	386,781
Remuneration of non-executive directors	179	185
Supplies and services - clinical (excluding drugs costs)	63,252	58,099
Supplies and services - general	10,197	10,534
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	68,433	63,077
Consultancy costs	2,241	-
Establishment	6,869	5,968
Premises	22,780	22,826
Transport (including patient travel)	1,263	1,315
Depreciation on property, plant and equipment, and Right of use assets	21,769	19,382
Amortisation on intangible assets	1,983	2,637
Net impairments	63,425	10,400
Movement in credit loss allowance: contract receivables / contract assets	259	668
Increase/(decrease) in other provisions	3	297
Change in provisions discount rate(s)	15	18
Audit services- statutory audit (VAT inclusive)	460	311
Other auditor remuneration (external auditor only)	60	80
Internal audit costs	97	-
Clinical negligence	16,324	17,176
Legal fees	305	306
Insurance (as a policy holder)	522	592
Research and development	3,832	4,611
Education and training	4,055	4,313
Expenditure on low value leases	91	102
Hospitality	84	31
Losses, ex gratia & special payments	402	84
Other non-NHS charitable fund resources expended	1,543	684
Other	190	328
Total	**708,415**	**614,485**
Of which:		
Related to continuing operations	708,415	614,485
Related to discontinued operations	-	-

Note 6.1 Other auditor remuneration (Group)

	2025/26	2024/25
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit of accounts of any associate of the Trust	60	80
Total	**60**	**80**

Note 6.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1 million (2024/25: £1 million).

Note 7 Impairment of assets (Group)

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	-	333
Changes in market price	63,425	10,067
Total net impairments charged to operating surplus / deficit	**63,425**	**10,400**
Impairments charged to the revaluation reserve	12,902	2,117
Total net impairments	**76,327**	**12,517**

Note 8 Employee benefits (Group)

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	316,835	300,160
Social security costs	40,307	31,307
Apprenticeship levy	1,464	1,413
Employer's contributions to NHS pensions	56,962	54,548
Pension cost - other	481	408
Temporary staff (including agency)	5,345	5,073
NHS charitable funds staff	730	777
Total gross staff costs	**422,124**	**393,686**
Recoveries in respect of seconded staff	-	-
Total staff costs	**422,124**	**393,686**
Of which		
Costs capitalised as part of assets	2,978	2,111

Note 8.1 Retirements due to ill-health (Group)

During 2025/26, there were 6 early retirements from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £547k (£0k in 2024/25).

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 2026 is based on valuation data as at 31 March 2024, updated to 31 March 2026 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.

The amount recognised as an expense in respect of defined contribution plans represents employer contributions payable for the year and amounted to £56.962 million (2024/25: £54.548 million).

The Trust expects to make employer contributions to the NHS Pension Scheme during the next financial year at rates set nationally by the scheme actuary and the Department of Health and Social Care. Based on current staffing levels, contributions in the next reporting period are expected to be broadly consistent with those recognised in the current year.

As the NHS Pension Scheme is a multi-employer defined benefit scheme, the Trust is unable to identify its share of the underlying scheme assets and liabilities. Any deficit or surplus within the scheme is managed at a national level and does not give rise to additional obligations for individual employers beyond the payment of contributions at the rate set by the scheme actuary.

The Trust is one of a large number of participating employers in the NHS Pension Scheme and its level of participation is consistent with that of other NHS trusts and foundation trusts.

Note 10 Finance income (Group)

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	1,627	2,063
NHS charitable fund investment income	124	258
Total finance income	**1,751**	**2,321**

Note 11.1 Finance expenditure (Group)

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	111	118
Interest on lease obligations	1,821	1,740
Interest on late payment of commercial debt	4	-
Total interest expense	**1,936**	**1,858**
Unwinding of discount on provisions	148	15
Total finance costs	**2,084**	**1,873**

Note 12 Other gains / (losses) (Group)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	11	29
Losses on disposal of assets	-	(15)
Total gains on disposal of assets	**11**	**14**

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 £76.1 million (2024/25: £1.9 million). The Trust's total comprehensive expense for the period was £73.7million (2024/25: £1.1 million).

