Royal United Hospitals Bath
NHS Foundation Trust

Annual Report and Accounts

2021/22

Royal United Hospitals Bath NHS Foundation Trust

Annual Report and Accounts

2021/22

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

Contents

Message from the Chair and Chief Executive

We would like to open this year's statement with a huge thank you to all our staff here at the Royal United Hospitals Bath NHS Foundation Trust (RUH) for their hard work, resilience and dedication in the face of yet another challenging 12 months, working with and under the pressures and restrictions caused by COVID-19. We remain in awe of the professionalism and compassion staff have shown as they continue to provide outstanding care to our patients despite the circumstances. Our teams went above and beyond, often at risk to themselves and those closest to them, to provide the best quality care to all our patients in often trying conditions, and in the face of ever changing guidance as the different variants took hold.

We know that this unrelenting pressure has taken its toll on some of our colleagues, and we are working hard to provide all the support we can to ensure that our teams can replenish and refresh themselves. This will include ensuring that we do all we can to recruit to all our vacant posts both clinical and non-clinical and equipping our managers to help their teams better manage their own health and wellbeing.

Our Vaccination Centre at Bath Racecourse yet again played a vital role throughout the year in keeping our community safe, delivering well over 230,000 vaccinations since it opened in January 2021. In December 2021, the centre successfully stepped up to the challenge of delivering the COVID-19 booster programme, and by January 2022 had delivered more than 50,000 booster jabs. We say a massive thank you to all the staff, volunteers and partners who have contributed to the success of our local vaccination programme.

The Vaccination Centre is one example of the successful partnership working which has resulted from the pandemic when we learned just how crucial collaboration is within the health and care community. We are proud to have worked closely with partners across Bath and North East Somerset, Swindon and Wiltshire this year. Joint initiatives such as the temporary care facility opened in a Bath hotel and the additional ward opened at St Martin's Hospital, have helped to reduce pressure on our beds at a time of unprecedented demand. We are committed to building on the relationships we have established during in this time and working together to strengthen our community.

One of the key priorities for the whole of the NHS this year has been providing timely and appropriate care to the many thousands of patients whose elective operations and other episodes of care had to be postponed during the worst of the pandemic. In June 2021, we took the almost unprecedented step of purchasing a 100% interest in one of the local private hospitals in Bath, the Circle Bath Hospital (now renamed Sulis Hospital Bath). It is worth noting that we purchased the business, but not the building, which is subject to a lease arrangement.

One of the main reasons for making this acquisition was to secure extra capacity for the care of NHS patients at this critical time of recovery for our waiting lists. Sulis

Hospital has already treated over a thousand patients who were on NHS waiting lists and we continue to progress an ambitious strategy to increase capacity at the site so that as many of our patients as possible are able to receive the care that they need as soon as possible. We are also keen that whatever surplus Sulis Hospital is able to generate from its private work is re-invested into NHS care.

As the worst of the pandemic has started to fade, we are seeing demand for our emergency services reach and indeed exceed pre-pandemic levels. Patients are having to wait much longer than they should to be seen in our Emergency Department, and on numerous occasions, ambulances have been significantly delayed in conveying patients here. While many of these delays were attributable to rises in demand, staff absences as a result of COVID, and the extra steps that we have had to take to keep our patients and staff safe from infection, many patients who although medically fit enough to be discharged, are having to remain in hospital for considerable periods. This is either because there is not the support available for them to return to their own homes, or the appropriate step-down facilities to care for them in the community are not accessible to them. This sadly has meant that many, particularly elderly patients, having stayed far too long in hospital become deconditioned and lose their independence, and the number of beds available for new admissions, is further reduced. Again, we are working closely with our community and local authority partners to find new and innovative solutions to these issues.

Despite the pandemic, we continue to look ahead, and we are moving forward with major capital projects that have been transforming the hospital site and making the RUH fit for the future. In March 2022 we reached a new milestone on the biggest ongoing project on our site, the new Dyson Cancer Centre, when we held a ‘topping out’ ceremony to mark completion of the frame of the new building. The building, which will bring the majority of our cancer services under one roof, is on-track to open in Autumn 2023.

We have also been focusing on the steps that we need to take to make our site and the services that we provide as sustainable as possible. We are keen to ensure that the Trust, and its staff and partners, are all able to do our bit to reduce our impact on the environment, and help avoid the worst impacts of climate change. This year we appointed a dedicated Energy Manger and a Net Zero Carbon Apprentice, to work on energy efficiency projects and help deliver our ambitious Carbon Reduction Strategy with the ultimate aim of becoming carbon neutral by 2030. We have made great progress this year, reducing our carbon emissions from gas and electricity by around 14% and introducing a number of initiatives to reduce our impact on the planet.

Finally, we must of course acknowledge the huge contribution of everyone who supports the Trust – our Council of Governors, our 17,000 members, the Forever Friends Appeal and Friends of the RUH and their generous supporters, as well as

the many volunteers from across our community. All have a vital part to play and we are hugely appreciative of each and every person.

Here’s to a brighter 2022/23, building further on the successes of this year and embedding important learning from the pandemic as we go.

Performance Report

Overview of performance during 2021/22

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

About the Trust

Statutory background

The Royal United Hospitals Bath NHS Foundation Trust is authorised under the National Health Service Act 2006 to provide goods and services for the purposes of the Health Service in England. It was established as an NHS Trust in 1992 and achieved Foundation status in November 2014. On 1 February 2015 the Trust acquired the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RNHRD) which further expanded the RUH's portfolio of specialist treatment and rehabilitation.

On 1 June 2021, following a competitive bidding process, the Trust acquired from the Circle Health Group, 100% of the share capital of Circle Hospital Bath. The background to this acquisition was that as part of its bid to acquire BMI Holdings (which owned Bath Clinic), the Competitions and Markets Authority mandated that Circle Holdings would need to divest itself of Circle Hospital Bath, to avoid it gaining a monopoly over private healthcare provision within the city. Circle Bath had provided necessary extra elective capacity for the NHS over the years, and the Trust took the view that it would be prudent to seek to acquire the facility both to safeguard that capacity, but also to provide a "cold" elective site for the wider area. The Trust was successful in its bid and the hospital was renamed Sulis Hospital Bath with effect from 1 June.

Sulis Hospital is situated in the Peasedown St John area on the outskirts of Bath, and it contains 28 en-suite bedrooms, 22 day case beds and 4 operating theatres. The hospital carries out a range of acute, minor and more complex surgery, as well as other types of treatments. As well as its care for private self-funded and insured patients, since its inception the hospital has also treated NHS patients as part of the "Choose and Book" system, and it played a key part in helping ease the pressure on elective surgery backlogs in the early part of the COVID-19 pandemic. Sulis Hospital Bath is managed as a limited liability company by its own board of directors but it is a wholly owned subsidiary of the RUH.

Purpose and activities

The Trust serves a population of approximately 500,000 residents across Bath and North East Somerset, West Wiltshire, Somerset and South Gloucestershire. In

addition to our core local population, we also treat people visiting our area, including tourists, students and overseas visitors.

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

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

Our core business is the provision of NHS services under contracts to Bath and North East Somerset, Swindon and Wiltshire (BSW) and South Gloucestershire clinical commissioning groups (CCG) as well as NHS England specialised service commissioners. It is worth noting that the BSW CCG came into existence on 1 April 2020 following a merger of the previous BaNES, Swindon and Wiltshire CCGs. We are conscious of the new arrangements that will come into force now that the Health and Care Act 2022 has received Royal Assent, and as the Integrated Care Systems established by the Act take on their statutory roles from 1 July 2022. A key feature of this new world will be the requirement for the constituent organisations of the ICS to work together in order that care is provided seamlessly. There is a clear commitment to collaborate within BSW, and although it may take some time for the new arrangements to bed in, there is optimism that those who use services locally will start to realise the benefits of integration in the very near future.

The Trust is a key member of the BaNES, Swindon and Wiltshire Integrated Care System (BSW ICS). Integrated Care Systems are formal partnerships between NHS organisations, local authorities and other key local organisations whose role is to take responsibility for managing available resources with a view to improving the health of the local population.

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

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

- Pulmonary hypertension

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

As stated above, in June 2021, the Trust acquired 100% of the share capital of a local private hospital, Circle Hospital Bath, which was subsequently renamed Sulis Hospital Bath. The unit, situated on the outskirts of Bath, contains 28 en-suite bedrooms, 22 day-case beds and 4 operating theatres. It provides a range of hospital treatments including minor and more complex orthopaedic surgery, diagnostic investigations and some medical procedures. Sulis Hospital is governed by its own board, which is currently chaired by an RUH Non-Executive Director, and it is a private limited liability company registered with Companies House. Although this company is a wholly owned subsidiary of the RUH, the Trust is not involved in its operational management.

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

In common with other areas, our population is evolving:

- We have a growing population of people with more complex needs, in all age groups but in particular in our older population and those with long-term conditions
- There are, rightly, rising public expectations in terms of the quality and availability of public services
- There are two universities located within the City of Bath, meaning that we have a large student population that is temporary and always changing

Patients are at the heart of all we do, and we aspire to be responsive and compassionate at all times. We place great importance on gathering feedback from patients and carers, and involving them in decisions and developments. This is embedded in the Trust through our Patient Experience Strategy supported by an Engagement Toolkit and a range of initiatives and practices, such as our complaints service, consultations and events, social media and other communications, and our volunteers, membership and governors. We have had to adapt the way that we engage with patients and their families and carers during the pandemic, with more reliance placed on virtual opportunities to receive feedback, such as by telephone, email or via the Trust website.

We aim to provide the highest quality of services in response to the needs of our patients and the communities we serve. Our Trust Strategy sets out our overall goals to achieve high quality care and patient experience, putting patients at the heart of all we do. It is built around five key strategic goals and also reflects our core trust

values. Our programme of whole organisation development “Improving Together” is designed to support its delivery.

Supporting and developing our workforce has been a key focus of this strategy, and our innovative quality improvement programme, Improving Together, which was launched in 2018, seeks to galvanise all of our staff to take responsibility for suggesting and implementing improvements in their areas, regardless of their seniority or professional background. As part of this approach, four focus areas were identified as “breakthrough objectives”, relating to our strategic goals, for focused improvement activity by our frontline teams. These are areas that we identified as requiring significant changes to the way that we operate. The breakthrough objectives for 2021/22 were:

- 40% of staff answer question 11a of the NHS Staff Survey (2021) – ‘My organisation takes positive action on health and wellbeing’ positively
- There are 0 waits over 60 minutes for ambulance handovers
- Reduce hospital acquired infections.

On 28 April 2022, the Heath and Care Act 2022 received Royal Assent, meaning that with effect from 1 July 2022, Integrated Care Systems will be able to take on their statutory responsibilities. For the BSW area, this will mean that all the key partners from across the health and care network, including the third sector, will be able to work collaboratively and pool resources to improve the health outcomes of all citizens, although to start with, organisations will continue to be accountable for the use of the resources that have been specifically allocated to them. The RUH already works closely with the two other acute hospitals in the patch, Great Western Hospitals Foundation Trust and Salisbury Foundation Trust. The ICS will have an important role in setting the strategic direction for services and making key decisions

as to how funding is shared among partners. The Trust is already heavily involved in key aspects of the ICS' work, both centrally and at "Place" (local) level, and looks forward to continuing on this path from 1 July 2022.

Performance analysis

Operational performance

The Trust produces an integrated balanced scorecard which outlines how it is performing against five domains: Caring, Effective, Responsive, Safe and Well-led. It manages performance against the NHS Single Oversight Framework which does not give a performance assessment in its own right, but aims to help providers attain and maintain Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework looks at providers across five themes: Quality of care (safe, effective, caring and responsive), Finance and use of resources, Operational performance, Strategic Change and Leadership and improvement capability (well-led).

The Trust's integrated balanced scorecard incorporates all the national indicators within NHSI's previous Single Oversight Framework across these five themes.

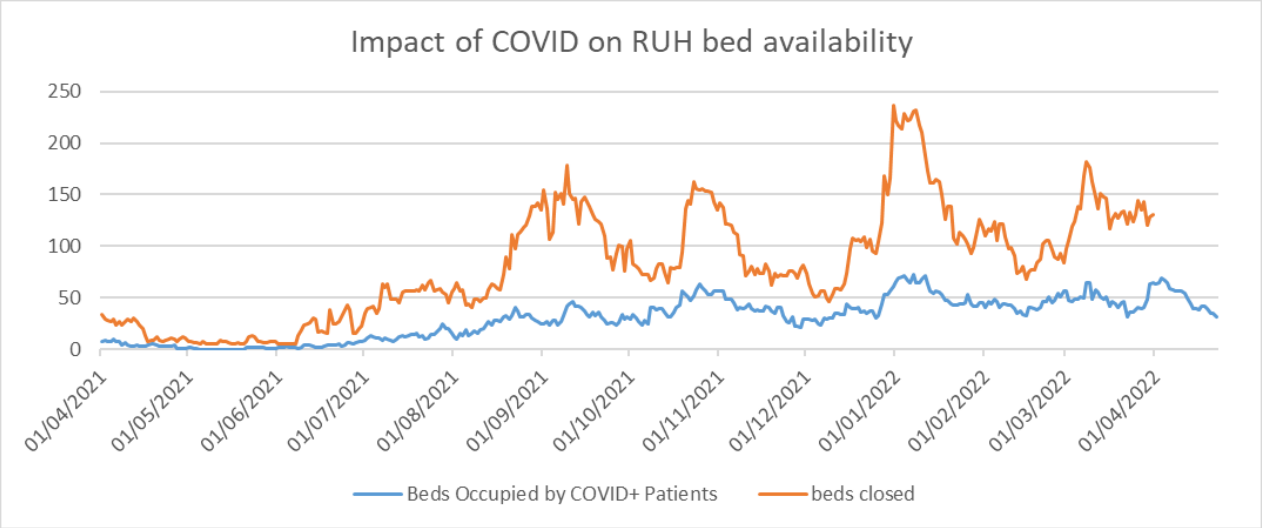
The Trust has a well embedded data quality assurance framework to ensure a high level of data integrity is maintained which is led by the Trust's Quality Board. Our reporting against national standards is robust and regularly audited as part of the Trust's Quality accounts.

This section is presented in three sections:

- COVID
- Urgent Care
- Elective Care

Covid-19 Summary

COVID has continued to impact on the hospital, as demonstrated by the below table. COVID created challenges in terms of COVID admissions, infection spread, and staff sickness. At points in the year the hospital had almost 100 patients with COVID with even more beds being quarantined to reduce the risk of infection spread.



As a result of the large number of COVID cases within the hospital, the high prevalence within the community and challenges with the RUH infrastructure, the hospital has seen a number of nosocomial infections. To try and limit the impact and prevent further spread of infections the hospital has implemented strong Infection Prevention and Control measures including isolation of cases, rigorous testing of all admissions, and adherence to use of Personal Protective Equipment. During the pandemic the Trust built an additional ICU area for infectious patients and this has provided invaluable capacity for patients needing intensive care with COVID or other infections.

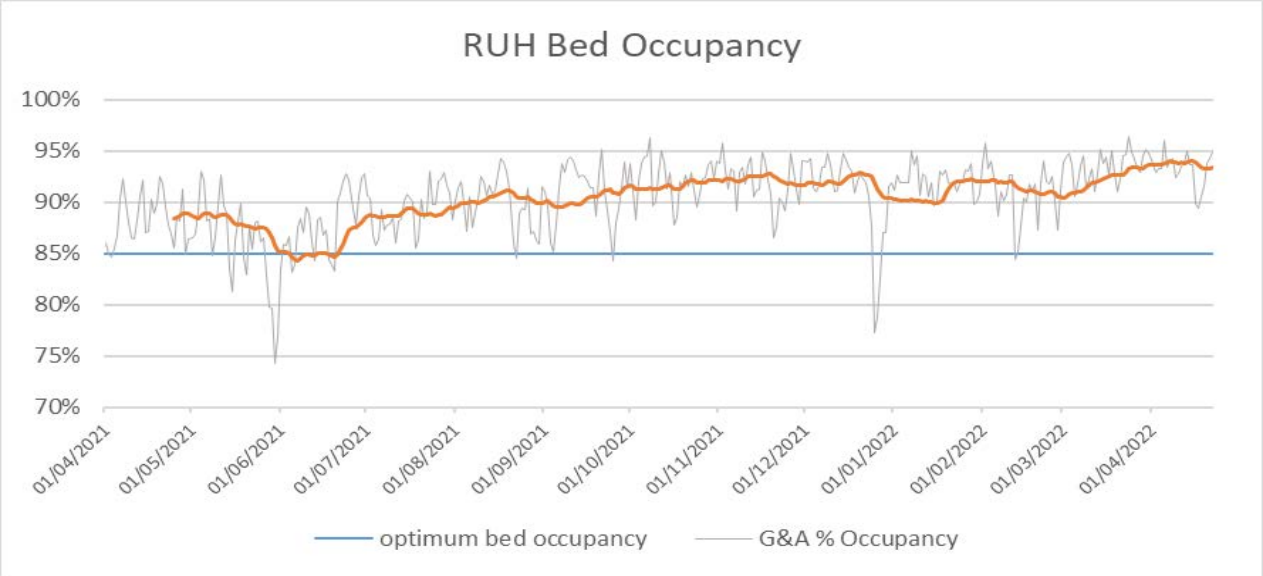
COVID has also impacted on the hospital's staffing position. At several points during the past year the Trust has had significant spikes of staff absence. This has impacted on the organisation's ability to deliver elements of its core function, with the focus being placed on continuing to provide safe services.

It is through the continued commitment and hard work of all of our staff that we have seen the successful management of what has been challenging COVID demands and the ability to provide safe, high quality services to all of our patients. However, improving our staffing levels is a key priority for us in the year ahead as we ensure a resilient workforce that is sustainable for our teams.

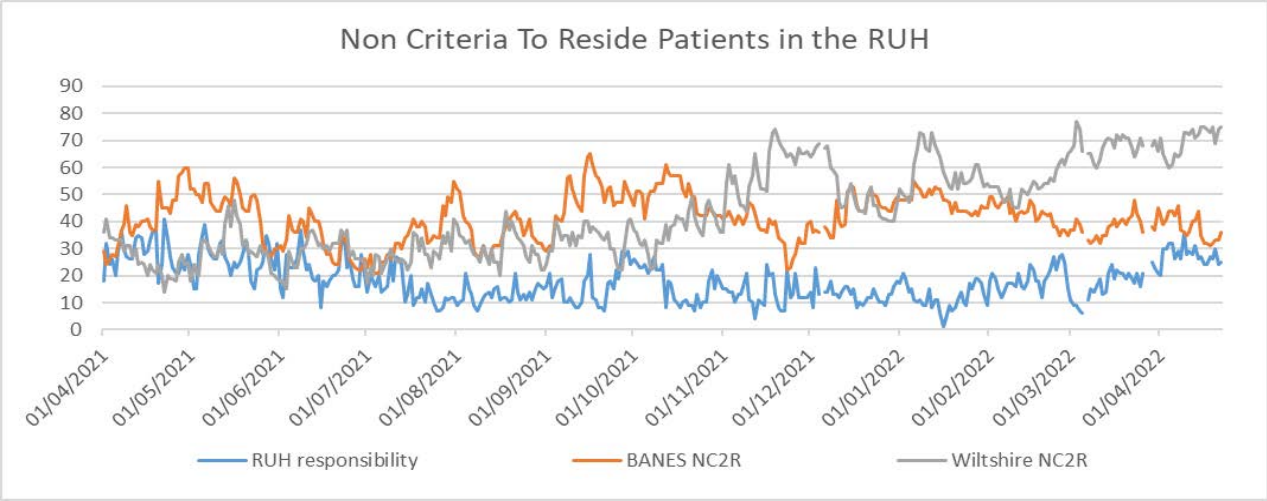
Urgent Care

During 2021/22 the Trust continued to be monitored against the national access target of treating 95% of patients attending its Emergency Department within 4 hours of admission. The RUH has, alongside the rest of the NHS, seen significant challenges in the delivery of the 4 hour performance target. Despite these challenges, the RUH has moved from being in the bottom quartile for ED performance to being in the third quartile due to a programme of work to improve flow. The challenges behind urgent care performance are due to a number of factors outlined below.

Bed availability – Research indicated that hospitals start losing their efficiency for effective flow when bed occupancy is above 85%. The graph below demonstrates that over the last two years the RUH bed occupancy has continually increased. This in turn has posed challenges to flow for urgent care and the continuation of elective surgery.



This higher bed occupancy has been driven by an increase in demand but also challenges in discharging patients once medically fit. This is demonstrated within the hospital's Non Criteria to Reside (NC2R) position. Over the last year the Trust has had an average of 121 patients, but peaked at over 170 patients, who are waiting for community capacity to support their discharge. These patients occupy an average of 21% of the adult beds available within the RUH. The following graph shows the distribution of the patients waiting.