Note 14 Intangible assets - 2025/26

Group	Software licences	Licences & trademarks	Goodwill	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**2,698**	**15,277**	**974**	**3,228**	**22,177**
Additions	1,154	-	-	5,313	**6,467**
Reclassifications	297	(17)	-	(280)	**-**
Disposals / derecognition	(177)	(1,339)	-	-	**(1,516)**
Cost at 31 March 2026	**3,972**	**13,921**	**974**	**8,261**	**27,128**
Amortisation at 1 April 2025 - brought forward	**1,003**	**13,104**	**-**	**-**	**14,107**
Provided during the year	720	1,263	-	-	**1,983**
Disposals / derecognition	(177)	(1,339)	-	-	**(1,516)**
Amortisation at 31 March 2026	**1,546**	**13,028**	**-**	**-**	**14,574**
Net book value at 31 March 2026	**2,426**	**893**	**974**	**8,261**	**12,554**
Net book value at 1 April 2025	**1,695**	**2,173**	**974**	**3,228**	**8,070**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 14.1 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 15 Intangible assets - 2025/26

Trust	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**2,698**	**15,277**	**3,228**	**21,203**
Additions	1,046	-	5,313	**6,359**
Reclassifications	280	-	(280)	**-**
Disposals / derecognition	(126)	(1,356)	-	**(1,482)**
Cost at 31 March 2026	**3,898**	**13,921**	**8,261**	**26,080**
Amortisation at 1 April 2025 - brought forward	**1,003**	**13,103**	**-**	**14,106**
Provided during the year	717	1,263	-	**1,980**
Disposals / derecognition	(126)	(1,338)	-	**(1,464)**
Amortisation at 31 March 2026	**1,594**	**13,028**	**-**	**14,622**
Net book value at 31 March 2026	**2,304**	**893**	**8,261**	**11,458**
Net book value at 1 April 2025	**1,695**	**2,174**	**3,228**	**7,097**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 15.1 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 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. The impairment of £410k was charged to the accounts in 2021/22. No impairment charge has been made in 2025/26 accounts.

	2025/26	**2024/25**
	£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**

Note 17 Property, plant and equipment - 2025/26

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 2025 - brought forward	**11,728**	**231,242**	**4,086**	**41,602**	**76,738**	**16,732**	**2,149**	**384,277**
Additions	-	14,632	173	15,987	2,151	1,440	243	**34,626**
Impairments	(4,666)	(76,527)	(1,180)	-	-	-	-	**(82,373)**
Reversals of impairments	-	6,046	-	-	-	-	-	**6,046**
Revaluations	-	8,673	-	-	-	-	-	**8,673**
Reclassifications	-	26,111	-	(30,214)	4,097	1	5	**-**
Disposals / derecognition	-	(401)	-	-	(3,450)	(2,859)	(18)	**(6,728)**
Valuation/gross cost at 31 March 2026	**7,062**	**209,776**	**3,079**	**27,375**	**79,536**	**15,314**	**2,379**	**344,521**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**1,215**	**-**	**-**	**38,522**	**9,175**	**1,149**	**50,061**
Provided during the year	-	7,441	140	-	7,534	3,098	198	**18,411**
Impairments	-	-	-	-	-	-	-	**-**
Revaluations	-	(6,468)	(140)	-	-	-	-	**(6,608)**
Disposals / derecognition	-	(401)	-	-	(3,437)	(2,842)	(18)	**(6,698)**
Accumulated depreciation at 31 March 2026	**-**	**1,787**	**-**	**-**	**42,619**	**9,431**	**1,329**	**55,166**
Net book value at 31 March 2026	**7,062**	**207,989**	**3,079**	**27,375**	**36,917**	**5,883**	**1,050**	**289,355**
Net book value at 1 April 2025	**11,728**	**230,027**	**4,086**	**41,602**	**38,216**	**7,557**	**1,000**	**334,216**

Note 17.1 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 17.2 Property, plant and equipment financing - 31 March 2026

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	7,062	201,370	3,079	7,310	30,492	5,878	1,023	**256,214**
Owned - donated/granted	-	6,619	-	20,065	6,425	5	27	**33,141**
NBV total at 31 March 2026	**7,062**	**207,989**	**3,079**	**27,375**	**36,917**	**5,883**	**1,050**	**289,355**

Note 17.3 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 17.4 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