To drive improvement within the NC2R position the Trust is working closely with system partners to diagnose the drivers for this challenge and launch improvement

work. Therefore in early 2022/23 the Trust, alongside Bath and North East Somerset (BaNES) Council, will be launching its own in house care agency called United Care Bath to try and increase domiciliary care provision within the community. This innovative approach is being funded by BaNES Council, with the Trust taking responsibility for sourcing, recruiting and inducting the staff who will be providing the service. The aim of the service is to enable more patients to be discharged and beds freed up for urgent care at the RUH. The RUH is also launching a Home First programme aimed at maximising patient independence after admission and reducing the need for admission unless required through expanding Same Day Emergency Care Services.

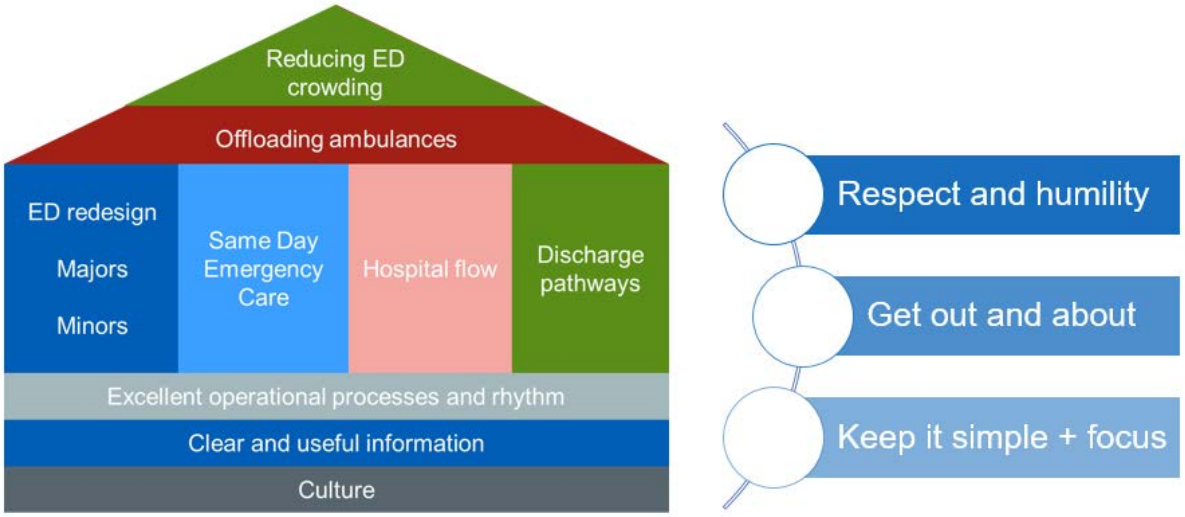
Demand – Towards the end of 2021/22 emergency demand had returned to pre-pandemic levels. The RUH is responding to this increase in demand and projected continued future growth through a number of initiatives including:

- A recruitment campaign to enable ED to achieve its establishment levels and reduce vacancies. This has been very successful and is continuing. In addition, following a benchmarking exercise with neighbouring hospitals, the Trust is recruiting additional posts to ensure similar staffing levels as nearby hospitals.
- Redesigning the physical layout within ED including a new paediatric ED, coordinators hub, and resuscitation area to ensure adequate and appropriate space to manage new arrivals
- Merging the Urgent Care Centre and Minors teams within the ED. This has significantly increased safety within the department as patients are now managed within a single queue with clear oversight by the full ED clinical team.
- Launching a revised Medical Assessment Unit and a newly built Direct Assessment Area as a Same Day Emergency Care (SDEC) unit. These new services have proven hugely successful and over the coming the year the Trust will be continuing the development of SDEC services with a focus on frailty services.

<u>Improving Patient Flow Together Programme (IPFT)</u>

To support improvements in Urgent and Emergency Care, the hospital continues to develop and implement the Improving Patient Flow Together Programme. This programme aims to improve flow through ED thereby improving safety for patients and reducing ambulance offload times. Emergency flow is a whole hospital and system challenge and the programme has been designed to reflect this and includes pillars of work in the Emergency Department, Same day assessment, ward processes and discharge from hospital.

Diagram 1: Improving Patient Flow Together Programme



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

Elective Care

Sulis Hospital

In June 2021 the Trust purchased Sulis Hospital Bath (previously Circle Bath) as part of its elective care strategy. Sulis is an independent hospital based in the outskirts of Bath that provides high quality elective care for both private and NHS patients. The Sulis strategy aims to make the most of the skills of the teams there as well as the benefit of a dedicated elective site to maximise elective capacity for patients to help reduce the longer waiting lists resulting from COVID.

In 2021 Sulis has provided operations for over 500 RUH patients enabling those patients to get treatment more quickly. The Trust aims to continue to grow capacity at the Sulis site both for operations and diagnostics to ensure continuing improvements in access to care for patients across the area. The hospital will continue to be a high quality provider of private health care alongside treating NHS patients.

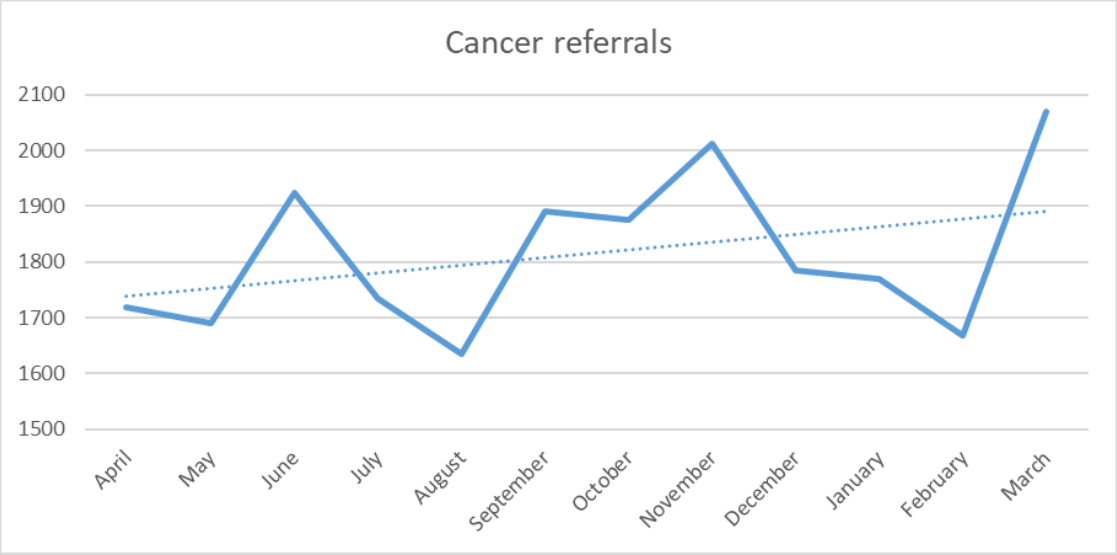
Elective waiting times and activity

COVID has caused significant challenges for the hospital in managing elective waiting times and the hospital has prioritised investment and capacity to ensure recovery of elective waits. The RUH continues to have some of the lowest 104 week waits across the region and we are continuing to reduce the number of patients waiting over 52 weeks. It currently performs in the top 20% of Trusts for elective activity compared to before COVID and is continuing to work with teams on how to increase capacity for elective care through improving productivity and expanding our clinical teams.

The Trust has been working through a number of national initiatives such as the Elective Recovery Fund to increase elective capacity. We have ambitious plans for 2022/23, working alongside the wider system, to support the development of further elective activity through increasing capacity, maximising productivity of services and working across the RUH and Sulis sites.

Cancer

Before the pandemic, the RUH was consistently enabling more than 80% of patients to begin their cancer treatment within 62 days. This performance has been challenged more recently due to a combination of growing demand and reduced capacity during COVID. As can be seen from the chart below, the Trust is currently experiencing an 8% growth in demand for cancer appointments.



In an effort to improve access to cancer care, the Trust has introduced a weekly recovery group chaired by the Chief Operating Officer and involving teams across the Trust. Thanks to focussed work by teams on maximising capacity and reducing waits, the number of patients waiting over 62 days for cancer care at the RUH has halved since Autumn 2021. Reducing cancer waiting times remains a priority for 2022/23, in respect of both diagnostics and treatment, and in preparation for the opening of the Dyson Cancer Centre which is being built on site.

Diagnostics

Diagnostic capacity remains a challenge across the NHS as demand increases as we come out of the pandemic. The RUH has made creating diagnostic capacity a priority in order to reduce waits for all patients but with a particular focus on those at risk of cancer. Some of the key projects delivered in 2021/22 include:

- Completion of a 5th endoscopy suite build
- Completion of a 4th CT build
- Purchase of Sulis and additional MRI in process of being built as a Regional Diagnostic Centre capacity

Diagnostic demand continues to grow and as such the RUH is working closely with the system to ensure robust plans are in place to meet current and projected future demand.

Performance against 2021/22 Breakthrough Objectives

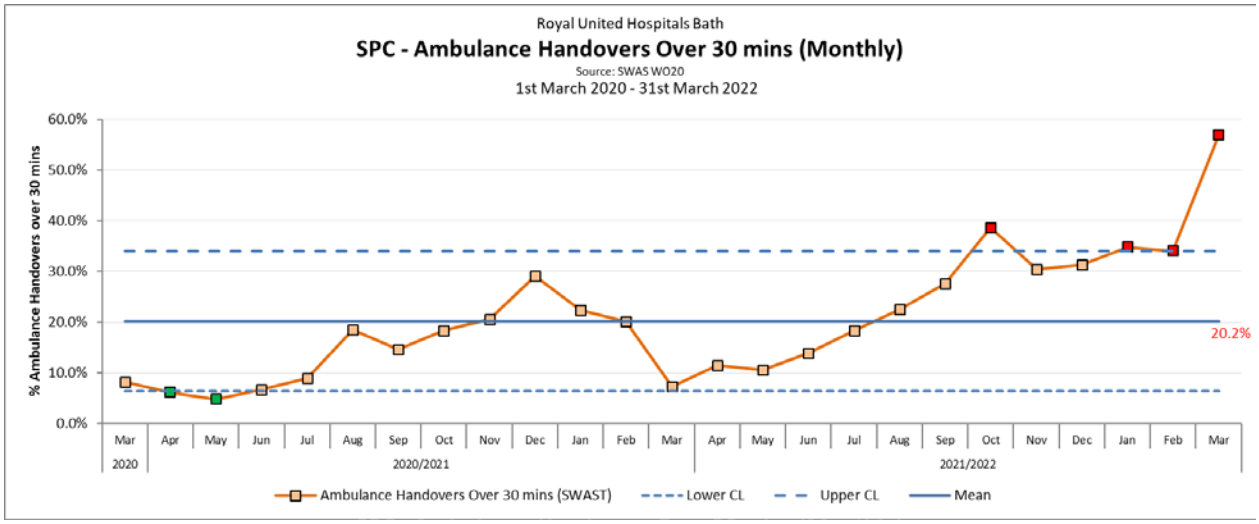
In recognition of the impact that the COVID-19 pandemic has had in the Trust, and the key areas of focus for the organisation the following Breakthrough Objectives were agreed for 2021/22:

- Ambulance handovers

- Health and wellbeing
- Infection Prevention and Control.

Ambulance handovers

The Trust experienced significant challenges to its ambulance handover position during 2021/22. The graph below shows the number of patients who have waited more than 30 minutes from arriving at the hospital until they are accepted into the ED.



This position was influenced by a combination of factors including significant staff shortages, the return of demand for emergency care to pre-pandemic levels, and poor flow through the hospital caused in large part by the inability to discharge patients despite the fact that they were medically fit to leave hospital. The measures that have been described above that are aimed at bringing about improvements in overall flow will support a significant reduction in the number of patients waiting to off load. Additionally the ED is working closely with the South Western Ambulance Service (SWAST) to identify areas where processes could be managed differently to reduce delays. This has led to the introduction of:

- Ambulance Cohort Area – this enables SWAST crews to offload and get back on to the road whilst patients are waiting to come into ED
- Pit stopping – this service started in March 2022 and will expand during 2022/23 to get more senior decision makers into patients pathway as soon as possible.

Health and Wellbeing

The Staff Report section of this Annual Report includes a breakdown of the Trust's results in the 2021 Staff Survey. The survey was re-designed for 2021 to match the elements of the People Promise, and the section that most captures staff health and wellbeing is the "We are safe and healthy" theme. The Trust scored 5.8 against this theme, slightly below its benchmarking group. This score is a demonstration of the amount of pressure that staff have been under this year, through a combination of staff absences caused by COVID, rises in the number of very ill patients arriving at

ED and the need to start to make inroads into the waiting lists for elective care. The Trust continues to work on ways to keep staff safe and healthy, including taking action to recruit to vacancies and ensuring that appropriate and responsive systems are in place support staff in all aspects of wellbeing.

Infection Prevention and Control

During 2021/22, the COVID pandemic severely tested the Trust's approach to infection prevention and control. The controls that had been put in place to ensure that patients were tested before admission and that there was effective separation between negative patients and those who may be positive were well followed by all staff, and although the RUH, like many other hospitals, experienced nosocomial outbreaks, by and large patients were kept safe. However, the hospital's relative shortage of side rooms and en-suite facilities made it difficult to keep ward areas open where patients had subsequently tested positive and this had a significant impact on the Trust's ability to maintain its bed base when infection rates were at their highest.

Breakthrough Objectives for 2022/23

Following a review of our operational and performance targets during 2021/22, we have agreed the following Breakthrough Objectives for 2022/23.

Ambulance handover delays is to be retained as an objective, taking account of the significant patient safety risk that such delays can cause. The 2021/22 measure of reducing delays over 60 minutes to 0 has been replaced with the aim that the Trust achieves top quartile performance in this area.

Nurse recruitment to establishment replaces health and wellbeing. The Trust is carrying a large number of vacancies, particularly within its nursing workforce, and recruitment activity to fill these, as well as a taking steps to retain as many of the staff currently in post, will remain key area of focus.

Infection Prevention and Control is a continuation from the 2021/22 Breakthrough Objective, as Hospital Acquired Infections continue to be a key focus for the Trust.

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

Overview of financial performance

In 2021/22 the NHS has continued to work with significant pressures resulting from the COVID-19 pandemic. Whilst there was a significant drive to regain momentum delivering elective services and address waiting times, very high levels of COVID-19 related sickness created huge pressures for both emergency as well as elective services. The impact of this at the RUH was higher use of agency and bank staff to cover operational areas and managing high levels of patients with no criteria to reside which led to the need for escalation areas being created and losing elective wards to accommodate medically sick patients. The funding for direct COVID-19

costs was fixed within a block for 2021/22, this funding was used to support costs incurred for increased infection control measures, backfill for sickness, testing and monitoring staff absence. The Trust was able to remain within the envelope of funding provided for this purpose.

In June 2021 the Trust acquired Sulis Hospital Limited (formerly Circle Bath Limited) from Circle Holdings Limited. Since the acquisition, significant investment has been made to bring the IT systems in line with those of the RUH to allow the Trust to support their clinical and administrative systems as well as support finance functions such as payroll and banking arrangements.

Payments to the Trust for activity continued to operate on the same block basis introduced in 2020/21 however, there was a new funding stream made available to target increasing elective activity and creating additional capacity to help reduce waiting lists and minimise very long waits for treatment. The Elective Recovery Fund (ERF) was set up in the first half of the year with additional money being earned for achieving nationally set targets of elective activity which included day case, inpatient and outpatient care. The RUH earned £5.1 million through this scheme which was used to cover the costs of providing extended services to treat patients. These incentive funds were extended in the second half of the year to distribute pre-agreed funds to support specific schemes to maintain elective capacity though the winter. The Trust was awarded £2.9 million through the ERF+ scheme and £1.1 million from the Targets Investment Fund (TIF), all of which helped maintain some elective services through a very challenging winter and also covered costs for increased overtime and other sickness cover which escalated in this period.

Income flows from non-patient care services such as catering, car parking and non-clinical services increased over the course of the year plateauing at levels below pre-pandemic values. Reduced footfall due to limited visiting access, infection control measures in public and staff catering outlets and continuing virtual outpatient care has prevented a complete recovery. These streams of income supported the costs of providing of services to patients and staff which continued to be incurred, as many of the relevant posts are substantive and other overhead costs were maintained. These continue to drive part of the cost pressures faced by the Trust.

The financial performance of the group (RUH and Sulis) varied over the period due to the constantly changing financial regime and challenges particularly in respect to staff sickness and sustaining services. However, the Group closed the year with a surplus of £5.3 million. Following required adjustments for national reporting, the system reported an adjusted position for the Group of £19,000 surplus.

	2021/22 £000
Trust surplus for the period from continuing operations as per the Statement of Comprehensive Income	**813**
Impairments charged to revaluation reserve	836
Revaluations	2,882
Share of comprehensive income for Wiltshire Health and Care	56
Movement in fair value of charitable funds	723
Total comprehensive income for the period	**5,310**

The Trust has incurred significant cost pressures over the last few years resulting from insufficient inflation funding, rising costs for high cost drugs and other consumables and the increased operational costs to deliver pre-pandemic levels of activity, many of which reflect the national situation within the NHS. The cost of bringing waiting lists back to down to acceptable levels, managing continuing high levels of emergency and urgent care seen in recent months as well as recover income levels for non-patient care services to ensure we can cover overheads for such services remain the most significant. Elective recovery has significant focus across the Trust and BSW system with detailed plans being outlined for areas needing the most support to reduce waiting lists. National incentive schemes will continue into 2022/23 to ensure Trusts deliver as much of this activity as possible.

Capital investment

The Trust invested £35.4m in infrastructure and equipment during 2021/22, (£32.1m in 2020/21). This included assets acquired as part of the Sulis Hospital acquisition, and subsequent capital purchases to support its work during the year. The total programme was funded through a combination of internally generated cash and I&E surpluses, charitable donations, and significant additional public dividend capital (PDC) from the Department of Health and Social Care.

Further PDC funding was provided for the Cancer Centre project and New Hospital Programme to develop the strategic outline business case. Additional support was also made available for Targeted Investment Funding (TIF) related schemes related to elective care and critical and emergency care which supported the estate's critical infrastructure. The Trust also received considerable PDC TIF funding for digital and digital diagnostic schemes in support of elective recovery. Diagnostic funding was made available to replace a Linac and purchase an MRI for Sulis Hospital.

The capital programme has continued to achieve a balance between maintaining and replenishing the asset infrastructure, reducing risk and improving patient experience.

Significant in-year programmes included expenditure of:

- £6.0m on various estates schemes including upgrades to the Emergency Department, Paediatric reconfiguration, ENT and pre-operative assessment location change, Bioquell pods, Breast Unit Expansion and significant risk critical infrastructure backlog expenditure.
- £11.6m on the Cancer Centre which includes the main Kier related works, substation costs and generator replacement expenditure.
- £3.2m in respect of Sulis and subsequent capital investment in Sulis Hospital.
- £2.3m on the development of the strategic outline business case for the New Hospital Programme.
- £3.1m on the digital programme, including additional investment in hardware to support changes in working practices, telephony, and clinical systems to support post COVID working practises.
- £4.2m on medical equipment, including equipment at both the Trust and Sulis Hospital, including a new CT and surgical robot for Sulis.
- £2.7m on Linac replacement at the Trust and enabling works to the environment.
- £2.1m to support purchase of MRI at Sulis and related works.

These are capitalised costs only.

Capital Impairments

The Trust had net capital impairments totalling £1.1 million which included an impairment related to the strategic outline business case costs and demolition, but was offset by a reversal of an impairment on property valuation. There were also impairments associated with property, plant and equipment and intangibles where the scheme has ceased to continue.

Going Concern disclosure

After making enquiries, the Directors have a reasonable expectation that the services provided by the Royal United Hospitals NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the Directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Environmental matters

Introduction

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

- Reducing our dependence on unrenewable resources such as fossil fuels and heavy metals
- Reducing our dependence on substances that persist in nature
- Reducing our destruction of nature
- Ensuring we are not stopping people meeting their needs

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

The reference to SDAT in the table below is the Sustainable Development Assessment Tool.

Recapping on the last year

Area of focus	Objective	Achievements in the last 12 months	SDAT score 2019/20	SDAT score 2020/21	Trend on last year
Managing our Carbon & Greenhouse Gases	To manage our carbon emissions to remain within safe limits in order to avoid irreversible climate change	• Achieved an 8% reduction in carbon for electricity and gas. • Developed an Energy Strategy, including a roadmap to Net Zero, to tackle one of the biggest contributors of our carbon footprint. • A Nitrous Oxide Waste Working Group has been initiated to tackle an anaesthetic gas that has a high global warming potential.	41%	59%	Up
Adapting to Climate Change	Develop sites and services that are resilient to the adverse effects of climate change	• Climate Change has been put on the BAF (Strategic Risk Register) • Sustainability Team hosted a student from the Netherlands, who researched considerations for adaptation plans	35%	60%	Up

		• The Trust has started working with the national Greener NHS team to support the creation of a Climate Change Risk Assessment			
Designing sustainable care models	To improve care whilst maintaining environmental, social and financial sustainability	• Theatres set up a Sustainability Working Group to reduce their impact, including their impact from anaesthetic gases. • Clinical Strategy has been developed as part of the SaHF/NHP project which includes review and transformation of a number of care models. • New lower carbon models of care have been introduced as part of COVID response such as virtual appointments.	31%	71%	Up

Enabling sustainable travel & logistics	To be a Trust that approaches travel in a way that is innovative and prioritises sustainable modes of transport that are accessible to all	• Fleet vehicles have continued to transition to electric alternatives.
		• Installation of electric vehicle charge points have continued.
		• Successful bid to be part of WECA FTZ E-Cargo Bike Trial
		• Numerous enabling projects have been implemented:
		  • free e-bike loans
		  • doubled cycle compound spaces
		  • upgrades to locker and charging facilities
			54%	74%	Up

Embedding sustainability	To become a thriving organisation that delivers benefits that extend beyond the traditional organisational boundaries whilst maintaining the highest quality of care.	• A Sustainable Impact Assessment has been designed and being trialled on a number of business cases. • Working with the Bath, Swindon and Wiltshire Integrated Care System (ICS) to standardise sustainability across the region. • Supported Great Western Hospitals with setting up and monitoring of air quality. • Hosted a Healthy Planet schools art exhibition to	40%	61%	Up

		raise the profile of COP26.			
Managing our assets & utilities	To manage the trust's operational assets in a way that continually improves their efficiency and longevity	• Recruited an Energy Manager to help drive energy efficiencies and carbon reduction. • Energy & Infrastructure Strategy completed to identify route to net zero for direct emissions. • Energy projects underway including; BMS upgrades; window replacements; and lighting upgrades.	51%	75%	Up
Using resources sustainably	To ensure that we do not extract or pollute at a greater rate than nature regenerates	• Full implementation of Anytakers, which rehomes unwanted furniture in one part of the site to a new home somewhere else on site. • Developed a campaign to support Plastic Free July, which included audits completed by our Sustainability Champions. • Offensive waste (non-infected clinical waste) is now disposed via Energy from Waste instead of landfill.	43%	43%	Same
Creating a sustainable built environment	To ensure that sustainability underpins the design and construction of our capital projects	• Sustainability principles are underpinning the Estates solution for the New Hospitals Framework. • Work has commenced to identify what our minimum specification for buildings should be in regards to sustainability and Net Zero Carbon. • We have input to the NHSi/E standard for NZC buildings	30%	65%	Up
Empowering our people	To create a supportive environment where all our people feel motivated and empowered to consider sustainability in everything they do	• Ran a behaviour change programme called Green Impact to help guide teams in implementing sustainable actions. • Set up training on ESR to educate staff on sustainability. • Ran a Sustainability Day that was celebrated with a solar powered ice-cream van. Staff were encouraged to pledge in	71%	55%	Down

		return for an ice-cream and 686 sustainability pledges were made.			
Enhancing Greenspace	To Protect and enhance the natural systems that we rely on, realising the benefits this brings to the health of our diverse population	• Greenspaces and Biodiversity Management Plan drafted. • Collaborated with NHSFOREST to allow staff to plant saplings on RUH site.	33%	32%	Down

Key areas of Focus

<u>Taking responsibility for our Carbon Footprint</u>

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

References to Scope 1, 2 and 3 emissions relate to the extent to which an organisation has control of or is responsible for. Scope 1 are direct emissions from owned or controlled sources. Scope 2 cover indirect emissions from the generation of purchased electricity, steam, heating and cooling consumed by the organisation. Scope 3 includes all other indirect emissions that occur in a company's value chain. The Trust came up with three steps to reducing our carbon footprint that comply with the Climate Change Act, support B&NES local plan to become carbon neutral by 2030 and more recently the Greener NHS (NHS England and Improvement) targets. These are:

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

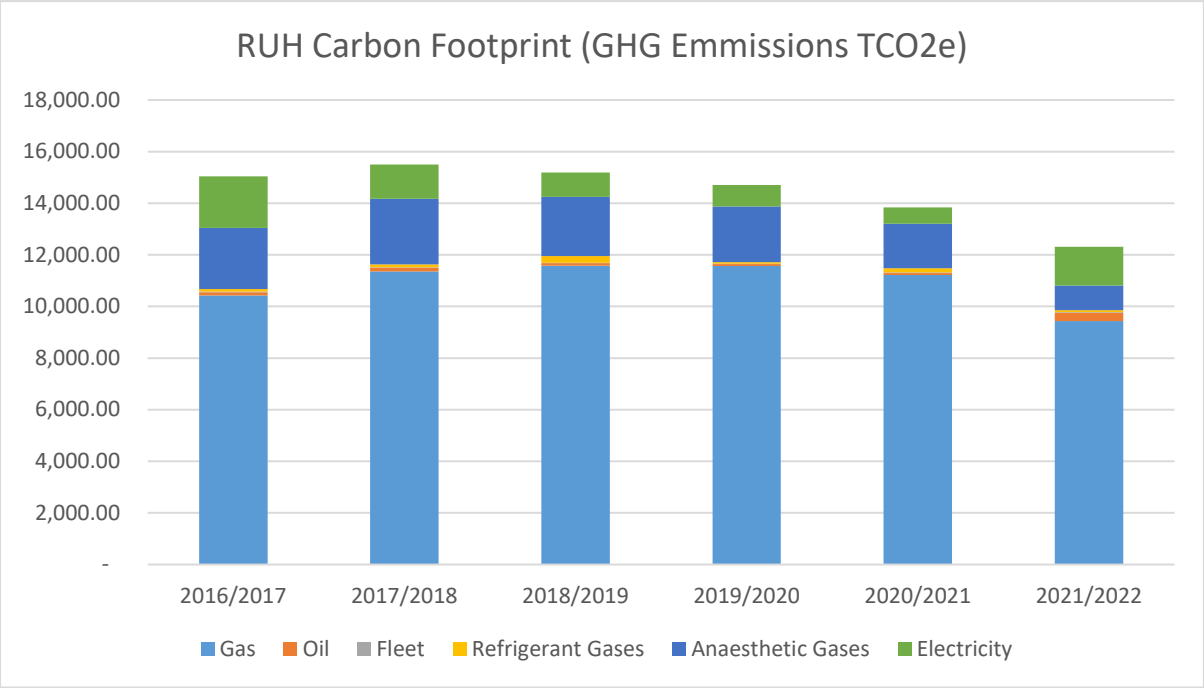


Figure 1: The Trust's Carbon Footprint for Scope 1 and 2 emissions over the last 6 years illustrating a small decline since 2017/2018, but a requirement for ambitious and challenging targets to achieve net zero carbon by 2030.

Improving Air Quality through Sustainable Travel

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

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

The Trust monitors the Nitrogen Oxide levels onsite in order to understand the air quality in the area. Diffusion tubes are placed across the site and are analysed monthly. During 2021/22 year, the Sustainability Team continued to run initiatives to reduce air pollution on site including:

- Switch off when you drop off campaign in Estates contractors car park and at the main bus stop.
- Doubling of cycle storage compounds.
- Installation of fast electric vehicle charge points.
- Procurement of further electric vehicles as we transition our fleet.
- Issued 71 CycleSheme Certificates.

- Invested in an E-Bike Loan scheme. To date these have seen a total of 33 loan periods of use.

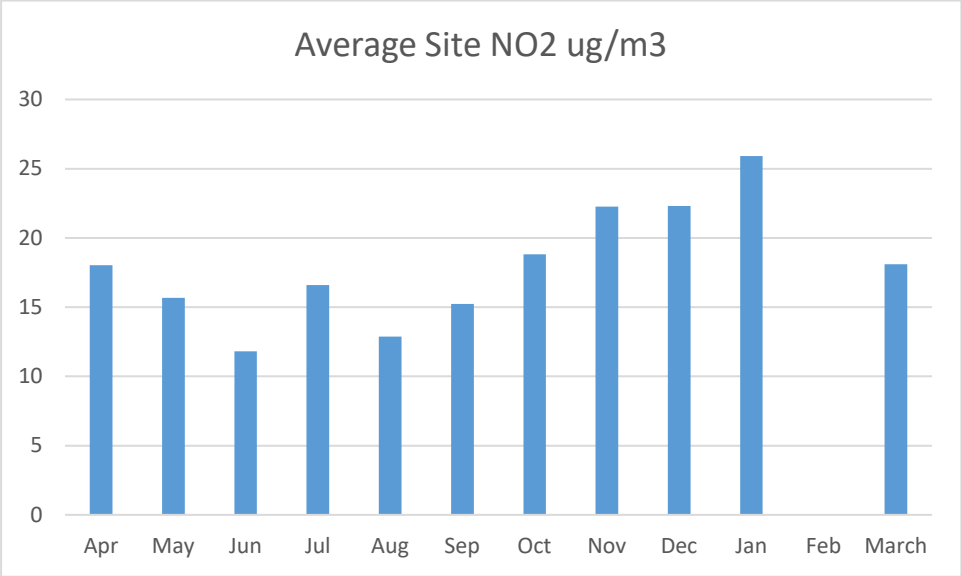


Figure 1 Average Nitrogen Dioxide levels across the site. February data has been omitted due to issues with the diffusion tubes.

Social, community, anti-bribery and human rights

All Trust policies and procedures are based on national employment legislation, are in line with NHS constitutional commitments and include an equality and diversity impact assessment. In addition, the Trust's implementation of the Equality Delivery System 2 and the Workplace Race Equality Standard, as well as reporting on the Gender Pay Gap, ensures that the organisation has a transparent approach to ensuring that the rights, interests and needs of all sections of the community are taken into account in terms of service delivery and development, and employment practices. During 2021/22, the Trust implemented a new People Policy, based on the six values set out in the NHS People Plan, including "everyone counts".

Reporting on the gender pay gap at the RUH can be found within the Equality, Diversity and Human Rights section of the Trust website as below, and it is reported on at page 77 of this report:

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

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

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

During 2021/22, the Trust had no social, community or human rights violation issues.

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

The Trust has not identified any important events that have occurred since the end of the financial year.

Details of overseas and subsidiary operations

The Trust has no branches or offices outside the UK.

Following the Trust's acquisition of a 100% interest Sulis Hospital Bath (previously Circle Bath), the private company that runs that hospital, Sulis Hospital Bath Ltd, became a wholly owned subsidiary of the RUH.

Cara Charles-Barks

Chief Executive

Accountability report

Directors' report

Directors' responsibility for the annual report and accounts

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

Directors of the Trust

Directors of the Royal United Hospitals Bath NHS Foundation Trust during 2021/22:

Alison Ryan	Chair
Jeremy Boss	Non-Executive Director Vice Chair and Senior Independent Director
Nigel Stevens	Non-Executive Director
Sumita Hutchison	Non-Executive Director
Anna Mealings	Non-Executive Director
Ian Orpen	Non-Executive Director
Antony Durbacz	Non-Executive Director
Cara Charles-Barks	Chief Executive
Libby Walters	Deputy Chief Executive & Director of Finance
Bernie Marden	Medical Director
Antonia Lynch	Chief Nurse (from 1 April 2021)
Simon Sethi	Chief Operating Officer
Claire Radley	Director for People* (until 28 January 2022)
Victoria Downing-Burn	Acting Director for People* (from 31 January 2022 to 21 February 2022)
Alfredo Thompson	Director for People and Culture (from 31 January 2022)*
Jocelyn Foster	Director of Strategy
Brian Johnson	Director of Estates and Facilities*

*Non-voting members

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

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

The Board of Directors

Non-Executive Directors

Alison Ryan, Chair (Appointed: 1 April 2019)

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

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

*Vice-Chair and Senior Independent Director from 1 November 2020

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

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

Nigel is Chair of both the Quality Governance and Subsidiary Oversight Committees, and is a member of the Board of Directors' Nominations and Remuneration, Finance and Performance, and Audit and Risk Committees. He is also the Non-Executive Director champion for patient and families' experience. Nigel has a BA (Hons) in Politics and Geography and an MA in Defence Studies. After 20 years as a logistics officer in the Royal Air Force, Nigel moved into the commercial sector. Following eight years as Chief Executive Officer for the UK and Ireland Division of a major,

global public transport group, he worked as Chief Operating Officer for Keolis UK, a role he combined with wider work in the commercial and public sectors on future transport solutions. He was recently appointed as Chair of Transport Focus.

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

Sumita has served since 1 November 2020 as chair of the Non-Clinical Governance Committee, and she sits on the People Committee as well as the Board of Directors' Nomination and Remuneration Committee. She is the Board lead for equality, diversity and inclusion and health and wellbeing. Sumita has an LLB (Hons) and has practised as a solicitor specialising in employment law. She has also worked as Engagement Development Manager at the Avon and Somerset Constabulary, leading on diversity and inclusion initiatives across the organisation. Sumita has been heavily involved in promoting race, disability and gender equality in the Bristol area, serving as Commissioner for Adult Social Care at both South Gloucestershire and Bristol City Councils and as a member of the Women's and Race Equality Commissions in Bristol. In addition to her role at the RUH, she also currently serves as a Non-Executive Director of the Gloucestershire Health and Care NHS Foundation Trust.

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

Anna chairs the People Committee, and is a member of the Quality Governance, Finance and Performance and Board of Directors' Nomination and Remuneration Committees. She also serves as Board lead for Freedom to Speak Up. Anna has a BCom degree in Economics, a BA in Anthropology and an MCom (Hons) in Strategic Employment Relations. She has extensive experience in human resources management, organisational effectiveness and change management across a range of private sector industries, including at a number of large multinational organisations, and is currently the Chief People Officer at XP Power PLC.

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

Ian joined the Board in September 2020 as the Trust's first dedicated clinically qualified non-executive director. He previously worked as a General Practitioner in the Bath area and served as Clinical Chair at the Bath and North East Somerset Clinical Commissioning Group from 2013 to 2020. In that capacity, Ian held the role of stakeholder governor on the RUH's Council of Governors right from the Trust's authorisation as a Foundation Trust in 2014. Ian is a member of the Quality Governance, People and Non-Clinical Governance Committees. He is the Board's Maternity Safety Champion and he leads on Children and Young People and Safeguarding. Ian's brother is a Non-Executive Director at University Hospitals Bristol and Weston NHS Foundation Trust. He is also a Local Government Association associate and has worked as a Band 5 vaccinator on the COVID 19 Vaccination Programme.

Antony Durbacz, Non-Executive Director (Appointed: 1 November 2020)

Antony is a chartered accountant by background and an experienced Non-Executive Director. Before he joined the RUH Board in September 2020, he had previously

served as a Non-Executive Director and Chair of the Audit Committee at Taunton and Somerset NHS Foundation Trust. He is also Chair of the Audit Committee at LiveWest, one of the largest housing associations in the South West. Antony has held a number of senior finance roles, mainly in the manufacturing sector. On the RUH Board, he chairs the Audit and Risk Committee, and sits on the Finance and Performance and Non-Clinical Governance Committees. He leads on environmental matters, infrastructure and estates. In addition to his membership of the LiveWest Board, Antony is also a Governor at Crispin School, and his daughter is a specialist trainee in Obstetrics and Gynaecology in the Severn Deanery.

Executive Directors (voting)

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

Cara has worked at board level within the NHS since 2008, including as Chief Operating Officer and Deputy CEO at Hinchingbrook Healthcare NHS Trust, and more latterly as CEO at Salisbury Foundation Trust between 2017 and 2020. Before that, Cara held senior healthcare management roles in her native Australia, including as Nursing Director at the Queen Elizabeth Hospital in Adelaide, South Australia. She holds Bachelors and Master's Degrees in Nursing as well as an MBA from the University of Adelaide. Cara is a member of the Advisory Panel of Nourish, an organisation that promotes healthy eating and nourishment for those going through illness or medical treatment. She is also a Visiting Fellow of the Faculty of Health and Applied Sciences at the University of the West of England.

Libby Walters, Deputy Chief Executive & Director of Finance (Appointed: June 2018)

Libby has worked in the NHS for 24 years and prior to joining the RUH held positions as the Director of Finance and Resources at Dorset County Hospital NHS Foundation Trust and as the Director of Finance and Deputy Chief Executive at Yeovil District Hospital NHS Foundation Trust. She is a member of the Chartered Institute of Public Finance and Accountancy and has a particular interest in ensuring the focus on use of resources is intrinsically linked with improving the quality of care provided. Libby is also an active member of the Healthcare Financial Management Association South West Branch. Libby served as Interim Chief Executive of the Trust between 1 June and 7 September 2020. By way of declared interests, her husband works 2 days a week as a Radiology Porter and on the radiology portering bank.

Bernie Marden, Medical Director (From: April 2018)

Bernie has been a Consultant Paediatrician and Neonatologist at the RUH for 14 years and he has previously been Head of the Women and Children's Division and Paediatric Clinical Lead. He is the Chief Clinical Information Officer leading on the Trust's clinical IT transformation strategy and serves as Caldicott Guardian. He holds a Masters' degree in Medical Law and Ethics and is an Honorary Clinical Senior Lecturer at the University of Bristol. His brother is a Consultant Gastroenterologist at the RUH.

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

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

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

Simon joined the RUH in January 2021 from Yeovil Hospital NHS Foundation Trust, where he was Chief Operating Officer and helped that trust develop its reputation for the quality and efficiency of its emergency services. He had previously held senior roles both in operational management and commissioning. Simon holds a Masters' degree in healthcare management and leadership as well as an MBA. In terms of declared interests, his wife is Director of Transformation at North Bristol NHS Trust.

Executive Directors (non-voting)

Claire Radley, Director of People (Until 28 January 2022)

Claire was previously the Assistant Director of Organisational Development at Cardiff and Vale Health Board. Prior to this she held a number of local and national roles in policing, spanning research, performance management, quality, culture, leadership and organisational development. She has a PhD in organisational and occupational culture. Claire is a member of the Honourable Company of Gloucestershire.

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

Alfredo joined the Trust at the end of January 2022 from North Middlesex University Hospital NHS Trust where he had led the culture change and leadership programmes. He has held a number of senior roles both within the NHS and in other sectors. He has no declared interests.

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

Joss was previously Director of Business Strategy for Kent County Council, Strategy Director at (Parcelforce) Royal Mail, Strategic and Corporate Development Director at Leicestershire Partnership NHS Trust, and has previous public and private sector experience in business strategy, planning, transformation and new business development. Joss has an MBA, DPhil, and BSc (Hons) in Biological Sciences. Her declared interests for 2021/22 was a financial interest in Veloscient Ltd, a company dedicated to facilitating structured data capture for a range of markets, including healthcare, and as a complaints panellist for the Dental Complaints Service .

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

Brian has over 30 years' experience working nationally and internationally across a broad range of technically challenging, high profile projects in a number of sectors

including education, sport and health. He has a wealth of design and construction delivery experience, and his most recent previous role was as Head of Capital Projects at the RUH, and before that he was Regional Operations Director at Capita Health Partners. As part of the NHS response to the COVID-19 pandemic in the South-West, Brian took on the additional role of Director of Estates and Facilities for the Bristol Nightingale Hospital. He currently also works part-time as Director of Estates for Salisbury NHS Foundation Trust under an agreement between both organisations, and other than this, he 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.

Additional Directors' report disclosure

Cost Allocation and Charging Requirements

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

Political Donations

The Trust has made no political donations over the course of the year.

Better Payment Practice Code

The Trust is required, by the national "better payment practice code", to aim to pay all valid invoices within 30 days of receipt, or the due date, whichever is the later. The table below includes the position for both the Trust and Sulis Hospital. Over the 12 months to 31 March 2022, the Group achieved the following performance:

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

Total interest paid to suppliers under the Late Payment of Commercial Debts Act 1998 was £0k (£1 in 2020-21).

Disclosures relating to NHS Improvement's Well-Led framework

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

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

1. Leadership capacity and capability – with the support of external consultants, the Board has spent time thinking about and taking steps towards working more cohesively to provide the leadership that the organisation needs, making use of a number of recognised management development techniques. It has also championed the Improving Together quality improvement methodology as a way of building leadership capacity and creating a culture of continuous

improvement across the organisation. Similar work is now being rolled out at the divisional management levels.