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	35	-	-	-	-	-	-	**35**
Not subject to an operating lease	7,027	207,989	3,079	27,375	36,917	5,883	1,050	**289,320**
NBV total at 31 March 2026	**7,062**	**207,989**	**3,079**	**27,375**	**36,917**	**5,883**	**1,050**	**289,355**

Note 17.5 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 18 Property, plant and equipment - 2025/26

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 2025 - brought forward	**11,728**	**229,225**	**4,086**	**41,601**	**73,623**	**16,441**	**2,081**	**378,785**
Additions	-	14,202	174	15,987	1,998	1,404	49	**33,814**
Impairments	(4,666)	(76,527)	(1,180)	-	-	-	-	**(82,373)**
Reversals of impairments	-	6,046	-	-	-	-	-	**6,046**
Revaluations	-	8,673	-	-	-	-	-	**8,673**
Reclassifications	-	22,664	-	(26,997)	4,333	-	-	**-**
Disposals / derecognition	-	(401)	-	(3,216)	(3,201)	(2,651)	(7)	**(9,476)**
Valuation/gross cost at 31 March 2026	**7,062**	**203,882**	**3,080**	**27,375**	**76,753**	**15,194**	**2,123**	**335,469**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**823**	**-**	**-**	**37,649**	**8,961**	**1,105**	**48,538**
Provided during the year	-	6,818	140	-	6,798	3,051	170	**16,977**
Revaluations	-	(6,468)	(140)	-	-	-	-	**(6,608)**
Disposals / derecognition	-	(401)	-	-	(3,188)	(2,634)	(7)	**(6,230)**
Accumulated depreciation at 31 March 2026	**-**	**772**	**-**	**-**	**41,259**	**9,378**	**1,268**	**52,677**
Net book value at 31 March 2026	**7,062**	**203,110**	**3,080**	**27,375**	**35,494**	**5,816**	**855**	**282,792**
Net book value at 1 April 2025	**11,728**	**228,402**	**4,086**	**41,601**	**35,974**	**7,480**	**976**	**330,247**

Note 18.1 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 18.2 Property, plant and equipment financing - 31 March 2026

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	7,062	196,491	3,080	7,310	29,069	5,811	828	**249,651**
Owned - donated / granted	-	6,619	-	20,065	6,425	5	27	**33,141**
Total net book value at 31 March 2026	**7,062**	**203,110**	**3,080**	**27,375**	**35,494**	**5,816**	**855**	**282,792**

Note 18.3 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 18.4 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

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	35	-	-	-	-	-	-	**35**
Not subject to an operating lease	7,027	203,110	3,080	27,375	35,494	5,816	855	**282,757**
Total net book value at 31 March 2026	**7,062**	**203,110**	**3,080**	**27,375**	**35,494**	**5,816**	**855**	**282,792**

Note 18.5 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**

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 were 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
Land	0	0
Buildings, excluding dwellings	2	62
Dwellings	30	46
Plant & machinery	2	22
Information technology	2	7
Furniture & fittings	2	17

Note 19 Donations of property, plant and equipment

The Trust received donations from which assets were purchased to the value of £9.7m (£2.5m 2024/25).

The donations were made up as follows:
- £9.1m Salix Grant for Decarbonisation Heat Scheme.
- £0.3m from RUHX for various medical equipment.
- £0.1m from Friends of RUH for medical equipment.
- £0.1m grant from National Institute for Health and Care Research for Drugs cabinets.
- £0.05m grant for sub metering scheme from Crown Commercial Service.
- £0.05m from Bath Cancer Support for Paediatric Oncology works scheme.

Note 20 Revaluations of property, plant and equipment

In 2024/25, the Trust undertook a full revaluation of its land and buildings. This valuation was carried out by Gerald Eve, who are members of the Royal Institution of Chartered Surveyors and are independent of the Trust.

In 2025/26, the Trust completed a further full revaluation of its Combe Park estate. As part of this process, a third party was engaged to support the Trust's Estates team in undertaking detailed estate modelling, enabling a more granular assessment of the Trust's property portfolio. This modelling facilitated the analysis and valuation of the estate on a clinical, non-clinical and residential basis, reflecting differences in use, specification and service delivery. Following the estate modelling exercise, the valuation of land, buildings and dwellings as at 31 March 2026 was carried out by Carter Jonas, who are members of RICS and are independent of the Trust.