2. Vision and strategy – During 2021/22, the Board began a conversation with the organisation, supported by an external facilitator, with a view to updating the Trust's vision statement and strategic narrative. One of the key aims of this work was to gain an understanding of the extent to which the whole organisation had a shared sense of ownership of the Trust's strategic direction and values. This work continues.
3. Culture – A key aspect of the new People Strategy that was approved in 2021/22 was the development of a Restorative Just Culture across the organisation – one that moved away from blame and punishment towards learning and engagement. Initial feedback via the 2021 Staff Survey and the Making a Difference surveys is that this approach has been well received by staff.
4. Clarity of roles and systems of accountability – The Trust has a clear and well-defined governance and accountability structure starting with the Board at the top, through the executive team and Management Board and into the clinical divisions and corporate directorates. These structures are set out in the Integrated Governance Framework, and are constantly fine-tuned to ensure that they remain aligned to the Trust's strategic direction.
5. Management of risks, issues and performance – The Trust has in place a comprehensive Strategic Framework for Risk Management which is currently in the process of being updated. This framework sets out the process by which risks are identified, articulated, rated and managed across the organisation, including the process around the development and use of the Board Assurance Framework. It also sets out the Trust's risk appetite and tolerance levels.
6. Appropriate information being processed, challenged and acted on – The Board has a comprehensive annual timetable which includes monthly scrutiny of the Integrated Performance Report, reporting by exception on operational and financial performance, quality and workforce issues. This report includes both quantitative and qualitative information on performance against all the key performance indicators, as well as highlighting areas where improvements are required and how these are being delivered.
7. Patient, public and staff engagement – While the restrictions that necessitated by the COVID19 pandemic made face-to-face engagement almost impossible during 2021/22, the Trust was able to make up for this through the use of electronic and other forms of communication. Indeed engagement with staff was enhanced through the production of regular (daily at a point during the year) video messages from members of the executive team, as well as monthly all staff briefs and question and answer sessions. The Chair continued to engage regularly with members of the Council of Governors through weekly briefs and informal meetings outside of the formal monthly meetings which carried on virtually. Engagement with the wider public was

mainly via the Trust website, on social media and through attendance at the bi-monthly virtual Public Board meetings.

8. Robust systems for learning, continuous improvement and innovation – Roll out and training on the quality improvement methodology Improving Together was paused for some of the year, but it has now been re-set, with more of a focus on its practical application to the issues facing the organisation than on the technical aspects of the programme itself. The overall aim of Improving Together is to empower all staff to take responsibility for identifying issues and making improvements in their areas. The RUH's Research Team were heavily involved in the development and use of new drugs and methods for treating COVID patients and these were shared with local and national partners.

There are no material inconsistencies between the Annual Governance Statement, the Corporate Governance Statement and reports arising from the most recent planned and responsive reviews of the Trust's services carried out by the CQC which was held in January 2021.

Enhanced quality governance reporting

Improving Patient and Carer Experience

Improving patient and family experience is one of the objectives of the Trust's vision to deliver the highest quality care, delivered by an outstanding team who all live by our values. For our patients and carers this means that it is our ambition to be a 'listening organisation, patient centred and compassionate'.

Our vision for improving patient experience is that we will listen, hear and act, putting the patient and family voice at the heart of our services.

Our goal is to continuously improve our patient experience and strengthen our patient voice in every service across the Trust.

We have used a problem-solving tool called an A3 to identify areas, where we know from patient feedback that we do less well, as a result the Trust is able to focus on projects to improve patient experience, such as:

- Developing a **Family Liaison Facilitator Team** to support communication between inpatients and their families and wards (further information is in the Responding to Patient Experience Feedback section below).
- Developing a **patient and carer engagement and experience strategy**. The Patient Experience Team are working with staff, patients and their families and carers, and the local community to co-produce a strategy. This will set out plans to assist staff to work together with patients and their families and carers to design services, improve service provision and improve patient and carer experience.

- Based on the findings of patient feedback we have identified areas of priority to **enhance communication**, such as:
    - a 'listening service' to work alongside the PALS and Complaints teams, as a further opportunity for patients' voices to be heard and used to learn and improve,
    - 'the waiting room experience' where staff and patients will work together to consider their first impressions of the waiting areas, from the perspective of a service user, recording the impact of how it appears; looks; sounds; smells as well as the information and communication provided in the area. The outcomes will inform improvement actions.

Collecting patient feedback to improve our services

Patients and their carers and families share their experiences of using the services we provide. This information is collected through a variety of ways, for example:

- Friends and Family Test (FFT)
- Patient Advice and Liaison Service (PALS) Concerns and Complaints
- Patient Stories
- Hospital questionnaires, telephone interviews, focus groups
- Social media – NHS website/Twitter/Facebook
- Annual and bi-annual National Patient Experience Surveys – Inpatient/Maternity/Emergency Department/Cancer

Friends and Family Test (FFT)

The response to the national FFT question helps us to understand patient experience across the hospital. The Covid-19 pandemic and the impact on patient experience is reflected in the feedback, for example difficulties due to visiting restrictions, communicating with family when an inpatient, waiting for appointments and attending outpatient appointments alone. This corresponds with feedback received via Complaints and PALS. The Trust's responses to patient experience feedback is detailed in the Responding to Patient Experience section below.

Patient Stories

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

As a result of listening to patient/ family stories we improve the care we provide and we also share good practice on the Trust's Intranet for staff to use in training and education, for example:

- A story from the wife of a patient who was admitted as an inpatient after contracting COVID-19 emphasised the kindness of all the staff involved in her husband's care, noting the support from the Royal Marines. She spoke about the daily telephone calls she received that provided much needed reassurance about

her husband's condition and praised the staff for giving her enough time to ask questions and understand his situation. The patient spent a number of weeks in the Intensive Care Unit and during that time highlighted the small things that made a difference – being able to see her husband on FaceTime, going outside for fresh air and photos with family messages around his bed space.

- A male patient shared his experience of Oncology services (brain) at the hospital. He suggested that there are four pillars that support a positive patient experience:

    - Clinical Excellence – RUH to aspire to be a Centre of Excellence
    - Communication – appointment letters, using IT to improve communication
    - Information – more information in the letters, open evenings
    - Environment – impact of this on patient experience

The Oncology team are reviewing clinic letters to include more information about the appointment and its purpose. The feedback was also shared at the Outpatient Steering group and will be used to inform the business case for a Patient Portal/improved outpatient communication. The team are also planning to implement an electronic pre-habilitation programme for all tumour sites.

The design of the new Cancer building has included feedback from patients and their families.

<u>See It My Way</u>

In 2020/21, due to the pandemic, the Trust suspended its very successful 'See It My Way' programme, in which patients and carers came to the hospital to share their experiences of a condition and/or care with staff.

In 2021/22 we reintroduced a virtual programme. A short film is produced following each event and is available on the Intranet for staff to use in education and training.

The Patient Experience team released a film **'See it my Way' film 'experience of COVID'**. Three patients who were cared for in Intensive Care shared their experience of having the illness, the impact on their family/friends and the care they received at the hospital. The video also featured staff reflecting on working in intensive care throughout the pandemic, describing how small acts of kindness can make such a difference for patients and their families. The film received excellent feedback from staff and patients.

'I have just watched the video which was incredibly moving and I just wanted to say how amazing it is and how fabulous everybody was.'

'well done they are so well produced, and really good to hear from the patients how the little things make such a difference to them… brought a tear to my eye, especially as I lost two family members to COVID, great to hear from those who survived.'

Complaints handling

Our Patient Advice and Liaison Service (PALS) aims to resolve patient and carer concerns and answer questions regarding treatment and care within 48 hours. The Trust sees complaints as a valuable source of feedback as it shows us where our services have not provided high quality care and gives early signs of service failures. The process of learning from complaints continued to be prioritised in 2021/22 and a focus on ownership of the learning at divisional level. The Trust is keen to hear from patients and their families when their care and treatment goes well but also when concerns have been raised so that we can use this information to learn and improve.

The Trust is also committed to ensuring that the opportunity to provide feedback is responsive and humane, to achieve this we have been exploring the best option for providing feedback or resolving concerns or complaints. We have introduced an initial contact/triage call, undertaken by the Head of Complaints which allows exploration of the best option with the patient or family. Early engagement by Matron's or other senior staff to engage, listen and resolve complaints at the earliest opportunity has also supported the Trust commitment to Actively listen – make time to listen, hear people and respond.

This year the Trust received 422 complaints compared to 249 in the previous year. This was a significant increase in the number of complaints received and has presented a challenge for the complaints team and clinical colleagues in terms of workload and timely responses. The majority of complaints related to communication issues and clinical care and concerns.

On receipt of a complaint, staff are encouraged to seek to resolve concerns at the time either through informal meetings or conversations on the telephone. We have developed and published guidance on our internal website to help staff effectively manage concerns informally where possible. Staff are also trained in how to manage the formal complaint process, including complaint meetings. This training has been given to junior doctors as well as junior and senior Sisters.

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

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

Patient Engagement to Improve Services

During 2021/22 the Patient Experience Team supported 38 RUH teams to collect patient and carer feedback (via questionnaires, telephone interviews and virtual focus group meetings) and use the information to improve their service. The **Improving Patient Experience Awards** provided an opportunity to celebrate the good practice:

The **Dementia Team** won the award for improving patient and family experience, particularly for vulnerable patients with Dementia. There work was judged as '*a fantastic project and that the team had been responsive to the needs of Dementia patients as a result of the pandemic. The project also included great feedback from families and carers*.'

The **Cancer Support Team** was awarded second place for improving patient and family experience for cancer patients. The judges were '*particularly impressed with the examples given such as attending appointments with needle phobic patients. An amazing project that benefits patients at their most difficult time*.'

The **MSK & Pelvic Health Physio teams** were awarded third place for improving patient experience for those patients having virtual physiotherapy appointments. This was judged as a '*great project with good evidence of patient engagement and changes being made as a result of patient feedback*.'

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

Responding to Patient Experience Feedback

The impact of the pandemic on patient experience has continued to be evident with the restrictions on visiting and volunteers on the wards. The Arts Programme Manager has continued to provide wards with a range of **art and craft activities**, for example, 'Boredom Buster' newspapers, crossword puzzles, etc.

The Patient Advice and Liaison Service team have continued with the **Keeping in Touch service.** Families use a generic e-mail address to send messages to their loved ones during their hospital stay. These messages are sent to the wards with a card from the PALS team. Families were also able to bring in items of **food and clothing** to main reception for these to be taken to wards.

Following an increase in PALS concerns relating to poor communication at ward level and restrictions on visiting due to wards closed as a result of COVID or hospital visiting restrictions it was recognised that there was a need to improve communication with relatives and carers and facilitate virtual visits via Facetime or WhatsApp. To support communication between families and patients, each ward was given an iPad and iPhone in 2020/21 to enable **virtual visiting** to take place.

However, the recognised need for good communication between families and the wards and families and their loved ones in hospital enabled the Trust to take this further and fund a new service across all medical wards and admitting areas (ED

and Medical Assessment Wards). The **Family Liaison Facilitator Team** (FLF) support is very often for the most vulnerable patients, those with Dementia, frail elderly and those with additional communications needs (deaf or patients with a learning difficulty/disability). Since the introduction of the service, between, December 2021 and 31 March 2022 the team have facilitated 2,986 telephone calls and video calls between patients and their families and families and staff on wards.

During the pandemic, patients attending outpatient appointments at the hospital were asked to attend alone to reduce footfall and minimise the risk of infection. Some patients told us that they missed having their loved one at their appointment as they sometimes found it difficult to remember everything that was said. As a result patients are encouraged to '**phone a friend/family member'** during the appointment and use loudspeaker function so that the family member can be included in the consultation.

We have had a number of patients contacting the PALS service enquiring about when their outpatient appointment would be as **waiting times** have increased over the last year. A review of the Trust's external web pages highlighted that the information wasn't easy to understand or kept up to date. This was reviewed and is now updated every month. In addition there is an increased focus on improving communication channels between patients and outpatient departments, for example setting up dedicated email addresses for patient correspondence for each outpatient department and improving the telephone system.

Stakeholder relations

West of England Academic Health Science Network (WEAHSN)

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

The RUH hosts and continues to work in partnership with the West of England AHSN (WEAHSN) to explore new opportunities for collaboration and innovation, further improve patient safety and quality of care, and share best practice across the South West. A number of our clinical teams have been participating in specific work streams to support the rapid implementation of innovation and service improvement and share best practice across the NHS. For example, the RUH has worked with partners funded by the WEAHSN to improve safety and outcomes of maternal and neonatal care by reducing unwarranted variation and providing high quality healthcare experience to all women, babies and families. Furthermore, the RUH was one of eight early implementers of the Royal College of Physicians Structured Judgement review process and are working collectively with the other earlier implementers to deliver the national Learning form Deaths programme requirements.

Third Sector

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

The last year saw huge changes to the way in which volunteers gave their time to the hospital. Many of our previous volunteers were in the high risk and vulnerable groups and so unable to come to the hospital. However, the Trust was overwhelmed with offers of support from the local community, some of this was from people who had been furloughed and others who had some time to give. New volunteer roles were developed in response to the needs of staff – we had volunteers supporting doctors in the doctors rest room, Emergency department (ED) 'runners' helping staff in ED to access equipment and not have to put on and take off their personal protective equipment (PPE), housekeeping volunteers and volunteers assisting our Estates and Facilities team.

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

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

Undergraduate and postgraduate medical training

Undergraduate medical students: The RUH hosts Bath Academy as a teaching hub for Bristol University Medical School, supporting the education and training of nearly 400 medical students, equating to 9000 student weeks, per year. Around 25 Consultants act as Coordinators and Tutors providing and organising the teaching of medical students. They work alongside eight Clinical Teaching Fellows (Junior Doctors) as the keystone to providing the teaching both on the wards and in the classroom.

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

Postgraduate Doctors: The RUH continues to respond to and embed the changes in Post-Graduate Medical Education precipitated by the 2016 Junior Doctors Contract. Results from the National Training Survey and Quality Panels have shown the RUH continues to offer excellent training. The pioneering Local Trainee Support Faculty

run by the Associate Director of Medical Education for Support is in place to help those trainees who need additional advice and guidance.

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

Primary care services

During 2021/22, the Trust continued to work closely with 22 Primary Care Networks across BSW to support them both in their short term aim of making general practice financially sustainable and their longer term goal of improving access and care.

Community services

In July 2016, Wiltshire Health and Care (a limited liability partnership (LLP) created between Great Western Hospitals Foundation Trust, Salisbury Foundation Trust and the RUH) commenced its £40 million a year contract to deliver seamless and improved community services across Wiltshire. Since launch, the Trust's relationships with its partners across Wiltshire have been strengthened, and opportunities for improved pathway development have been realised – including the rolling out of the Home First pathway with Wiltshire Health and Care. Home First builds on a successful active rehabilitation project, helping patients with therapy requirements to return home from hospital earlier than would otherwise have been the case. The partnership has supported the RUH in its efforts to reduce delays in discharging patients who, though medically fit to leave hospital, still require some support. This relationship was particularly helpful in addressing the need for as many of the hospital's beds to be freed up in anticipation of surges in demand caused by the COVID-19 outbreak.

Learning from best practice networks

The RUH remains a member of NHS Quest and NHS Providers. These membership organisations retain a relentless focus on the sharing of best practice. NHS Providers in particular has provided a strong representative voice for provider organisations during the COVID-19 pandemic and its aftermath, both with government and NHS leadership, but also in informing the public. Across both organisations, members work together to share challenges, benchmark, peer review and design innovative solutions to provide the best care possible for patients and staff. A small annual membership fee is paid by the Trust towards the running costs of these networks.

The COVID-19 pandemic meant that the roll out of training on the Trust's organisational development and improvement methodology, Improving Together, remained suspended during most of 2021/22. The Trust remains committed to this methodology, and a re-launch took place in the second half of the year. The approach to training staff has been altered to focus more on supporting managers to

train their own teams. The original aim of building the RUH's staff into an army of improvers remains, and Improving Together now forms the basis for Board and Committee reporting, as well as the identification and management of strategic risk.

Consultation with local groups and organisations

As the restrictions necessitated by the COVID-19 pandemic continued during 2021/22, much of the Trust's routine engagement with local groups and organisations remained suspended, both because it remained difficult for anyone to visit the hospital for non-clinical purposes, but also as the vast majority of our staff were engaged, in one way or another in helping to manage the impact of COVID. That said, the support and good wishes from both our existing and new volunteers, our Foundation Trust members, the Friends of RUH and the supporters of our own charity, the Forever Friends Appeal, among many others, were greatly appreciated.

Members of our Council of Governors have held the first of a planned series of virtual meetings in April 2021 with members and this was well received. Plans for face to face meetings later in the calendar year will be set out as lockdown restrictions are eased.

Research

During 2021/22, the RUH continued to respond to the changed focus of research activity towards COVID-19. As one of the most research-active district general hospitals in the county, it was and remains involved in a series of relevant and timely trials and projects, including:

- contribution to a large study around acute respiratory problems linked to infectious diseases
- participation in a trial that considered treatment options for COVID-19, the outcomes of which influenced practice around the world, and
- identification as one of the key sites for a short study considering the safety and immune responses to giving COVID and flu vaccines at the same time.

Statement as to disclosure to the auditor

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

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

Income Disclosures

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

Investments

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 is also the Vice Chair and Senior Independent Director of the RUH. Two of the other three directors, Simon Sethi and Bernie Marden also sit on the RUH Board. All three directors have declared their respective interests to both boards.

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

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

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

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

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, Forever Friends Appeal, are focused on improving the environment within the hospital for staff and patients and supporting innovative developments not funded by the NHS. The financial position of the charity is reported within the Trust's accounts and forms part of the Group accounts.

Remuneration report

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

The following report details how the remuneration of senior managers is determined. A 'senior manager' is defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust'. The Trust deems this to be the Executive and Non-Executive members of the Board of Directors.

Annual Statement on Remuneration

Chair of the Remuneration Committee's annual statement on remuneration

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

The Nominations and Remuneration Committee is chaired by the Trust Chair and has delegated responsibility for the remuneration and terms of service for the Chief Executive and Executive Directors of the Trust. Its responsibility includes all aspects of salary, provision of other benefits, and arrangements for termination of employment and other contractual terms. The membership of the Committee consists of all the Non-Executive Directors. The Chief Executive and the Director for People and Culture are in attendance at meetings of the Committee to provide advice, but are not present during any discussions relating to their own remuneration. Benchmarking data, taken from the 'NHSI Guidance on pay for very senior managers in NHS trusts and foundation trusts' (including Annex A), is adopted for comparisons.

Senior Managers' Remuneration Policy

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

excluded from eligibility for the Directors' Bonus Payments Scheme. This situation was rectified in March 2020, when the Nominations and Remuneration Committee approved a proposal to amend the Medical Director's contract, to better reflect the relative amount of his time spent on his management responsibilities compared to his duties as a consultant.

The remuneration of the Chief Executive and Executive Directors is determined by the Board of Directors' Nominations and Remuneration Committee taking into account market levels, key skills, performance and responsibilities. In reviewing remuneration, including making decisions about whether to pay the Chief Executive and any of the individual Executive Directors more than £150,000 per annum, as outlined in the guidance issued by the Cabinet Office, the Committee has regard to the Trust's overall performance, delivery of agreed objectives, remuneration benchmarking data in relation to similar NHS Foundation Trusts and the wider NHS, and the individual Director's level of experience and development of the role. However, the Trust has not directly consulted with the wider employee body in setting the remuneration policy for senior managers

Remuneration of Senior Managers

Pay component	Cost of Living uplift (annual)	Bonus payment (annual)	Relevant Senior Managers
Agreed through the Nominations and Remuneration Committee and benchmarked against the 'NHSI Guidance for pay for very senior managers.'	Application of nationally recommended uplift reviewed and determined by Nominations and Remuneration Committee.	Up to 10% of salary, non-consolidated, determined by the Nominations and Remuneration Committee. Awarded based upon assessment of individual and Trust performance.	All Executive Directors of the Trust including the Chief Executive.

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

Individual performance is reviewed through the Trust's appraisal process to evaluate the extent to which the Chief Executive and Executive Directors have met their objectives and contributed to the delivery of the Trust's strategic objectives. The annual review comprises, where applicable, a cost of living uplift (offered in line with any guidance from NHS England) and, at the Committee's discretion, a Directors' non-consolidated bonus payments scheme of up to 10% of the individual Executive Director's salary for outstanding performance over the last 12 months. The performance of the Chief Executive and Executive Directors is assessed on a continuing basis via formal appraisal and unsatisfactory performance may provide grounds for termination of contract.

Any non-consolidated performance payments awarded are removed each year and are only then awarded where the Nominations and Remuneration Committee determines that performance measures have been achieved, as assessed through the appraisal process. The Nominations and Remuneration Committee receives a report identifying the achievement or otherwise of the performance measures.

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

The provision of a non-consolidated performance payment for senior managers, as described in this report, is not replicated for other groups although Medical and Dental staff do have the opportunity to apply for national or local Clinical Excellence Awards which are consolidated.

The Board of Directors' Nominations and Remuneration Committee met on 2 February 2022 to consider among other items the Chief Executive and Executive Directors' remuneration and performance bonus for 2021/22. The meeting was chaired by Alison Ryan, Chair, and was attended by Ian Orpen, Antony Durbacz, Jeremy Boss, Nigel Stevens, Sumita Hutchison and Anna Mealings.

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

Remuneration of the Chair and Non-Executive Directors

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

In November 2019, NHS Improvement published a document entitled *Structure to align remuneration for Chairs and non-executive directors of NHS trusts and NHS foundation trusts.* In it, they published research on the pay rates for chairs and non-executive directors of trusts and foundation trusts of different sizes, comparing them to rates paid to directors of private sector companies with similar turnovers. They then made recommendations aimed at aligning pay to directors of trusts and foundation trusts based on their turnover.

In January 2021, the Council of Governors met to review non-executive pay rates in light of this guidance, which recommended a base rate of £13,000 for all Non-Executive Directors. As a result of this process they agreed the following rates to take effect from 1 April 2021:

Jeremy Boss	£15500	Including an extra £1500 as Senior Independent Director, and £1000 as Chair of the Finance & Performance Committee
Antony Durbacz	£14500	Including an extra £1500 as Chair of the Audit and Risk Committee
Sumita Hutchison	£14000	Including an extra £1000 as Chair of the Non-Clinical Governance Committee
Anna Mealings	£14000	Including an extra £1000 as Chair of the People Committee
Nigel Stevens	£14000	Including an extra £1000 as Chair of the Clinical Governance Committee
Ian Orpen	£13500	Including an extra £500 to reflect the additional commitment as Non-Executive Director Board Maternity Champion (as recommended by the Ockenden Review) and Designated Board Member for Medical Disciplinary Issues.

Details of all directors' attendance at Board and Board Committee meetings are set out at pages 65 to 66 of this report.

Annual Report on Remuneration

Service Contracts

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

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

Name	NHS FT terms of office	Current term of Office	Notice period
Alison Ryan **Chair**	01-Apr-2019-31-Mar-2025	1-Apr-2022-31-Mar-2025	3 months
Jeremy Boss, **Non-Executive Director**	6 March 2017–8 Feb-2023	9-Feb-2020–8-Feb 2023	3 months
Nigel Stevens **Non-Executive Director**	01-April 2018-31 Mar 2024	01-April 2021-31 Mar 2024	3 months
Sumita Hutchison **Non-Executive Director**	04-Sept-2019-31-Aug-2025	01-Sept-2022-31-Aug-2025	3 months
Anna Mealings **Non-Executive Director**	04-Sept-2019-31-Aug-2022	04-Sept-2019-31-Aug-2022	3 months
Ian Orpen **Non-Executive Director**	07-Sept-2020-31-Aug-2023	07-Sept-2020-31-Aug-2023	3 months
Antony Durbacz **Non-Executive Director**	07-Sept-2020-31-Aug-2023	07-Sept-2020-31-Aug-2023	3 months
Libby Walters **Deputy Chief Executive & Director of Finance**	04-Jun- 2018	N/A	6 months
Bernie Marden **Medical Director**	30-Apr-2018	N/A	6 months
Simon Sethi **Chief Operating Officer**	17-Jan-2021	N/A	6 months
Antonia Lynch **Chief Nurse**	01-Apr-2021	N/A	6 months
Jocelyn Foster **Director of Strategy**	30-Jul-2012	N/A	6 months
Alfredo Thompson **Director for People and Culture***	31-Jan-2022	N/A	6 months
Brian Johnson **Director of Estates and Facilities***	01-Apr-2019	N/A	6 months

*Indicates non-voting members of the Board of Directors

Disclosures in accordance with the Health and Social Care Act

Director and governor expenses

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

Directors' expenses

No taxable expenses were paid to any Executive or Non-Executive Director during the reporting period or the previous financial year. The full list of Executive and Non-Executive Directors who served during 2021/22 is set out in pages 32 and 36 below.

Governors' expenses

Governors are not remunerated, but are entitled to claim expenses for costs incurred whilst undertaking duties for the Trust as a Governor (for example, travel expenses to attend Council of Governors' meetings). No expenses were paid to any of the Governors in the period 1 April 2021 to 31 March 2022 (£117.65 was paid to 2 Governors in the period 1 April 2020 to 31 March 2021).

Senior Managers' Remuneration (subject to audit)

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

Remuneration for Senior Managers for 2021-22:	**Salary and Fees (bands of £5,000)**	**Salary and Fees for Clinical Duties (bands of £5,000)**	**Annual Performance Related Bonuses (bands of £5,000)**	**Pension Related Benefits (bands of £2,500)**	**Total (bands of £5,000)**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Cara Charles-Barks **Chief Executive**	190-195	-	15-20	55.0-57.5	265-270
Libby Walters **Director of Finance & Deputy Chief Executive**	145-150	-	10-15	2.5	155-160
Bernie Marden **Medical Director**	105-110	85-90	15-20	60-62.5	270-275

Jocelyn Foster **Director of Strategy**	115-120	-	5-10	30-32.5	155-160
Claire Radley **Director of People** (left 31/01/22)	90-95	-	5-10	17.5-20	120-125
Alfredo Thompson **Director for People and Culture**	20-25	-	-	-	20-25
Brian Johnson **Director of Estates and Facilities**	105-190	-	5-10	25-27.5	140-145
Simon Sethi **Chief Operating Officer**	135-140	-	5	70-72.5	205-210
Alison Ryan **Chair**	45-50	-	-	-	45-50
Jeremy Boss **Non Executive Director**	15-20	-	-	-	10-15
Nigel Stevens **Non Executive Director**	10-15	-	-	-	10-15
Sumita Hutchinson **Non Executive Director**	10-15	-	-	-	10-15
Anna Mealings **Non Executive Director**	10-15	-	-	-	10-15
Ian Orpen **Non Executive Director** (wef 09/09/2020)	10-15	-	-	-	5-10
Antony Durbacz **Non Executive Director** (wef 01/11/2020)	10-15	-	-	-	5-10

Remuneration for Senior Managers for 2020-21:	**Salary and Fees (bands of £5,000)**	**Salary and Fees for Clinical Duties (bands of £5,000)**	**Annual Performance Related Bonuses (bands of £5,000)**	**Pension Related Benefits (bands of £2,500)**	**Total (bands of £5,000)**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Cara Charles-Barks **Chief Executive** (wef 01/09/2020)	110-115	-	10-15	40-42.5	165-170
James Scott **Chief Executive** (from 02/04/2020 – 31/05/2020)	30-35	-	20-25	-	50-55
Libby Walters **Director of Finance & Deputy Chief Executive**	155-160	-	25-30	72.5-75.0	260-265
Bernie Marden **Medical Director**	100-105	85-90	15-20	72.5-75	280-285
Jocelyn Foster **Director of Strategy**	115-120	-	20-25	30-32.5	175-180
Rebecca Carlton **Chief Operating Officer** (left 12/08/2020)	45-50	-	10-15	10-12.5	65-70
Lisa Cheek **Director of Nursing & Midwifery** (left 28/03/2021)	110-115	-	20-25	22.5-25	155-160
Claire Radley **Director of People**	110-115	-	20-25	27.5-30	160-165
Brian Johnson **Director of Estates and Facilities**	95-100	-	15-20	22.5-25	140-145

Simon Sethi **Chief Operating Officer** (wef 22/02/2021)	25-30	-	-	2.5-5	30-35
Rhiannon Hills **Acting Chief Operating Officer (from 17/08/20 – 17/01/2021)**	40-45	-	-	27.5-30	70-75
Simon Wade **Acting Director of Financ**e (from 01/04/2020 – 31/08/2020)	40-45	-	-	55-57.5	100-105
Alison Ryan **Chair**	45-50	-	-	-	45-50
Jeremy Boss **Non Executive Director**	10-15	-	-	-	10-15
Joanna Hole **Non Executive Director** (left 31/10/2020)	5-10	-	-	-	5-10
Nigel Stevens **Non Executive Director**	10-15	-	-	-	10-15
Sumita Hutchinson **Non Executive Director**	10-15	-	-	-	10-15
Anna Mealings **Non Executive Director**	10-15	-	-	-	10-15
Ian Orpen **Non Executive Director** (wef 09/09/2020)	5-10	-	-	-	5-10
Antony Durbacz **Non Executive Director** (wef 01/11/2020)	5-10	-	-	-	5-10

Total Pension Entitlement

	Real Increase in Pension at Pension Age (bands of £2,500)	Real Increase in Pension Lump Sum at Pension Age (bands of £2,500)	Total Accrued Pension at Pension Age at 31 March 2022 (bands of £5,000)	Lump Sum at Pension Age, Related to Accrued Pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real Increase in Cash Equivalent Value Transfer	Cash Equivalent Transfer Value at 31 March 2022	Employer's Contribution to Stakeholder Pension
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Cara Charles-Barks **Chief Executive**	2.5-5	0-2.5	35-40	50-55	557	39	624	28
Antonia Lynch **Chief Nurse***	2.5-5	0-2.5	40 - 45	85 – 90	774	48	840	17
Jocelyn Foster **Director of Strategy**	0-2.5	0 - 2.5	20 - 25	20 - 25	336	23	376	17
Bernie Marden **Medical Director**	2.5 - 5	0-2.5	70 – 75	145-150	1,274	65	1,367	28
Libby Walters **Director of Finance & Deputy Chief Executive**	0-2.5	0-2.5	55 - 60	110 - 115	956	0	957	21
Claire Radley **Director for People***	0 - 2.5	0 - 2.5	10 - 15	0 -5	116	8	141	14
Alfredo Thompson **Director for People and Culture***								
Simon Sethi **Chief Operating Officer**	2.5-5	2.5-5	25-30	45-50	319	38	377	20
Brian Johnson **Director of Estates and Facilities**	0 - 2.5	0 - 2.5	5-10	0-5	56	13	83	15

*Not in post for the full year

No directors received any taxable benefits during 2021/22. The Trust does not pay its directors long-term performance-related bonuses.

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

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

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

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

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

The Nominations and Remuneration Committee uses and considers the nationally recommended cost of living uplift for the executive team. A maximum non-consolidated performance payment of 10% can be awarded by the Nominations and Remuneration Committee to members of the executive team following consideration of the achievement of individual and collective objectives that support delivery of the Trust strategy.

Performance pay, determined by the Nominations and Remuneration Committee, is based upon the following criteria:

- A. Outstanding annual uplift, consolidated into salary, plus up to a 10% non-consolidated bonus.
- B. Exceeds expectation annual uplift, consolidated into salary, plus up to a 5% non-consolidated bonus (lower than A).
- C. Satisfactory annual uplift, consolidated into salary.
- D. Not satisfactory, no increase.

Any performance pay is paid retrospectively for the previous annual period of performance. For 2021/22, the Committee agreed to award an 8% bonus to all the members of the executive team.

The minimum level of performance required for the Nominations and Remuneration Committee to consider the non-consolidated performance pay (over and above the cost of living uplift) is 'exceeds expectations'. There are no additional levels of performance set.

The performance measures and targets for each member of the executive team are set annually by the CEO in discussion, both collectively and with individual members of the team. The CEO's performance measures and targets are set by the Chair of the Trust. The Nominations and Remuneration Committee also includes in their considerations Trust performance against key national targets.

Where a director's performance is deemed 'not satisfactory', no annual cost of living uplift or non-consolidated payment is considered. 'Earn-back' is applied to all staff at Band 8C and above to whom Agenda for Change applies.

There have been no new components within the pay for Executive Directors or other senior managers for the 2021/22 period.

Where senior managers are paid above £150,000, the Trust has taken steps to ensure that this is reasonable. As stated above, the Trust uses NHSI pay benchmarking data to understand the pay norms for a medium-sized NHS acute provider, and reports this to Nomination and Remuneration Committee to help inform decision making. Any such salary above £150,000 requires that referral be made to the Cabinet Office for their opinion (formal approval is not required because of the Trust's NHS Foundation Trust status).

Statement of consideration of employment conditions elsewhere in the Trust

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

Fair Pay Multiple

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

The banded remuneration for the highest paid Director in the Royal United Hospitals Bath NHS Foundation Trust for the financial year 2021-22 was £210,000 - £215,000 (2020-21 £210,000 - £215,000). This is a change between years of 0% (2020-21 0%).

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

For employees of the Trust as a whole, the range of remuneration in 2021-22 was from £21 to £248,838 (2020-21 £2,527 to £240,999). 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 3.15%. 8 employees received remuneration in excess of the highest-paid director in 2021-22 (2020/21 3).

	20/21	21/22	%age difference
Salary of Highest paid director	£ 191,398.12	£ 194,535.12	1.639
Bonus of the highest paid director	£ 19,139.81	£ 15,562.80	-18.689
Total of annualised Pay - the highest paid director / FTE employees	£ 44,442.32	£ 45,907.33	3.296
Total of performance pay and bonus's - highest paid director / FTE employees	£ 33.15	£ 9.57	-71.13

Highest Paid Director Bonus - The difference has decreased due to the payment of two bonuses during 2020/21 compared to one bonus in 2021/22.

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.

2021/2022	25th Percentile	Median	75th Percentile
Salary Component of pay	£ 15,924.48	£ 21,777.00	£ 32,306.00
Total Pay and Benefits excluding pension benefits	£ 21,777.00	£ 31,534.00	£ 43,175.51
Pay and Benefits excluding pension : pay ratio for highest paid director	9.65	6.66	4.87

Payments for loss of office

There have been no payments made to any senior manager during 2020-21 or 2021-22 for loss of office. Any compensation payable for loss of office is conducted under the terms and conditions of the appropriate contract of employment.

Payments to past senior managers (on exit payments)

There were no payments to past senior managers during the reporting period. (31 March 2021: none).

	Term of Appointment	Board of Directors	Audit Committee	Non-Clinical Governance Committee	Quality Governance Committee	Nominations and Remuneration Committee	Subsidiary Oversight Committee	Charities Committee	Finance and Performance Committee	People Committee
					Attendance/actual/maximum					
Non-Executive Directors										
Alison Ryan, **Chair**	1/04/2019-31/03/2025	7/7	-	-	-	3/3	-	4/4	-	-
Jeremy Boss, **Vice Chair and Senior Independent Director**	06/03/2017-05/03/2023	7/7	-	-	-	2/3	1/1	3/4	10/10	-
Nigel Stevens	01/04/2018-31/03/2024	6/7	4/4	-	5/6	3/3	6/6	-	7/10	-
Sumita Hutchison	04/09/2019-31/08/2025	6/7	4/4	3/3	-	3/3	-	-	-	5/5
Anna Mealings	04/09/2019-03/09/2022	7/7	-		6/6	3/3	-	-	-	4/5
Ian Orpen	07/09/2020-06/09/2023	7/7	-	3/3	6/6	3/3	6/6	-	-	5/5
Antony Durbacz	01/11/2020-31/10/2023	6/7	4/4	3/3	-	2/3	-	-	9/10	-
Executive Directors										
Cara Charles-Barks, **Chief Executive**	01/09/2020-ongoing	6/7	1/4	-	3/6	-	5/6	-	8/10	4/5

	Term of Appointment	Board of Directors	Audit Committee	Non-Clinical Governance Committee	Quality Governance Committee	Nominations and Remuneration Committee	Subsidiary Oversight Committee	Charities Committee	Finance and Performance Committee	People Committee
Attendance/actual/maximum										
Libby Walters **Deputy Chief Executive & Director of Finance**	01/06/2018 – ongoing	7/7	4/4	2/3	-	-	5/6	3/4	10/10	-
Antonia Lynch, **Chief Nurse**	01/04/2021 – ongoing	6/6	-	-	5/6	-	4/6	3/4	-	2/5
Bernie Marden **Medical Director**	01/04/2018 – ongoing	7/7	-	-	6/6	-	-	-	3/10	4/5
Jocelyn Foster **Director of Strategy**	01/07/2012 - ongoing	6/7	-	3/3	-	-	4/6	2/4	-	-
Simon Sethi **Chief Operating Officer**	15/01/2021 - ongoing	7/7	-	1/3	-	-	2/6	-	8/10	-
Claire Radley **Director for People**	01/04/2018 – 28/01/2022	6/6	-	-	-	1/1 (3)	4/4	-	-	4/4
Alfredo Thompson, **Director for People and Culture**	31/01/2022 - ongoing	1/1	-	-	-	1/1	2/2	-	-	1/1
Brian Johnson **Director of Estates & Facilities**	01/04/2019 – ongoing	5/7	-	3/3	-	-	-	-	-	3/5

Cara Charles-Barks

Chief Executive (Accounting Officer)

21st June 2022

Staff report

Analysis of staff numbers

An analysis of average staff numbers across the Trust is outlined in the table below:

	Permanent Number	Other Number	2021/22 Total Number	2020/21 Total Number
Medical and dental	659	17	**676**	664
Ambulance staff	-	-	**-**	1
Administration and estates	878	147	**1,025**	939
Healthcare assistants and other support staff	1,559	214	**1,773**	1,710
Nursing, midwifery and health visiting staff	1,448	214	**1,662**	1,617
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	478	10	**488**	473
Healthcare science staff	144	3	**147**	146
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**5,166**	**605**	**5,771**	**5,550**
Of which:				
Number of employees (WTE) engaged on capital projects	25	2	**27**	19

Analysis of staff costs for 2021/22

	Permanent £000	Other £000	2021/22 Total £000	2020/21 Total £000
Salaries and wages	232,764	-	**232,764**	207,188
Social security costs	22,470	-	**22,470**	19,813
Apprenticeship levy	1,269	-	**1,269**	977
Employer's contributions to NHS pension scheme	36,994	-	**36,994**	34,087
Pension cost - other	192	-	**192**	-
Other post-employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	11,888	**11,888**	7,070
NHS charitable funds staff	663	-	**663**	527
Total gross staff costs	**294,352**	**11,888**	**306,240**	**269,662**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**294,352**	**11,888**	**306,240**	**269,662**
Of which				
Costs capitalised as part of assets	1,892	-	**1,892**	1,526

Analysis of staff costs for 2020/21

Employee Expenses 20/21	Permanently Employed	Other	Total
	2020/21 £000	2020/21 £000	2020/21 £000
Salaries and wages	204,340	2,848	207,188
Social security costs	19,813	0	19,813
Apprenticeship levy	977	0	977
Pension cost - employer contributions to NHS pension scheme	34,087	0	34,087
Temporary staff - agency/contract staff	0	7,070	7,070
NHS charitable funds staff	527	0	527
Total Gross Staff Costs	**259,744**	**9,918**	**269,662**

Sickness absence data

Figures Converted by DH to Best Estimates of Required Data Items		Statistics Produced by NHS Digital from ESR Data Warehouse		
Average FTE 2021	Adjusted FTE days lost to Cabinet Office definitions	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
5009	53072	1,828,175	86,094	10.6

NHS Sickness Absence Figures for NHS 2021-22 Annual Report and Accounts

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse
Period covered: January to December 2021

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

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

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

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

Staff policies and actions applied during the financial year

The ten-year strategy for the human resources and organisational development services in the NHS has been launched (The Future of NHS Human Resources and Organisational Development Report) encapsulating the NHS People Plan and the NHS People Promise. Together with the RUH People and Culture Strategy, the Trust has positioned the workforce (known here as 'our RUH people') at the centre of our efforts to improve our people's experiences of work in the full knowledge that in doing so the experiences of our patients will be improved.

Our RUH people have shown huge loyalty and strength during all of the phases of the pandemic, but we know that this has not been without personal cost. We continue to listen to our people and aim to provide support and care for those who so diligently support and care for our patients and their families.

We are a Team

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

The Trust has expanded its celebration of the diversity of staff, with celebrations held during Black History month and Rainbow walkways being unveiled during LGBT+ History month. The staff networks and inclusion ambassadors continue to work with the Trust to acknowledge important cultural and religious festivals throughout the year in recognition of our multicultural teams. Families and children of staff working during key religious holidays, (Christmas, Passover, Ramadan etc.) can receive a letter from the Chief Executive acknowledging their family member's contribution to

the running of the hospital. Additionally, our catering team produced a variety of food from different countries for our staff to enjoy and taste.

Gender Analysis

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

- Directors
- Other Senior Manager
- Employees

Position at 31st March 2022

	Female	Male	Total
Directors	4	4	8
Other Senior Managers	64	36	100
Employees	4420	1334	5754
Total	4488	1374	5862

Staff Surveys

Staff engagement

The Trust monitors the impact of staff engagement using the key indicators in the annual NHS Staff Survey, the Friends and Family Test (FFT) for Staff results and the Making a Difference quarterly pulse survey scores. These surveys are complimented by a number other support measures including listening events and targeted team interventions.