Three assets were excluded from the Modern Equivalent Asset (MEA) valuation and instead valued at fair value, as they are occupied by third parties and are not used in the delivery of healthcare services by the Trust.

Separately, the Trust's building at Sulis Hospital, the Sulis Orthopaedic Centre, was revalued by Gerald Eve upon becoming operational during 2025/26. An appropriate indexation adjustment has been applied as at 31 March 2026 to ensure the asset is held at current value.

The valuation was completed in accordance with the RICS Appraisal and Valuation Manual, insofar as these requirements are consistent with the agreed requirements of the Department of Health and Social Care Group Accounting Manual (GAM) and HM Treasury's Financial Reporting Manual (FReM), and in line with the Trust's accounting policies (see note 1).

Valuation basis and key assumptions

Land and buildings were valued on an Depreciated Replacement Cost (DRC) on Modern Equivalent Asset (MEA) basis, with key valuation assumptions including:

•allowances for optimisation of floor area and land arising from obsolete space; significant inefficiencies caused by lack of co-location and requirement in perimeter service roads, curtilage and lightwells required.

•cost per square metre benchmarks reflecting asset type and condition, with an adjustment for age based depreciation compared to a modern equivalent asset with gross life of 60 years.

•allowances for functional and economic obsolescence arising from modern clinical and non-clinical building standard and space optimisation, such as use of natural light.

•compliance requirements associated for modern methods of construction, building & energy efficiency regulations and backlog maintenance considerations, where relevant.

The substantive change to valuation giving rise to the reduced valuation of land and buildings as been driven by a revised assessment of floor area (reduction of 14%) and land (reduction of 24 to 14 acres) requirements.

The key judgement and assumptions have been prepared by Trust Estates team and Trust's Valuation specialists. These have been scrutinised and assured by Trust Management. Trust Management has enquired on the robustness of the assumptions and supporting evidence, including benchmarking equivalent NHS Hospitals and building standards and DHSC design principles.

Note 20 Revaluations of property, plant and equipment (continued)

Each assumption can give risk to a material change in valuation of the Trust assets. A sensitivity analysis has been undertaken and 5% point changes in assumptions upwards or downwards would give rise to following range of valuation:

Gross Internal Asset (GIA) floor area: £11.5m

Age-based Physical depreciation useful life remaining: £18.7m

Running Cost Inefficiency 15%/17.5%: £11.9m

The Trust view is that there is no reasonably possible change in land or functional obsolescence that would lead to a material movement in valuation.

Assets outside the MEA approach were valued on a fair value basis, reflecting their alternative use and income-generating characteristics.

Impact of revaluations

As a result of the revaluation undertaken in 2025/26, a total net impairment of £63.43 million, after taking into account movements in revaluation reserves on relevant assets, has been recognised in the accounts in respect of land, buildings and dwellings. The impairment primarily reflects updated valuation assumptions and the refined classification of the Trust's estate following detailed estate modelling.

Estate classification	Gross carrying amount at 31 March 2025 (Trust) £'m	Revaluation movements £'m	Impairments recognised £'m	Additions £'m	Brought into Use £'m	Gross carrying amount at 31 March 2026 (Trust) £'m	Accumulated depreciation (Trust) £'m	Net book value at 31 March 2026 (Trust) £'m
Clinical estate	186	2	- 29	11	2	172	-	172
Non-clinical estate	47	- 7	- 16	1	-	25	-	25
Fair Value	-	-	-	-	-	-	-	-
Sulis Orthopaedic Centre	22	-	- 13	-	-	9	-	9
Land	12	-	- 5	-	-	7	-	7
Total	**267**	- **5**	- **63**	**12**	**2**	**213**	-	**213**

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 Sulis Hospital Site.