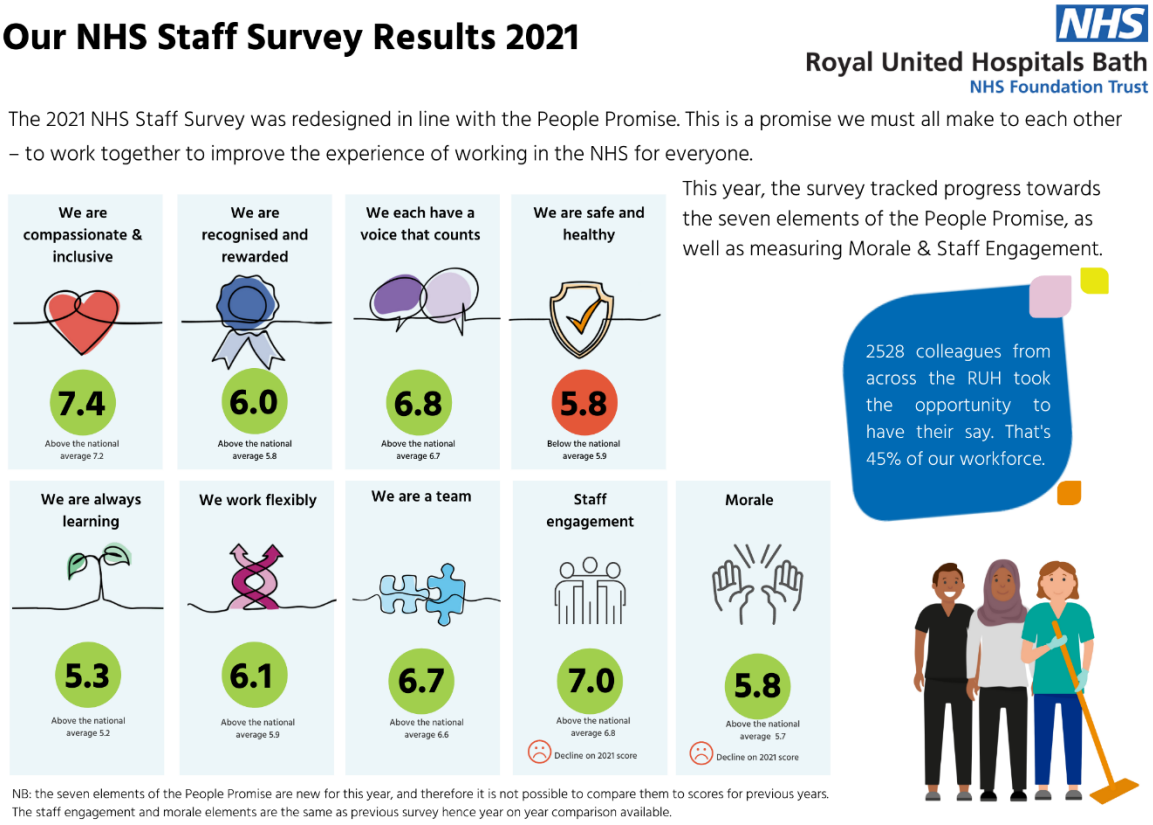
NHS Staff Survey – Summary of performance

This year the NHS Staff Survey was redesigned in line with the NHS People Promise. It tracked our progress towards the seven elements of the People Promise, as well as measuring Morale & Staff Engagement.

All staff across the Trust were invited to complete the annual NHS Staff Survey in autumn 2021. A total of 2,528 responses were received, equivalent to a response rate of 45%, which is slight increase on last year's response rate (44%).

The NHS Staff Survey staff engagement score for 2021 at the RUH was 7.0, and shows a slight decrease on 2021 which reflects the national position. Question level data shows that overall the scores are lower (worse) than in 2020, although from the graphic below it is clear that in a number of areas our position is better than other employers, showing the challenges across the whole of the NHS and the impact on staff.

Monitoring of the Trust's staff engagement work is through the Staff Engagement Group and the Strategic Workforce Committee.



Element or Theme	2021/22		2020/21		2019/20	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
We are compassionate and inclusive	7.4	7.2				
We are recognised and rewarded	6.0	5.8				
We each have a voice that counts	6.8	6.7				
We are safe and healthy	5.8	5.9				
We are always learning	5.3	5.2				
We work flexibly	6.1	5.9				
We are a team	6.7	6.6				
Staff Engagement	7.0	6.8	7.1	7.0	7.0	7.0
Morale	5.8	5.7	6.1	6.0	5.8	5.9

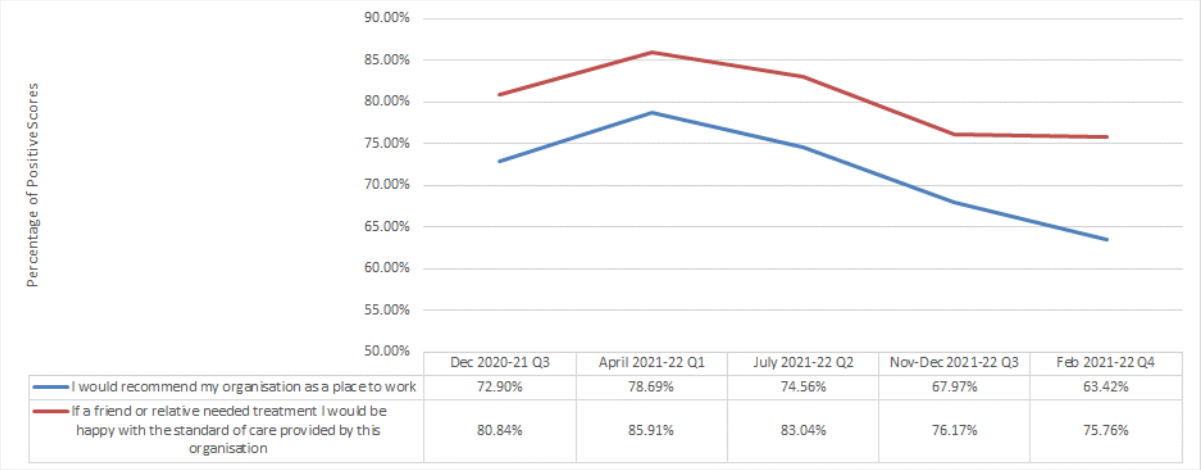
5 Key priorities and targets for 2022

In responding to the data, the RUH Staff Survey Steering Group oversee the work across the Trust and in Divisions to deliver improvements in 5 key areas:

1. Improving our staffing levels
2. The experience of colleagues from black and ethnic minority backgrounds
3. Encouraging the reporting of violence and abuse
4. Preventing exhaustion
5. Ensuring everyone has a good quality annual appraisal

Staff Friends and Family Test (FFT)

The most recent Staff Friends and Family scores (Feb 2021) are below and show a steady decline in the positive responses to the questions relating to the RUH.



	Dec 2020-21 Q3	April 2021-22 Q1	July 2021-22 Q2	Nov-Dec 2021-22 Q3	Feb 2021-22 Q4
I would recommend my organisation as a place to work	72.90%	78.69%	74.56%	67.97%	63.42%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	80.84%	85.91%	83.04%	76.17%	75.76%

Making a Difference (pulse survey)

The Trust continues to use the Making a Difference pulse surveys to monitor staff engagement levels at regular three month intervals. From April 2022 we shall be gathering the views from all staff each quarter including for the first time bank staff and students. To maximise ways in which staff can complete this a QR code and posters have been introduced.

The Making a Difference model gives a staff engagement score out of 5. Our engagement score is currently 3.88, which is lower than a year ago (3.97).

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

The three lowest enablers of staff engagement are Resources, Workload and Perceived Fairness and triangulates with data from Freedom to Speak Up and the Employee Assistance Programme.

Relevant union officials

The total number of employees who were relevant union officials during 2021/22 was:

Number of employees who were relevant union officials 21/22	Full-time equivalent employee number
51	5,804

Percentage of time spent on facility time during 21/22

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

Percentage of time spent on facility time during 21/22

Total cost of facility time	£76,323.00
Total pay bill	£278,363,669.98
% of total pay bill spent on facility time	0.027%

Paid trade union activities during 21/22

Time spent on paid trade union activities as a percentage of total paid facility time hours	9.92%

Off payroll engagements

In accordance with the HM Treasury annual reporting guidance the Trust is required to report the number of off-payroll engagements, of more than £245 per day, that were in place as at 31st March 2022 (Table 1); all off-payroll workers engaged at any point during the year ended 31 March 2022 (Table 2); and any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022 (Table 3). Table 4 shows the detail of the Exit package details for the Trust for the period, with the sole area of exit packages being contractual payments made in lieu of notice.

From April 2017, the Government has reformed the legislation associated with off-payroll payments so that public sector bodies are responsible for deducting and paying all employment taxes and national insurance contributions from the

individuals concerned. As a result of this all off-payroll arrangements, irrespective of value, are assessed and steps taken to ensure that tax and national insurance is deducted correctly.

Table 1

Off-payroll worker engagements as at 31 March 2022

Number of existing engagements as of 31 March 2022	
Of which	
Number that have existed for less than one year at time of reporting	11
Number that have existed for between one and two years at time of reporting.	3
Number that have existed for between two and three years at time of reporting	nil
Number that have existed for between three and four years at time of reporting	nil
Number that have existed for four or more years at time of reporting.	nil

Table 2

All off-payroll workers engaged at any point during the year ended 31 March 2022

Number of off-payroll workers engaged during the year ended 31 March 2022	
Of which	
Not subject to off-payroll legislation	nil
Subject to off-payroll legislation and determined as in_scope of IR35	nil
Subject to off-payroll legislation and determined as out of-scope of IR35	14
Number of engagements reassessed for compliance or assurance purposes during the year	nil
Of which: number of engagements that saw a change to IR35 status following review	nil

Table 3

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	nil
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.	31

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

Table 4: **Exit packages 2021/2022**

Details of exit packages for 2021-2022:

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

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

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

Expenses 2021 - 2022

Year	Staff group	Amount	No of individuals
2020/2021	Directors	£ 1,586.24	5
2020/2021	NED's	£ -	0

Equality Report including Gender Pay Gap

The Trust's Equality, Diversity and Inclusion Policy, as well as a number of other supporting policies, is the touchstone in our approach to consistently and effectively delivering equality of employment opportunity and experience at work. We have much to do but have our inclusion agenda as one of our highest priorities.

We recognise our responsibility to provide, as far as is reasonably practicable, job security of all employees.

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

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

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

The Trust has four established staff networks, Fusion, (representing staff from ethnic minorities), Equal Abilities (staff with disabilities) and LGBT+ and allies, (lesbian, gay, bisexual and transgender) and a Women's network. These continue to grow from strength to strength. As well as providing support for these staff groups the networks are very much an opportunity for these staff to voice concerns and comment on the work of the Trust and provide feedback to the executive team.

The networks also help us to increase the inclusivity of our Trust through celebratory events such as Black history month and LGBT+ History month, providing opportunities for staff to both educate and share their culture with all our staff.

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

Gender pay

Our median gender pay gap favours women, (with women on average being paid 2.49% more than men). Our mean gap has seen little movement, with a slight decrease to 21.03% favouring men. There has been however marked improvement in the gender pay gap across bonus payments with no gap existing when looking at the median average bonus payments between men and women and a reduction of 21.02% of the mean average gap, to 14.20% favouring men. The full report can be read here.

Model Employer Data

Ten- year aspirational goals set by NHS England for all NHS Trusts; aimed at creating a senior leadership that will be reflective of its staff profile. Each Trust has yearly projections for bands 8a,b,c,d, 9 and very senior managers, in relation to its Black, Asian and ethnic minority staff. We are below our target in relation to numbers of Black, Asian and ethnic minority staff at 8a but exceeding our targets in bands 8b and above.

We are focused on improving the opportunities for staff from all backgrounds whilst recognising that we have some targeted work to do. In recognition of this, the equality, diversity and inclusion team are currently working with a consultant to understand the capacity and competency requirements to deliver our ambitious plans to be the best place to work where staff can flourish. This is in addition to ongoing work such as working with the Rainbow Badge external Accreditation team to assess how inclusive our patient services are to those identifying as LGBT+.

Governance of the Trust

Role of the Board of Directors

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

The Board of Directors is responsible for:

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

The Board of Directors meets bi-monthly in public, but as a result of the restrictions brought about by the COVID-19 pandemic, in-person meetings were replaced by virtual meetings which members of the public could join via a livestreaming platform. The Board has a formal schedule of matters specifically reserved for its decision, including approving strategy, business plans and budgets, approving high value expenditure and contracts, regulations and control, receiving and interrogating updates on operational and financial performance, quality of care, and people-related matters, annual reporting and monitoring how strategy is being implemented at an operational level. The Board of Directors delegates other matters to its sub-committees and to the Executive Directors and senior management.

Board of Directors' focus

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

Board meetings follow a formal agenda which, with effect from January 2022, is ordered under the five goals that underpin the Trust's Vision:

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

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

The Board of Directors develops its understanding of the views of governors and members/stakeholders through a variety of mechanisms. This includes Executive and Non-Executive Director attendance at meetings of the Council of Governors and its working groups; attendance at joint Board and Council away day events; participation in meetings involving members, such as at the Annual Members' Meeting, at the Members' *Caring for You* events; and Executive Director attendance at Governor Constituency meetings. The COVID-19 pandemic meant that some of these events had to be suspended or held differently, but the Board continued to prioritise engagement with the Council of Governors, with the Chair setting up a regular programme of informal catch-ups with groups of Governors in between the formal Council meetings.

Role of the Chair

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

Role of the Non-Executive Directors

Non-Executive Directors share the corporate responsibility for ensuring that the Trust is run efficiently, economically and effectively. Non-Executive Directors use their expertise and experience to scrutinise the performance of management, monitor the

reporting of performance and satisfy themselves as to the integrity of financial, clinical and other information. The Non-Executive Directors also fulfil their responsibility for determining appropriate levels of remuneration for Executive Directors.

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

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

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

Board of Directors Completeness

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

All of the Non-Executive Directors of the Trust are considered to be independent in accordance with the NHS Foundation Trust Code of Governance as published by NHS Improvement. The Board considers that the Non-Executive Directors bring a wide range of business, commercial, strategic and financial knowledge required for the successful direction of the Trust.

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

Non-Executive Director Appointments

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

No new Non-Executive Directors were appointed during 2021/22, but in February 2022, the Council of Governor's Nominations Committee met to consider proposals to re-appoint Alison Ryan as Chair of the Trust for a second three year term. In considering this proposal, the Committee, which for this item was chaired by Jeremy Boss as Vice-Chair and Senior Independent Director, received details of Ms Ryan's

most recent appraisal, which had been performed by Mr Boss, as well as feedback from the Executive Directors and a majority of the Governors. All of the feedback was positive, and the Committee agreed to recommend to the Council of Governors that Alison Ryan be re-appointed.

At the same meeting, the Committee also received a proposal for the re-appointment of Sumita Hutchison for a second three year term as Non-Executive Director. On the basis of Ms Hutchison's most recent appraisal, the Committee agreed to recommend that she be re-appointed. Both Alison Ryan and Sumita Hutchison were re-appointed by the Council of Governors at their meeting on 10 March 2022.

Board evaluation and development

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

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

Board Committees

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

Management Board

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

clinical posts, service developments and capital projects up to a specified limit. The Management Board has also continued in its role of monitoring progress against the completion of projects of key organisational importance in line with the Improving Together methodology.

Membership of Management Board consists of the Executive Directors, members of the divisional management triumvirates (heads of divisions, divisional directors of operations and heads of nursing/midwifery), and the various corporate leads, including for human resources, IT, estates and communications are required to attend meetings. These meetings are held monthly.

Audit and Risk Committee

The Audit and Risk Committee is chaired by Antony Durbacz. The Committee is responsible for:

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

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

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

The current external auditor, Deloitte, has not provided any non-audit services for the Trust in 2021/22.

Non-Clinical Governance Committee (NCGC)

The Non-Clinical Governance Committee is chaired by Sumita Hutchison. The NCGC focuses primarily on providing assurance to the Board that the Trust has a robust framework for the management of risks arising from or associated with: estates and facilities; capital development, environment and equipment; digital developments; environmental sustainability; health and safety; information governance; business continuity; business development and other non-clinical areas as may be identified. In 2021/22, this Committee has been particularly focused on ensuring that the Trust is well placed to invest in and take advantage of digital developments, the importance of which has been highlighted during the pandemic.

Quality Governance Committee

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

People Committee

The People Committee was established is chaired by Anna Mealings, and its role is to provide assurance to the Board that all people-related risks are being appropriately managed, and that the Trust's employment processes are fit for purpose and legally compliant. In 2021/22 the Committee has maintained its focus on gaining assurance as to the effectiveness of the Trust's staff health and wellbeing provision as the organisation emerges from the pandemic. It is also paying close attention to the development of a restorative just culture and on equality, diversity and inclusion across the Trust.

Finance and Performance Committee

The Finance and Performance Committee is chaired by Jeremy Boss, and its key role is to provide assurance to the Board on the Trust's operational and financial performance. Specifically, it assesses the effectiveness of the Trust's business planning and financial management systems, and the extent to which the organisation is operating in line with its annual business plan objectives. Going forward, one of the committee's key areas of focus will be on the Trust's relationship with its BSW partners, and the changing approaches to commissioning, contracting, joint working and the allocation of resources. The Committee has had a key focus during 2021/22 on the steps that the Trust is taking to address the backlogs in non-elective care that have developed during the pandemic.

Subsidiary Oversight Committee

The Subsidiary Oversight Committee is the newest Board Committee, having been established in June 2021, following the acquisition of Sulis Hospital (then known as Circle Bath Hospital). It is chaired by Nigel Stevens, and its key role is to ensure that the Trust has appropriate oversight of the performance and governance of its subsidiary(ies) – it acts as the main governance link between the Trust as parent and the subsidiaries within the group.

Board of Directors' Nominations and Remuneration Committee

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

The Charities Committee

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

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

The Charitable Fund has a significant and proactive fundraising operation in the form of The Forever Friends Appeal that is primarily, but not totally, focused on principal campaigns agreed with the Charities Committee and the Corporate Trustee.

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

The charity is currently undertaking a major re-branding exercise, the results of which will be presented for approval to this Committee for sign-off as Trustee Representatives.

Commercial Transactions Steering Group

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

The Council of Governors

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

The Council of Governors is made up of 21 governors:

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

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

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

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

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

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

The Working Groups continue to meet regularly to take forward tasks assigned by the Council and provide a full report at each of the Council of Governors meetings.

All Governors are invited to participate in their working groups. Working Group meetings were attended by Executive Directors and Senior Managers to support information sharing and engagement with Governors.

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

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

2021/22 Governor Elections

Governor elections are held every two years out of three. No elections were held during 2021/22.

During 2021/22, two Governor vacancies arose due to resignations. Where a vacancy arises, the Trust's constitution allows us to invite the next highest polling candidate to take the seat. As a result, Peter Buttle took up the North Wiltshire Public Governor seat (taking over from Anna Shantry who resigned in March 2021), and Horace Prickett took up the South Wiltshire seat following Jill Scott's resignation in October 2021. The Governor's terms of appointment can be seen in the table below:

Governors by constituency – 1 April 2020 to 31 March 2021
There are 21 Governor positions in total. As at 31 March 2022, there were 18 Governors in post (10 public, 4 staff and 4 appointed) and 3 vacancies.

Name	Constituency	Term of Appointment
Mike Midgley	City of Bath	01/11/2016 - 31/10/2019 01/11/2019 - 31/10/2022
Nesta Collingridge-Padbury	City of Bath	02/11/2020 - 31/10/2023
Melanie Hilton	North East Somerset	01/11/2019 - 31/10/2022
Suzanne Harris	North East Somerset	02/11/2020 - 31/10/2023
Anne Martin	Somerset (Mendip)	01/11/2016 - 31/10/2019 01/11/2019 - 31/10/2022
John Osman	Somerset (Mendip)	02/11/2020 - 31/10/2023
Peter McCowen (Deputy Lead Governor)	North Wiltshire	02/11/2020 - 31/10/2023
Peter Buttle	North Wiltshire	29/04/2021 - 31/10/2022
Gill Little (Lead Governor)	South Wiltshire	01/11/2019 - 31/10/2022

Jill Scott	South Wiltshire	02/11/2020 - 31/10/2023 (stood down October 2021)
Horace Prickett	South Wiltshire	27/10/2021 – 31/10/2023
Virginia McNab	Rest of England & Wales	02/11/2020 - 31/10/2023 (stood down March 2022)
Narinder Tegally	Staff	01/11/2019 - 31/10/2022
Sarah Bond	Staff	01/11/2019 - 31/10/2022 (stood down January 2022)
Sophie Legg	Staff	01/11/2019 - 31/10/2023
Julie Stone	Staff	02/11/2020 - 31/10/2023
Baz Harding-Clark	Staff	02/11/2020 - 31/10/2023
Cllr Alison Born	BaNES Council	20/05/2021 – 20/05/2024
Cllr Johnny Kidney	Wiltshire Council	01/10/2017 - 30/09/2023
Dr Bryn Bird	BSW CCG	01/04/2020 - 31/03/2023
Dr Catrinel Wright	BSW CCG	20/05/2021 – 20/05/2024
Prof. Dave Clarke	University of the West of England	15/06/2020 – 24/02/2022

Council of Governor Meetings

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

Due to the Covid-19 pandemic, all Council of Governor meetings held during 2020/21 we held virtually using MS Teams and were livestreamed on the Trust's website for public viewing. Among the decisions taken in 2021/22 were the following:

- Approved the proposal to establish a Deputy Lead Governor role.
- Reappointed the Chair, Alison Ryan for a further 3 year term until 31 March 2025.
- Reappointed Sumita Hutchison, Non-Executive Director for a further 3 year term until 31 August 2025.
- Appointed Peter McCowen, Public Governor as Deputy Lead Governor.

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

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

- Email: RUHmembership@nhs.net
- Post: RUH Membership Office (D1) , Royal United Hospitals Bath NHS Foundation Trust,
  Combe Park, Bath, BA1 3NG
- Telephone: 01225 821262

Membership and attendance at Council of Governors meetings 2021/22

The following table sets out Governor Attendance at Council of Governor meetings during the period 1st April 2021 to 31st March 2022. The figure in brackets denotes the number of meetings an individual could be expected to attend by virtue of their membership of the Council. A figure of zero in brackets (0) indicates that the individual was not a member or that their attendance was not mandatory.

Name	Council of Governors Meeting Attendance			
Mike Midgley	2/4		**Non-Executive Directors**	
Nesta Collingridge-Padbury	4/4		Alison Ryan (Chair)	4/4
Melanie Hilton	4/4		Jeremy Boss	3 (0)
Suzanne Harris	3/4		Nigel Stevens	3 (0)
Anne Martin	4/4		Sumita Hutchison	1 (0)
John Osman	3/4		Anna Mealings	1 (0)
Peter McCowen	4/4		Anthony Durbacz	3 (0)
Peter Buttle	3/4		Ian Orpen	4 (0)
Gill Little	4/4			
Jill Scott	2/2		**Executive Directors**	
Horace Prickett	1/2		Cara Charles-Barks	3 (0)
Virginia McNab	3/4		Libby Walters	0 (0)
Narinder Tegally	2/4		Simon Sethi	1 (0)
Sarah Bond	3/3		Joss Foster	1 (0)
Sophie Legg	2/4		Alfredo Thompson	1 (0)
Julie Stone	4/4		Brian Johnson	0 (0)
Baz Harding-Clark	3/4		Bernie Marden	1 (0)
Cllr Alison Born	1/4		Toni Lynch	0 (0)
Cllr Johnny Kidney	2/4			
Dr Bryn Bird	3/4			
Dr Catrinel Wright	1/4			
Prof. Dave Clarke	0/3			

Foundation Trust Membership

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

Public members

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

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

Staff members

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

Developing a representative membership and engagement

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

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

As at 31st March 2022, the Trust had 15,509 members, made up of 11,030 public members (patients, carers and the public) and 4,479 staff members. The Trust has a number of channels for engaging and communicating with its members, including:

- Members' quarterly newsletter and Insight magazine and e-communications

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

Ongoing restrictions relating to the Covid-19 pandemic have meant that the Trust has continued to be limited in the scale and scope of its engagement activities during 2021/22. A number of virtual events were held including an All Constituency Governors and Members' Meeting on 18 May 2021 and an Informal Coffee Morning on 18 August 2021. During these events Members had the opportunity to interact with Governors and were updated on a wide range of RUH activities including the New Hospitals Programme, our Covid-19 Recovery Plan and the success of our Critical Care Follow Up Clinic. In addition, the most recent Annual General Meeting was held virtually on Wednesday 22 September with more than 50 people in attendance. Recruitment of new members has remained constrained due to the continued prevalence of Covid-19, however a small number of members have been recruited by our Governors and via our online application form.

Membership size and movements 2021/22:

Public constituency			**Staff constituency**	
As at 1st April 2021	11,340		As at 1st April 2021	5,007
As at 31st March 2022	11,030		As at 31st March 2022	4,479

Analysis of current membership		
Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	1	159,588
17-21	335	47,441
22+	9,916	615,625
Ethnicity:		
White	9,349	728,501
Mixed	85	9,462
Asian or Asian British	182	11,684
Black or Black British	122	4,764
Other	35	1,865
Socio-economic groupings*:		
AB	3,296	88,240
C1	3,240	104,376
C2	2,217	75,392
DE	2,252	75,794
Gender analysis		
Male	3,724	406,090
Female	7,202	416,561
The analysis section of this report excludes:		
- 778 public members with no dates of birth, 1257 members with no stated ethnicity and 104 members with no gender		
General exclusions: Out of Trust Area, Suspended Members, Inactive Members		

NHS Foundation Trust Code of Governance

The Royal United Hospitals Bath NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code 49 issued in 2012.

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

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

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

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

Ref No	Code Provision	Annual Report and Accounts Section
FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a Chair or Non-Executive Director.	Directors' Report
B.3.1	A Chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the annual report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next annual report.	Directors' Report
B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed Governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Governance of the Trust
FT ARM	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the Directors to attend a Governors' meeting for the purpose of obtaining information about the Foundation Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or Directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act (2012)	This power has not been exercised.
B.6.1	The Board of Directors should state in the annual report how performance evaluation of the Board, its committees, and its Directors, including the chairperson, has been conducted.	Directors' Report
B.6.2	Where there has been external evaluation of the Board and/or governance of the Trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the Trust.	There has been no external evaluation of the Trust

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

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

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

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

The Royal United Hospitals Bath NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

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

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

		incurred in the execution of their functions will be met by the Trust.
A.3.1	The Chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A Chief Executive should not go on to be the Chairperson of the same NHS Foundation Trust.	**Confirmed:** The Trust Chair and Chief Executive are compliant with this provision. The Trust's Chair meets the independence criteria.
A.4.1	In consultation with the Council, the Board should appoint one of the independent Directors to be the Senior Independent Director.	**Confirmed:** The Vice Chair is the Senior Independent Director. The current Vice-Chair and Senior Independent Director, Jeremy Boss, took up office on 1 November 2020.
A.4.2	The Chairperson should hold meetings with the Non-Executive Directors.	**Confirmed:** The Trust Chair holds regular meetings with Non-Executive Directors.
A.4.3	Where Directors have concerns that cannot be resolved about the running of the NHS Foundation Trust or a proposed action, they should ensure that their concerns are recorded in the Board minutes.	**Confirmed:** All discussions at the Board of Directors' meetings are contained in the minutes of each meeting.
A.5.1	The Council of Governors should meet sufficiently regularly to discharge its duties.	**Confirmed:** The Council of Governors meets quarterly which accords with other NHS Foundation Trusts. There is provision to hold additional meetings if required.
A.5.2	The Council of Governors should not be so large as to be unwieldy.	**Confirmed:** The size of the Council of Governors is considered to be appropriate and is regularly reviewed.
A.5.4	The roles and responsibilities of the Council of Governors should be set out in a written document.	**Confirmed:** A document setting out the roles and responsibilities of the Council of Governors is available from the Trust's public website and is also set out in the NHS Foundation Trust's Constitution.
A.5.5	The Chairperson is responsible for leadership of both the Board and the Council but the Governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive to their meetings and inviting attendance by other Executives and Non-Executives, as appropriate.	**Confirmed:** Members of the Board of Directors (both Executive and Non-Executive) are in attendance at Council of Governor meetings. Executive and Non-Executive Directors are invited to Governor Working Group meetings.
A.5.6	The Council should establish a policy for engagement with the Board of	**Confirmed:** The Trust has a Board of Directors' and Council of Governors'

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

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

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

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

	reputation and standing of the NHS Foundation Trust. b) The Board of Directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS Foundation Trust's financial condition; • the performance of its business; and/or the NHS Foundation Trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS Foundation Trust.	
C.3.1	The Board should establish an Audit Committee composed of at least three members who are all independent Non-Executive Directors.	**Confirmed:** The Trust's Audit Committee comprises three independent Non-Executive Directors.
C.3.3	The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors.	**Not applicable:** The external auditors were not re-appointed during 2021/22.
C.3.6	The NHS Foundation Trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS Foundation Trust.	**Confirmed:** The Council of Governors approved the recommendation to appoint Deloitte as the Trust's external auditors for the period from 1 April 2021 to 31 March 2024 at the meeting held in March 2021.
C.3.7	When the Council ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHS Improvement informing it of the reasons behind the decision.	**Confirmed:** The Trust Chair is aware of this requirement.
C.3.8	The Audit Committee should review arrangements that allow staff of the NHS Foundation Trust and other individuals, where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial	**Confirmed:** The Audit Committee receives regular reports from the Trust's Counter Fraud Service. The People Committee provides assurance to the Board of Directors on the Trust's Raising Concerns Policy. Sumita

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

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

NHS System Oversight Framework

NHS England and NHS Improvement's NHS System Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. The framework looks at five national themes:

- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- Finance and use of resources
- People
- Leadership and capability.

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

NHS Improvement had segmented trusts according to the level of support each trust is assessed as requiring across the five themes listed above to enable Trusts to deliver high quality, safe care for patients. Across the 20201/22 financial year (and during the 2020/21 financial year), the Trust was placed in segment 2 under the Single Oversight Framework.

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 Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions, which require the Royal United Hospitals Bath NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Royal United Hospitals Bath NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

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

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply

with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of and other irregularities.

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

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

Cara Charles-Barks,

Chief Executive

21st June 2022

Annual governance statement 2021/22

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Royal United Hospitals Bath NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Royal United Hospitals Bath NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

Operationally, the Royal United Hospitals Bath NHS Foundation Trust uses a web-enabled electronic risk management system (Datix) to record, manage and monitor risks on the Trust-wide Risk Register. Significant risks (significance is based on the rating allocated to each risk) are reviewed monthly by the Management Board, which comprises executive directors, divisional senior management and other senior

corporate leaders. The Management Board takes on oversight of the significant risks until they have been managed to an acceptable level of risk.

The Board of Directors reviews the top operational risks scoring 16 and above on a quarterly basis, alongside the Board Assurance Framework (BAF). The BAF is made up of a relatively small number of high level risks (16 on the current Framework) which could, if not properly managed or mitigated, prevent the Trust from achieving its key objectives. In addition, the monthly operational performance and finance reports that are presented at Board meetings highlight any key areas of risk and the Board of Directors' report template includes a section on risk. The Board of Directors also identifies risks as part of the self-certification documentation submitted to NHS Improvement.

Board Committees

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

<u>Audit and Risk Committee</u>

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

<u>Quality Governance Committee</u>

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

Non-Clinical Governance Committee

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

People Committee

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

Finance and Performance Committee

- Provides assurance that the Trust's financial and operational performance is in line with the Trust's operational targets and business plan objectives
- Scrutinises the effectiveness of the Trust's financial management systems
- Specifically ensures that the Trust is taking the right approach to meeting its NHS Constitutional targets
- Assesses the impact of the COVID-19 pandemic, and extent to which the recovery of elective care delivery is in line with agreed targets
- Reviews allocated risks on the BAF.

Subsidiary Oversight Committee

This is the newest of the Board Committees and was created as a result of the Trust's acquisition of Sulis Hospital Bath and the consequent establishment of Sulis Hospital Bath Ltd as a wholly owned subsidiary of the RUH. The overall role of the SOC is to provide the RUH Board with "line of sight" of Sulis' activities without overriding the independence of the Sulis Board. Specifically, its roles are to:

- Ensure that the aims and objectives of acquiring or setting up a subsidiary unit or organisation are being met

- Ensure that key business plan milestones are being achieved, and that there are robust plans in place to address any divergence from agreed performance levels
- Gain assurance that any quality, financial regulatory or legal risks incurred by the subsidiary are being properly managed.

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

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

Charities Committee

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

Divisional Boards

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

Leadership of the Risk Management Process

As Accounting Officer I have overall responsibility for risk management across all organisational, financial and clinical activities. Other members of the Executive Team exercise lead responsibility for the specific types of risk as follows:

Chief Nurse

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

Director of Finance

- Designated Director with responsibility and accountability for financial risk.

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

Medical Director

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

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

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

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

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

These responsibilities are managed operationally through the Head of Risk and Assurance who has responsibility for ensuring that staff are trained and equipped to manage risk effectively and in accordance with the Strategic Framework for Risk Management. This is achieved through risk training programmes and the provision of practical support to divisional teams.

Staff empowerment and risk management training

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

The Risk and Control Framework

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

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

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

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

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

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

The Trust seeks to ensure that lessons learned from incidents, complaints and other investigations are used to update and improve practice. These issues are regularly communicated to the Quality Board where Trust-wide representatives have the opportunity to discuss themes which may emerge from these investigations and make recommendations for, and implement, policy or procedural change. The Chief Nurse reports key messages emerging from the Quality Board's deliberations to the Quality Governance Committee to ensure Board visibility of these emerging themes and how they are being disseminated across the organisation.

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

The Trust's Internal Auditors conducted a Risk Management and BAF Audit in February 2022. They concluded that the Trust's processes provided "partial assurance with improvements required." The most important recommendation related to the need to ensure that the Strategic Framework for Risk Management which had missed its review date, was updated. This work is underway and the updated Framework will be presented at the June meeting of the Audit Committee. There were also a number of less urgent recommendations relating to the presentation and use of the BAF, and these are being taken into account in the preparation of the 2022/23 document.

Board Assurance Framework

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

The BAF is reviewed on a quarterly basis at private meetings of the Board of Directors, and an update summary is subsequently presented at the next available public meeting. Each BAF risk is assigned to a lead Executive Director and to the relevant Board committee for oversight. The Board Committees review their respective risks at each meeting and their comments are reported to the Board of Directors, with the responsible Executive Director updating the controls and mitigations regularly. The Committees may also increase or decrease the ratings for their risks to reflect the effectiveness of the mitigations and controls, and /or developments in the external environment. The BAF risks are also regularly reviewed at the Board of Directors' Away Days which are held quarterly. The

Framework is fully refreshed at the start of each financial year, with the Board holding a workshop to agree on the key areas of focus.

Risks to data security

The Trust manages its risks to data security through a number of different methods. The Director of Finance acts as senior information risk owner (SIRO). The SIRO chairs an information governance group (IGG) which is responsible for setting the framework for information governance standards in the Trust and ensuring delivery of action plans to improve compliance. The Trust's Caldicott Guardian role is held by the Medical Director who is a member of the Information Governance Group. Their role is to ensure the protection of patient information, and that this is accessed only to the extent that is necessary.

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

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

Description of the principal risks facing the Trust

The Management Board identified the Trust's current top clinical and operational risks at its March 2022 meeting as including:

- **Ambulance handover delays and the impact on patient safety:** Although attendances at ED have levelled off since the peaks in September and October 2021, the number of ambulance handover delays lasting longer than 60 minutes has continued to grow, with the RUH recording 790 such delays in the 30 days leading up to the end of March 2022. Although the immediate COVID-19 pressures in the Emergency Department have eased, continued staffing shortages, the number of beds that remain closed as a result of COVID, and in particular inadequate community provision, are all contributing to poor patient flow through the hospital, with many medically fit patients not being discharged.

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

  A combination of short and longer term actions are being taken to address this problem. In the short term, the Trust is working with its community and

local authority partners to access nursing and care home capacity as well as domiciliary support to enable medically fit patients to be safely discharged, while in the longer term, a number of innovative models, such as direct control of empty nursing homes and involvement in the provision of domiciliary care are being explored and implemented.

- **Recovery of elective performance:** Like a number of other trusts, many of the Trust's patients have experienced significant delays in accessing elective care, such as for hip, knee and other orthopaedic procedures. Although some types of elective activity, such as in outpatients and diagnostics have recovered well following the COVID restrictions, inpatient orthopaedic activity remains low because a key ward is still being used for non-elective work. The continued delays are causing leading to complications and de-conditioning in some patients, adding to their pain and discomfort in many cases, and further complicating the process of activity recovery for the Trust.

  Sulis Hospital will continue to play a key role, both for the RUH and other local providers in recovering the position, especially during the winter months when it becomes more difficult to maintain elective work on the RUH site. Steps are being taken to increase the range of surgical and other work that can be safely done there, and there are plans at an advanced stage to increase operating capacity on that site. In addition, work is ongoing to ensure that the operating capacity within the RUH is utilised as efficiently as possible.

- **Registered Nurse shortages:** In January 2022, the outcome of a 4 month long nursing and midwifery establishment review showed that the Trust is around 200 whole time equivalent nurses and midwives below what it should have to run consistently safe services. In addition, COVID related absences continue to run at over 200 a day. Taken together, this means that many wards and clinical areas are often running either with significant shortages of nurses and other clinical staff, or there is reliance on expensive agency staff who have not worked in the particular area before and may therefore be unable to provide the quality of care that patients need and deserve.

  There is evidence that the constant shortages are having a detrimental impact on the morale and wellbeing of staff, as was revealed through the recently published Staff Survey, and there is a danger of burnout or that some colleagues will leave to go elsewhere, which would have the impact of making the situation worse.

  The actions to be taken to address this risk revolve around the need to increase both recruitment and retention of staff. On recruitment, there is

recognition nationally that currently, not enough nurses and midwives are being trained to meet the needs across the country, and as such, the RUH, similar to many other trusts is investing heavily in attracting good quality and motivated international colleagues, while also working with its local educational partners to attract more and a wider range of people to the clinical professions. In addition, work is being done to make the recruitment and onboarding process as smooth and seamless as possible. On the retention front, the Trust is taking a number of steps to ensure that it remains as attractive as possible to those who have already chosen to work here. This includes creating and maintaining the right kind of work culture, providing a good range and variety of benefits, particularly on the health and wellbeing front, to maintain the Trust as the employer of choice for the vast majority of existing staff.

- **Capital finance** - The capital envelope for the BSW system remains well below the capital priorities across each of the Trusts. Capital has been allocated to each Trust in the system on a risk based approach, but there remains a significant number of urgent risks schemes that cannot proceed due to a lack of funding. A lack of sufficient capital funding presents a risk to the safety of our services as we have to delay the replacement of medical equipment, reduce essential work to the estate and limit investments in our services. These risks are being managed through a risk based prioritisation process but it remains a high risk position to the safe running of our services.

- **2022/23 financial position** – As the additional funding made available to the NHS through the COVID-19 pandemic is scaled back, the Trust is anticipating being in a deficit position in 2022/23. The Trust remains financially sustainable for 2022/23 due to sufficient cash flows to meet expected liabilities during the financial year. This position may becoming more challenging in 2023/24. In response, the Trust is working with its BSW partners to try to ensure that overall services are delivered across the system within the funding available.

These and other key risks will continue to be managed throughout 2022/23.

Governance

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

Communication with stakeholders

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

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

Developing workforce safeguards

The Trust operates an evidence-based approach to the effective and safe deployment of staff to ensure that the right people are in the right place at the right time and with the right skills. It also ensures that in clinical areas sufficient numbers of clinical staff are deployed to ensure that patients receive safe care. This evidence base includes data from benchmarking sources such as the Model Hospital, national guidance from bodies such as NHS England/Improvement and professional regulatory bodies, the professional judgement of senior nurses and medical heads of division as well as the regular reporting and monitoring of outcomes for patients, and the experiences of patients and staff. Regular reports from the Trust's Freedom to Speak Up Guardian also provide insights into issues that may be causing concern among staff.

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

At an operational level there is a daily review of staffing in light of demands due to seasonal changes, acuity and activity. This is a dynamic process and is overseen by senior nursing staff. Where skill mix reviews are conducted they are subject to

quality impact assessments. The Trust has well established governance arrangements for the development and implementation of short, medium and long-term workforce planning and strategies.

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

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

Compliance with the Care Quality Commission

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

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

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

Compliance with NHS pension scheme regulations

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

Compliance with equality, diversity and human rights legislation

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

Compliance with obligations under the Climate Change Act

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

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

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

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

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

Information governance

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

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

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

- Information governance management;
- Confidentiality and Data Protection Assurance;
- Information Security Assurance;
- Clinical Information Assurance;

- Secondary Use Assurance;
- Corporate Information Assurance.

The Trust was able to self-assess itself as Standards Met on the most recent Data Security and Protection Toolkit (DSPT) submission made in June 2021. That notwithstanding a number of improvement plans have been put in place in relation to some aspects of the DSPT, notably in relation to Information Governance training, where compliance has not always reached the required level across the organisation.

Between 1 April 2021 and 31 March 2022, the Trust has not had occasion to report any potentially serious information governance incidents to the Information Commissioner's Office (ICO).

Annual Quality Report

The *NHS Foundation Trust Annual Reporting Manual* for 2021/22 indicated that the preparation of a quality report is now no longer required so one has not been prepared.

Quality Governance Arrangements

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

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

The Trust's participation in national and regional patient safety initiatives sets the tone for the rest of the organisation and demonstrates that quality improvement is a top priority. The Trust hosts and has a close working relationship with the West of England Academic Health Science Network. The Trust is also a member of

NHS Quest, a member network for NHS Foundation Trusts who wish to focus on improving quality and safety.

It is the role of the Quality and Non-Clinical Governance Committees to “test” the Trust’s systems and processes in order to assure the Board of Directors that there are robust systems in place for monitoring quality and safety and ensuring that there are appropriate controls in place to ensure the accuracy of data.

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

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

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

Capabilities and culture

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

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

Systems and processes

Patients' experience of using the Trust's services is reviewed by the Board of Directors in a number of different ways:

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

Data monitoring and reporting on quality

- The Trust reviews the implementation status of all National Institute for Clinical Excellence guidance and Central Alerting System guidance to risk-assess any development areas for the Trust and to take action to implement recommendations.
- The Board of Directors receives an annual mortality review report which compares the Trust's hospital standardised mortality rate (HSMR) with other comparable Trusts. The Trust uses clinical outcome data to assess and improve services with participation in national audits as well as undertaking local audits.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the Executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board of Directors, Audit and Risk Committee, Quality Governance Committee, Non-Clinical Governance Committee and the Management Board. When issues are identified, plans are put in

place to address any weaknesses and ensure that any learning is embedded in the organisation. This ensures that the system is subject to continuous improvement.