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 - 2025/26

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 2025 - brought forward	**56,798**	**6,359**	**159**	**63,316**	**1,496**
Additions	425	-	36	**461**	-
Remeasurements of the lease liability	989	-	-	**989**	-
Movements in provisions for restoration / removal costs	2,970	-	-	**2,970**	-
Disposals / derecognition	(3,933)	(575)	(18)	**(4,526)**	-
Valuation/gross cost at 31 March 2026	**57,249**	**5,784**	**177**	**63,210**	**1,496**
Accumulated depreciation at 1 April 2025 - brought forward	**10,170**	**2,480**	**82**	**12,732**	**630**
Provided during the year	2,872	456	30	**3,358**	218
Disposals / derecognition	(3,266)	(575)	(18)	**(3,859)**	-
Accumulated depreciation at 31 March 2026	**9,776**	**2,361**	**94**	**12,231**	**848**
Net book value at 31 March 2026	**47,473**	**3,423**	**83**	**50,979**	**648**
Net book value at 1 April 2025	**46,628**	**3,879**	**77**	**50,584**	**866**

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	648

Note 23.1 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	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 24 Right of use assets - 2025/26

Trust	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 2025 - brought forward	**54,126**	**5,417**	**159**	**59,702**	**1,497**
Additions	413	-	36	**449**	-
Remeasurements of the lease liability	989	-	-	**989**	-
Movements in provisions for restoration / removal costs	2,970	-	-	**2,970**	-
Disposals / derecognition	(3,933)	(575)	(18)	**(4,526)**	-
Valuation/gross cost at 31 March 2026	**54,565**	**4,842**	**177**	**59,584**	**1,497**
Accumulated depreciation at 1 April 2025 - brought forward	**8,212**	**1,679**	**81**	**9,972**	**833**
Provided during the year	2,479	725	30	**3,234**	218
Reclassifications	-	-	-	**-**	(203)
Disposals / derecognition	(3,266)	(575)	(18)	**(3,859)**	-
Accumulated depreciation at 31 March 2026	**7,425**	**1,829**	**93**	**9,347**	**848**
Net book value at 31 March 2026	**47,140**	**3,013**	**84**	**50,237**	**649**
Net book value at 1 April 2025	**45,914**	**3,738**	**78**	**49,730**	**664**

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	649

Note 24.1 Right of use assets - 2024/25

Trust	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	**53,248**	**2,621**	**85**	**55,954**	**1,497**
Additions	-	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 24.2 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 33.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April	**53,006**	**52,000**	**52,543**	**51,595**
Lease additions	461	3,081	449	2,870
Lease liability remeasurements	989	662	989	662
Interest charge arising in year	1,821	1,740	1,802	1,717
Early terminations	(676)	(32)	(676)	-
Lease payments (cash outflows)	(3,850)	(4,445)	(3,703)	(4,301)
Carrying value at 31 March	**51,751**	**53,006**	**51,404**	**52,543**

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 2026

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2026	31 March 2026
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	3,919	225	3,778	225
- later than one year and not later than five years;	14,218	442	13,988	442
- later than five years.	55,985	-	55,986	-
Total gross future lease payments	**74,122**	**667**	**73,752**	**667**
Finance charges allocated to future periods	(22,371)	(9)	(22,348)	(9)
Net lease liabilities at 31 March 2026	**51,751**	**658**	**51,404**	**658**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		658		658

Note 24.4 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	183
- later than one year and not later than five years;	15,463	548	15,106	548
- later than five years.	57,109	-	57,108	-
Total gross future lease payments	**76,684**	**731**	**76,179**	**731**
Finance charges allocated to future periods	(23,678)	(10)	(23,636)	(10)
Net finance lease liabilities at 31 March 2025	**53,006**	**721**	**52,543**	**721**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		721		721

Note 25 Other investments / financial assets (non-current)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**3,953**	**4,833**	**3,941**	**3,941**
Acquisitions in year	45	40	-	-
Movement in fair value through OCI	119	80	-	-
Disposals	-	(1,000)	-	-
Carrying value at 31 March	**4,117**	**3,953**	**3,941**	**3,941**

Note 26 Analysis of charitable fund reserves

	31 March 2026	31 March 2025
	£000	£000
Unrestricted funds:		
Unrestricted income funds	4,260	3,977
Restricted funds:		
Other restricted income funds	2,549	3,659
	6,809	**7,636**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 27 Inventories

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Drugs	1,929	3,249	1,883	2,508
Consumables	6,549	5,474	4,280	4,161
Energy	143	113	143	113
Total inventories	**8,621**	**8,836**	**6,306**	**6,782**

Inventories recognised in expenses for the year were £106,400k (2024/25: £91,664k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

Note 28 Receivables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Contract receivables	34,244	23,321	27,251	19,119
Capital receivables	1,526	4,835	1,526	4,835
Allowance for impaired contract receivables / assets	(1,530)	(1,383)	(1,263)	(1,062)
Deposits and advances	12	15	12	15
Prepayments (non-PFI)	7,469	6,435	6,802	5,558
Finance lease receivables	-	-	834	361
PDC dividend receivable	795	1,192	795	1,192
VAT receivable	532	177	532	177
Other receivables	561	550	559	552
NHS charitable funds receivables	879	1,580	-	-
Total current receivables	**44,488**	**36,722**	**37,048**	**30,747**
Non-current				
Contract assets	1,432	1,516	1,432	1,521
Allowance for impaired contract receivables / assets	(291)	(307)	(291)	(307)
Finance lease receivables	-	-	5,574	3,232
Other receivables	668	738	668	738
NHS charitable funds receivables	50	-	-	-
Total non-current receivables	**1,859**	**1,947**	**7,383**	**5,184**
Of which receivable from NHS and DHSC group bodies:				
Current	16,227	14,682	14,285	12,789
Non-current	668	738	668	738

Note 28.1 Allowances for credit losses - 2025/26

	Group Contract receivables and contract assets	Trust Contract receivables and contract assets
	£000	£000
Allowances as at 1 Apr 2025 - brought forward	**1,690**	**1,369**
New allowances arising	151	179
Changes in existing allowances	309	311
Reversals of allowances	(201)	(201)
Utilisation of allowances (write offs)	(128)	(102)
Allowances as at 31 Mar 2026	**1,821**	**1,555**

Note 28.2 Allowances for credit losses - 2024/25

	Group Contract receivables and contract assets	Trust 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 29 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 29.1 Reconciliation of the carrying value of finance lease receivables (net investment in the lease)

	Trust	
	2025/26	**2024/25**
	£000	**£000**
Finance lease receivables at 1 April	**3,593**	3,941
Additions	3,646	-
Interest arising (unwinding of discount)	275	123
Lease receipts (cash payments received)	(1,106)	(471)
Finance lease receivables at 31 March	**6,408**	**3,593**

Note 29.2 Finance lease receivables maturity analysis as at 31 March 2026

	Trust	
	Total	**Of which leased to DHSC group bodies:**
	31 March 2026	**31 March 2026**
	£000	**£000**
Undiscounted future lease receipts receivable in:		
not later than one year;	834	-
later than one year and not later than two years;	1,013	-
later than two years and not later than three years;	1,014	-
later than three years and not later than four years;	971	-
later than four years and not later than five years;	928	-
later than five years.	2,974	-
Total future finance lease payments to be received	**7,734**	**-**
Unearned interest income	(1,326)	-
Net investment in lease (net lease receivable)	**6,408**	**-**
of which:		
Leased to other NHS providers		-
Leased to other DHSC group bodies		-

Note 29.3 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 30 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	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	**40,024**	**38,526**	**36,648**	**33,865**
Net change in year	(11,720)	1,498	(13,409)	2,783
At 31 March	**28,304**	**40,024**	**23,239**	**36,648**
Broken down into:				
Cash at commercial banks and in hand	2,378	2,738	4	4
Cash with the Government Banking Service	25,926	37,286	23,235	36,644
Total cash and cash equivalents as in SoFP	**28,304**	**40,024**	**23,239**	**36,648**
Total cash and cash equivalents as in SoCF	**28,304**	**40,024**	**23,239**	**36,648**

Note 30.1 Breakdown of cash and cash equivalents held by Sulis Hospital and RUH X Charity

	Sulis Hospital		RUH X Charity	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Cash at commercial banks and in hand	2,374	901	-	1,833
Cash with the Government Banking Service	-	-	2,691	642
	2,374	**901**	**2,691**	**2,475**

The Trust does not have any liquid investments or short term loans with National Loan Fund as at year-end.

Note 30.2 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 2026	31 March 2025
	£000	£000
Bank balances	**12**	**12**

Note 31 Trade and other payables

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Trade payables	6,917	2,287	2,250	1,437
Capital payables	4,740	9,139	4,740	9,139
Accruals	19,719	19,801	15,968	16,153
Social security costs	8,472	7,394	8,351	7,394
VAT payables	175	-	-	-
Pension contributions payable	4,890	4,554	4,848	4,554
Other payables	27,195	24,123	27,164	22,947
NHS charitable funds: trade and other payables	928	372	-	-
Total current trade and other payables	**73,036**	**67,670**	**63,321**	**61,625**
Of which payables from NHS and DHSC group bodies:				
Current	5,290	4,034	5,290	3,877

Note 31.1 Early retirements in NHS payables above

There were no early retirements in the NHS payables stated above.

Note 32 Other liabilities

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Deferred income: contract liabilities	13,612	10,857	10,761	8,634
Total other current liabilities	**13,612**	**10,857**	**10,761**	**8,634**

Note 33 Borrowings

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Loans from DHSC	343	345	343	345
Lease liabilities	2,316	2,317	2,006	2,185
Total current borrowings	**2,659**	**2,662**	**2,349**	**2,530**
Non-current				
Loans from DHSC	4,225	4,538	4,225	4,538
Lease liabilities	49,435	50,689	49,398	50,358
Total non-current borrowings	**53,660**	**55,227**	**53,623**	**54,896**

Note 33.1 Reconciliation of liabilities arising from financing activities (Group)

Group - 2025/26	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2025	**4,883**	**53,006**	**57,889**
Cash movements:			
Financing cash flows - payments and receipts of principal	(313)	(2,029)	**(2,342)**
Financing cash flows - payments of interest	(113)	(1,821)	**(1,934)**
Non-cash movements:			
Additions	-	461	**461**
Lease liability remeasurements	-	989	**989**
Application of effective interest rate	111	1,821	**1,932**
Early terminations	-	(676)	**(676)**
Carrying value at 31 March 2026	**4,568**	**51,751**	**56,319**

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**

Note 33.2 Reconciliation of liabilities arising from financing activities

Trust - 2025/26	Loans from DHSC	Lease liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2025	**4,883**	**52,543**	**57,426**
Cash movements:			
Financing cash flows - payments and receipts of principal	(313)	(1,901)	**(2,214)**
Financing cash flows - payments of interest	(113)	(1,802)	**(1,915)**
Non-cash movements:			
Additions	-	449	**449**
Lease liability remeasurements	-	989	**989**
Application of effective interest rate	111	1,802	**1,913**
Early terminations	-	(676)	**(676)**
Carrying value at 31 March 2026	**4,568**	**51,404**	**55,972**

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**

Note 34 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 2025	**667**	**122**	**140**	**1,318**	**2,247**
Change in the discount rate	15	-	-	(51)	**(36)**
Arising during the year	27	163	-	3,021	**3,211**
Utilised during the year	(89)	-	-	(566)	**(655)**
Reversed unused	(7)	(122)	-	(89)	**(218)**
Unwinding of discount	30	-	-	161	**191**
At 31 March 2026	**643**	**163**	**140**	**3,794**	**4,740**
Expected timing of cash flows:					
- not later than one year;	89	163	140	38	**430**
- later than one year and not later than five years;	310	-	-	-	**310**
- later than five years.	244	-	-	3,756	**4,000**
Total	**643**	**163**	**140**	**3,794**	**4,740**

Note 34.1 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 2025	**667**	**122**	**140**	**1,318**	**2,247**
Change in the discount rate	15	-	-	(51)	**(36)**
Arising during the year	27	163	-	3,021	**3,211**
Utilised during the year	(89)	-	-	(566)	**(655)**
Reversed unused	(7)	(122)	-	(89)	**(218)**
Unwinding of discount	30	-	-	161	**191**
At 31 March 2026	**643**	**163**	**140**	**3,794**	**4,740**
Expected timing of cash flows:					
- not later than one year;	89	163	140	38	**430**
- later than one year and not later than five years;	310	-	-	-	**310**
- later than five years.	244	-	-	3,756	**4,000**
Total	**643**	**163**	**140**	**3,794**	**4,740**

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 recognised in respect of employment-related matters. The amounts provided represent management's best estimates based on known risks and salary costs and are therefore subject to inherent uncertainty. Other provisions include £2.97 million recognised under IFRS 16 for the estimated cost of restoring leased properties to their original condition at the end of the lease term. An equivalent amount was included in the cost of the right-of-use asset on initial recognition.

Note 34.2 Clinical negligence liabilities

At 31 March 2026, £199,186k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal United Hospitals Bath NHS Foundation Trust (31 March 2025: £197,058k).

Note 35 Contingent assets and liabilities

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	1	2	1	2
Gross value of contingent liabilities	**1**	**2**	**1**	**2**
Net value of contingent liabilities	**1**	**2**	**1**	**2**
Net value of contingent assets	**-**	**-**	**-**	**-**

NHS Resolution claims
Contingent liabilities represent potential legal claims and property-related costs managed by NHS Resolution (formerly the NHS Litigation Authority). The Trust has not identified any contingent assets for 2025/26 (nil reported in 2024/25).

Note 36 Contractual capital commitments

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Property, plant and equipment	3,568	14,403	3,568	14,403
Intangible assets	231	517	231	517
Total	**3,799**	**14,920**	**3,799**	**14,920**

Note 37 Financial instruments

Note 37.1 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 2026 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 37.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	36,611	-	**36,611**
Cash and cash equivalents	25,613	-	**25,613**
Consolidated NHS Charitable fund financial assets	879	6,858	**7,737**
Total at 31 March 2026	**63,103**	**6,858**	**69,961**

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**

Note 37.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	36,249	-	**36,249**
Cash and cash equivalents	25,613	-	**25,613**
Total at 31 March 2026	**61,862**	**-**	**61,862**

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**

Financial assets held at fair value through OCI

The Trust's only assets measured at fair value after initial recognition relate to investment funds held by the NHS Charitable Fund. These investments are traded in active markets and are valued using quoted market prices at the reporting date, without adjustment. As such, the fair value measurement is based on observable inputs and does not involve significant judgement or estimation. The Trust therefore categorises these investments within Level 1 of the fair value hierarchy. The Trust does not hold any assets or liabilities measured at fair value that are categorised within Level 2 or Level 3 of the fair value hierarchy. Consequently, disclosures relating to significant unobservable inputs, valuation processes, sensitivity analyses, movements within Level 3, or transfers between levels are not applicable.

Note 37.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	4,568	**4,568**
Obligations under leases	51,751	**51,751**
Trade and other payables excluding non financial liabilities	57,698	**57,698**
Provisions under contract	4,740	**4,740**
Consolidated NHS charitable fund financial liabilities	928	**928**
Total at 31 March 2026	**119,685**	**119,685**

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**

Note 37.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	4,568	**4,568**
Obligations under leases	51,404	**51,404**
Trade and other payables excluding non financial liabilities	60,038	**60,038**
Provisions under contract	4,740	**4,740**
Total at 31 March 2026	**120,750**	**120,750**

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**

Note 37.6 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 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
In one year or less	63,455	61,072	64,657	54,920
In more than one year but not more than five years	20,128	18,408	15,898	17,053
In more than five years	59,312	60,824	63,312	61,821
Total	**142,895**	**140,304**	**143,867**	**133,794**

Note 38 Losses and special payments

	2025/26		2024/25	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Fruitless payments and constructive losses	2	389	-	-
Bad debts and claims abandoned	3	-	23	61
Stores losses and damage to property	-	-	1	1
Total losses	**5**	**389**	**24**	**62**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	2	3
Ex-gratia payments	19	13	25	20
Total special payments	**19**	**13**	**27**	**23**
Total losses and special payments	**24**	**402**	**51**	**85**

Note 39 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, undertook any material transactions with Royal United Hospitals Bath NHS Foundation Trust.

The Department of Health and Social Care (DHSC) is regarded as a related party. During the period from 1 April 2025 to 31 March 2026, the Trust had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent body. These entities included:

Integrated Care Boards:
NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board
NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board
NHS Somerset Integrated Care Board

NHS bodies:
NHS England (including regional and specialised commissioning functions)
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 public sector bodies:
Department of Health and Social Care
NHS Resolution
NHS Blood and Transplant
Bath and North East Somerset Council
Wiltshire Council
Welsh Government and Welsh NHS bodies

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 2025/26, the Trust received £1.1m (2024/25: £2.3m) from RUH X for various medical equipment and Cancer Centre enabling works. The audited accounts of the Charitable Funds are available at www.ruh.nhs.uk.

Note 40 Events after the reporting date

The Group Chair, Paul von der Heyde, for the BSW Hospitals Group was appointed on 1 April 2026.