The Trust's Assurance Framework provides me with evidence of the effectiveness of controls that manage the risks to the organisation achieving its strategic objectives, have been reviewed and are being actively managed. Internal Audit provides me with an opinion about the effectiveness of the assurance framework and the internal controls reviewed as part of the Internal Audit plan. Work undertaken by Internal Audit is reviewed by the Assurance Committees (Audit and Risk, Non-Clinical and Clinical Governance, People and Finance and Performance Committees). The Assurance Framework and the top risks on the Risk Register are reviewed by the Board of Directors four times a year. The Board of Directors reviews the full Risk Register annually. This provides me and the Board of Directors with evidence of the effectiveness of controls in place to manage risks to achieving the Trust's principal priorities.

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

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

The Audit and Risk Committee agrees an annual risk based internal audit plan and receives reports on the outcomes of the reviews of the system of internal control during the course of the financial year.

KPMG (appointed in October 2021) are the providers of internal audit for the Trust, and in 2021/22, they completed 3 internal audit reports (this low number due to them taking over mid-year). The areas the reports covered included:

- Financial controls
- Board Assurance Framework and Risk Management
- Business Continuity Planning

The Head of Internal Audit's opinion for the period based 1 April 2021 to 31 March 2022 is one of significant assurance with some improvements required.

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

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

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

Conclusion

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

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

Annual Governance Statement signed

Cara Charles-Barks, Chief Executive (Accounting Officer), 21st June 2022

Accountability report signed

Cara Charles-Barks, Chief Executive (Accounting Officer), 21st June 2022

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

Report on the audit of the financial statements

Opinion

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

- give a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2022 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 policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the group income statement;
- the group statement of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of changes in taxpayers' equity;
- the group and foundation trust statements of cash flows; and
- the related notes 1 to 42.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice 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 accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

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

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

We have nothing to report in this regard.

Responsibilities of accounting officer

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

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

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

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

- determination of whether an expenditure is capital in nature and was resignised in the correct finncial period: we tested the expenditure on a sample basis to assess whether they meet the relevant accounting requirements to be recognised as capital in nature; we agreed a sample of year-end capital accruals to supporting documentation and assessed whether the capitalised expenditure is recognised in the correcting accounting period.
- accruals recorded at 31 March 2022 and the timing of their recognition at year-end is subject to potential management bias: we tested a sample of accruals to supporting documentation to assess whether the liability had been incurred as at 31 March 2022.

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

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

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;

- enquiring of management, internal audit and in-house legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance, and reviewing internal audit reports, and reviewing correspondence with CQC.

Report on other legal and regulatory requirements

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

In our opinion:

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

Matters on which we are required to report by exception

Use of resources

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

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

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

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

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the guidance, published by the Comptroller & Auditor General in December 2021, 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 2022 by the time of the issue of our audit report. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed [our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the Matters on which we are required to report by exception – Use of resources section of our report) and the work necessary to issue our statement on consolidation schedules. We are satisfied that our remaining work in these areas is unlikely to have a material impact on the financial statements or on our value for money conclusion.

Use of our report

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

Michelle Hopton (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Bristol, United Kingdom
21 June 2022

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

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements
In our audit report for the year ended 31 March 2022 issued on 21 June 2022 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2022 and of the group's and foundation trust's income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

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

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

As at the date of issue of our audit report for the year ended 31 March 2022 on 21 June 2022, we had not completed our work on the foundation trust's arrangements, and had nothing to report in respect of this matter as at that date.

Certificate of completion of the audit
In our audit report for the year ended 31 March 2022 issued on 21 June 2022, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources and the work necessary to issue our statement on consolidation schedules. We have now completed our work in these areas.

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

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

We certify that we have completed the audit of Royal United Hospitals Bath NHS Foundation Trust in accordance with requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Michelle Hopton (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Bristol, United Kingdom
24 August 2022

Royal United Hospitals Bath NHS Foundation Trust

Annual accounts for the year ended 31 March 2022

Foreword to the accounts

Royal United Hospitals Bath NHS Foundation Trust

These accounts, for the year ended 31 March 2022, 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 21 June 2022

Consolidated Statement of Comprehensive Income

For the year ended 31 March 2022

		Group	
		2021/22	2020/21
	Note	£000	£000
Operating income from patient care activities	3	436,373	362,848
Other operating income	4	46,996	53,194
Operating expenses	6, 8	(475,651)	(409,108)
Operating surplus from continuing operations		**7,718**	**6,934**
Finance income	11	183	183
Finance expenses	12	(201)	(229)
PDC dividends payable		(6,769)	(5,584)
Net finance costs		**(6,787)**	**(5,630)**
Other losses	13	(118)	(33)
Surplus for the year from continuing operations		**813**	**1,271**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments Reversals/ (Charge)	7	836	(2,126)
Revaluations	20	2,882	384
Share of comprehensive income from associates and joint ventures	22	56	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains on financial assets mandated at fair value through OCI	23	723	1,249
Total comprehensive income for the period		**5,310**	**778**

Statements of Financial Position

As at 31 March 2022

	Note	Group 31 March 2022 £000	Group 31 March 2021 £000	Trust 31 March 2022 £000	Trust 31 March 2021 £000
Non-current assets					
Intangible assets	15	8,586	8,665	7,612	8,665
Property, plant and equipment	18	247,728	225,664	246,129	225,664
Investments in associates and joint ventures	22	56	-	-	-
Investments / financial assets	23	10,157	9,324	3,241	-
Receivables	27	2,627	2,701	2,762	2,301
Total non-current assets		**269,154**	**246,354**	**259,744**	**236,630**
Current assets					
Inventories	26	5,791	4,236	4,581	4,236
Receivables	27	12,387	18,748	9,028	17,519
Cash and cash equivalents	28	53,151	30,297	48,542	28,275
Total current assets		**71,329**	**53,281**	**62,151**	**50,030**
Current liabilities					
Trade and other payables	29	(55,816)	(41,134)	(52,509)	(40,824)
Borrowings	32	(905)	(3,504)	(846)	(3,504)
Provisions	34	(170)	(185)	(170)	(185)
Other liabilities	31	(6,717)	(5,056)	(5,221)	(5,056)
Total current liabilities		**(63,608)**	**(49,879)**	**(58,746)**	**(49,569)**
Total assets less current liabilities		**276,875**	**249,756**	**263,149**	**237,091**
Non-current liabilities					
Borrowings	32	(7,008)	(7,469)	(6,661)	(7,469)
Provisions	34	(1,856)	(1,618)	(1,857)	(1,618)
Total non-current liabilities		**(8,864)**	**(9,087)**	**(8,518)**	**(9,087)**
Total assets employed		**268,011**	**240,669**	**254,631**	**228,004**
Financed by					
Public dividend capital		207,344	184,435	207,344	184,435
Revaluation reserve		39,906	37,350	39,906	37,350
Income and expenditure reserve		7,125	6,219	7,381	6,219
Charitable fund reserves	25	13,636	12,665	-	
Total taxpayers' equity		**268,011**	**240,669**	**254,631**	**228,004**

The notes on pages 145 to 199 form part of these accounts.

Signed ……

Name Cara Charles-Barks
Job title Chief Executive
Date 21 June 2022

Statements of Cash Flows

For the Year ended 31 March 2022

	Note	Group 2021/22 £000	Group 2020/21 £000	Trust 2021/22 £000	Trust 2020/21 £000
Cash flows from operating activities					
Operating surplus		7,718	6,934	7,042	6,555
Non-cash income and expense:					
Depreciation and amortisation	6.1	15,086	13,429	14,775	13,429
Net impairments	7	1,162	(397)	1,162	(397)
Income recognised in respect of capital donations	4	(600)	(682)	(1,340)	(833)
Decrease in receivables and other assets		7,171	3,965	8,100	3,916
(Increase) / decrease in inventories		(1,555)	13	(345)	13
Increase in payables and other liabilities		15,723	5,217	14,565	5,217
Increase in provisions		223	498	224	498
Movements in charitable fund working capital		97	(457)	-	-
Other movements in operating cash flows		(63)	(77)	-	-
Net cash flows from operating activities		**44,962**	**28,443**	**44,183**	**28,398**
Cash flows from investing activities					
Interest received		27	5	27	5
Purchase and sale of financial assets / investments		-	-	(3,651)	
Purchase of intangible assets		(2,076)	(1,548)	(1,131)	(1,548)
Sales of intangible assets		750	-	750	-
Purchase of PPE and investment property		(33,492)	(26,889)	(33,177)	(26,889)
Sales of PPE and investment property		3	2	3	2
Receipt of cash donations to purchase assets		829	401	853	424
Cash from acquisitions / disposals of subsidiaries		(789)	-	-	-
Net cash flows used in investing activities		**(34,748)**	**(28,029)**	**(36,326)**	**(28,006)**
Cash flows from financing activities					
Public dividend capital received		22,909	23,223	22,909	23,223
Payment on loans from DHSC		(2,967)	(2,958)	(2,697)	(2,958)
Capital element of finance lease rental payments		(456)	(483)	(821)	(483)
Interest on loans		(168)	(208)	(157)	(208)
Other interest		-	(1)	-	(1)
Interest paid on finance lease liabilities		(44)	(31)	(25)	(31)
PDC dividend paid		(6,799)	(5,171)	(6,799)	(5,171)
Cash flows from (used in) other financing activities		165	-	-	-
Net cash flows from financing activities		**12,640**	**14,371**	**12,410**	**14,371**
Increase in cash and cash equivalents		**22,854**	**14,785**	**20,267**	**14,763**
Cash and cash equivalents at 1 April - brought forward		**30,297**	**15,512**	**28,275**	**13,512**
Cash and cash equivalents at 31 March	28	**53,151**	**30,297**	**48,542**	**28,275**

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

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 2021 - brought forward		**184,435**	**37,350**	**6,219**	**11,788**	**239,792**
Surplus for the year		-	-	(1,051)	1,864	**813**
Impairments	7	-	836	-	-	**836**
Revaluations	20	-	2,882	-	-	**2,882**
Share of comprehensive income from associates and joint ventures		-	-	56	-	**56**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	23	-	-	-	723	**723**
Public dividend capital received	cashflow	22,909	-	-	-	**22,909**
Other reserve movements		-	(1,162)	1,901	(739)	**-**
Taxpayers' and others' equity at 31 March 2022		**207,344**	**39,906**	**7,125**	**13,636**	**268,011**

Consolidated Statement of Changes in Equity for the year ended 31 March 2021

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 2020 - brought forward		**161,212**	**40,350**	**4,247**	**10,843**	**216,652**
Adjustment for Charity investments following 2019/20 audit		-	-	-	16	16
Taxpayers' and others' equity at 1 April 2020 - restated		**161,212**	**40,350**	**4,247**	**10,859**	**216,668**
Surplus for the year		-	-	539	732	**1,271**
Other transfers between reserves		-	(1,258)	1,258	-	**-**
Impairments	7	-	(2,126)	-	-	**(2,126)**
Revaluations	20	-	384	-	-	**384**
Fair value gains on financial assets mandated at fair value through OCI	23	-	-	-	1,249	**1,249**
Public dividend capital received	Cashflow	23,223	-	-	-	**23,223**
Other reserve movements		-	-	175	(175)	**-**
Taxpayers' and others' equity at 31 March 2021		**184,435**	**37,350**	**6,219**	**12,665**	**240,669**

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

Trust	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward		**184,435**	**37,350**	**6,219**	**228,004**
Surplus/(deficit) for the year		-	-	-	**-**
Impairments	7	-	836	-	**836**
Revaluations	20	-	2,882	-	**2,882**
Public dividend capital received	Cashflow	22,909	-	-	**22,909**
Other reserve movements		-	(1,162)	1,162	**-**
Taxpayers' and others' equity at 31 March 2022		**207,344**	**39,906**	**7,381**	**254,631**

Statement of Changes in Equity for the year ended 31 March 2021

Trust	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward		**161,212**	**40,350**	**4,247**	**205,809**
Surplus/(deficit) for the year		-	-	539	**539**
Other transfers between reserves		-	(1,258)	1,258	**-**
Impairments	7	-	(2,126)	-	**(2,126)**
Revaluations	20	-	384	-	**384**
Public dividend capital received	Cashflow	23,223	-	-	**23,223**
Other reserve movements		-	-	175	**175**
Taxpayers' and others' equity at 31 March 2021		**184,435**	**37,350**	**6,219**	**228,004**

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 25.

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, and certain financial assets.

Note 1.2 Going concern
These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Consolidation

NHS Charitable Funds
The Trust is the corporate trustee to 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
Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

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

Where subsidiaries' accounting policies are not aligned with those of the Trust, then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

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

The LLP has a separate Board but strategic control of the organisation remains with the partners as detailed in the Members Agreement signed by the three NHS Foundation Trusts.

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

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The timing of satisfaction of performance obligations relates to the typical timing of payment (i.e. credit terms).

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a Sustainability and Transformation Partnership level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

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.

Note 1.5 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from Commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Note 1.8 Property, plant and equipment continued
Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	5	62
Dwellings	41	46
Plant & machinery	2	25
Transport equipment	5	5
Information technology	2	7
Furniture & fittings	2	15

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

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

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

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

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits. Except for Goodwill which is subject to an annual impairment review.

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	5
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.

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.12 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.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

The Trust has irrevocably elected to measure the following equity instruments at fair value through other comprehensive income. All gains and losses arising from investment funds held by The Royal United Charitable Fund will be measured at fair value through Other Comprehensive Income. The investment fund does not meet the criteria set out in the accounting standards to be recognised as a gain or loss through income and expenditure.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are determined by reference to past experience within separate categories of debt, including NHS debt. Judgement is also applied, where the expectation of future credit losses is anticipated to impact upon the recoverable amount of the asset. The age of a receivable is taken into account and the more overdue a receivable becomes, the higher the value of expected credit loss.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

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.

The Trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.14 Leases continued

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor

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

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the 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 2022:

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

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2022:

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

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 33 but is not recognised in the Trust’s accounts.

Note 1.15 Provisions continued

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 34 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 33, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation Tax
Under current legislation, Foundation Trusts are not liable for corporation tax.

The Trust's subsidiary company files a separate tax return to the Trust. The subsidiary is not expected to pay any corporation tax in the this financial period due to accumulated tax losses.

Deferred taxes are provided for on temporary differences and carryforwards. This is in line with the expected corporation tax rate increase, and the deferred tax assets not expected to be realised before this time. The rate change may affect future tax charges. In addition the utilisation of any tax losses and temporary differences for which no deferred tax asset has been recognised may also affect future tax charges. Deferred taxes at the balance sheet date have been measured using these enacted tax rates and reflected in these financial statements.

Note 1.20 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 1.21 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the 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 1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an 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 1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	29,257
Additional lease obligations recognised for existing operating leases	(29,257)
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(4,795)
Additional finance costs on lease liabilities	(294)
Lease rentals no longer charged to operating expenditure	4,823
Estimated impact on surplus / deficit in 2022/23	**(266)**
Estimated increase in capital additions for new leases commencing in 2022/23	**6,236**

Other standards, amendments and interpretations

IFRS 14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016 and is not applicable to DHSC group bodies.

IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

Note 1.27 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised.

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements

Valuation basis

Department of Health and Social Care guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets. The current site in determining the MEA, the Trust has to make assumptions that are practically achievable, however the Trust is not required to have any plans to make such changes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Trust, and would not impact on service delivery or the level and volume of service provided. This is because the catchment area for patients using the services, and transport infrastructure has been taken into account when deciding on an appropriate alternative site.

For the purpose of the MEA valuation, the Trust has assumed that the modern equivalent asset for Royal United Hospital would be a multi storey building, which would occupy less land. For the purpose of the MEA valuation, the Trust has not included unused space, unused land, underutilised space and any space not used for healthcare purposes or required to directly support the delivery of healthcare, in the calculation of modern equivalent asset.

Note 1.28 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:
Property Valuations

Land and buildings are included in the Trust's statement of financial position at current value in existing use. The assessment of current value represents a key source of uncertainty. The Trust uses an external professional valuer to determine current value in existing use, using modern equivalent asset value methodology.

Property, plant and equipment were valued using an index from Gerald Eve as at 31 March 2022. These valuations are based on the Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health. Property valuation techniques include an inherent element of estimation; in particular specialised assets that have no active market require valuation based on assessing the likely replacement cost of an asset. Future property values will be influenced by factors such as construction costs and developments in healthcare technology and any recognised impairments. Future asset values will inevitably fluctuate but the Trust mitigates against material correcting adjustments by commissioning regular professional asset valuation reviews.

Depreciation and Amortisation

Depreciation of property, plant and equipment and amortisation of computer software tThe Trust exercises judgement to determine the useful lives and residual values of property, plant and equipment and computer software. Depreciation and amortisation is provided so as to write down the value of these assets to their residual value over their estimated useful lives.

Useful economic life

The useful economic life of each category of fixed asset is assessed when acquired by the Foundation Trust. A degree of estimation is occasionally used in assessing the useful economic lives of assets.

Note 2 Operating Segments

The Trust Board is the Chief Operating Decision Maker and considers the Trust's healthcare services, along with all the operating segments due to them having similar economic characteristics.

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

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

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

On 1st June 2021 the Royal United Hospitals Bath NHS FT acquired Sulis Hospital Bath Ltd. Sulis Hospital is a Private Limited Company. The financial performance of Sulis is consolidated and reported to the Board monthly. The financial position of Sulis has been shown in the segmental analysis below.

No comparative information has been given for 2020/21 as the Charity was not considered material to the Trust accounts (other than the investments which are disclosed in Note 20. The reported position for the Charity in 2020/21 is not materially different to the values disclosed for this year.

Income and Expenditure analysis by Segment

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

Note 2 Operating Segments continued

Balance Sheet analysis by Segment

2021/22

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

Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2021/22	2020/21
	£000	£000
Block contract / system envelope income	342,666	332,434
High cost drugs income from commissioners (excluding pass-through costs)	1,382	3,218
Other NHS clinical income	24,944	2,459
Income from other sources (e.g. local authorities)	1,350	-
Private patient income	12,678	585
Elective recovery fund	8,035	-
Additional pension contribution central funding*	11,253	10,351
Other clinical income**	34,065	13,801
Total income from activities	**436,373**	**362,848**

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.
** Other clinical income includes includes income for the mass vaccination programme, critical care funding and system support funding

Note 3.2 Income from patient care activities (by source)

	2021/22	2020/21
Income from patient care activities received from:	**£000**	**£000**
NHS England	81,517	80,017
Clinical commissioning groups	334,323	276,913
Other NHS providers	1,948	309
NHS other	640	816
Local authorities	1,349	1,208
Non-NHS: private patients	12,678	585
Non-NHS: overseas patients (chargeable to patient)	166	131
Injury cost recovery scheme	44	650
Non NHS: other	3,708	2,219
Total income from activities	**436,373**	**362,848**
Of which:		
Related to continuing operations	436,373	362,848
Related to discontinued operations	-	-

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

	2021/22	2020/21
	£000	£000
Income recognised this year	166	131
Cash payments received in-year	101	98
Amounts added to provision for impairment of receivables	111	48
Amounts written off in-year	7	-

Note 4 Other operating income (Group)

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	4,128	-	**4,128**	3,503	-	**3,503**
Education and training	14,487	622	**15,109**	13,057	558	**13,615**
Non-patient care services to other bodies	8,671	-	**8,671**	7,442	-	**7,442**
Reimbursement and top up funding	7,578	-	**7,578**	16,219	-	**16,219**
Income in respect of employee benefits accounted on a gross basis	2,646	-	**2,646**	1,795	-	**1,795**
Receipt of capital grants and donations	-	600	**600**	-	682	**682**
Charitable and other contributions to expenditure	-	1,677	**1,677**	-	6,245	**6,245**
Rental revenue from operating leases	-	298	**298**	-	281	**281**
Charitable fund incoming resources	-	2,926	**2,926**	-	1,749	**1,749**
Other income	3,363	-	**3,363**	1,733	(70)	**1,663**
Total other operating income	**40,873**	**6,123**	**46,996**	**43,749**	**9,445**	**53,194**
Of which:						
Related to continuing operations			46,996			53,194
Related to discontinued operations			-			-

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2021/22	2020/21
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	422	1,625

Note 5.2 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2021/22	2020/21
	£000	£000
Income from services designated as commissioner requested services	436,373	362,848
Income from services not designated as commissioner requested services	46,996	53,194
Total	**483,369**	**416,042**

Note 5.3 Fees and charges (Group)

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2021/22	2020/21
	£000	£000
Income	2,117	1,258
Full cost	(1,766)	(1,576)
Surplus / (deficit)	**351**	**(318)**

Fees and charges relate to car parking and retail catering.

Note 6.1 Operating expenses (Group)

	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	104	-
Purchase of healthcare from non-NHS and non-DHSC bodies	3,044	1,625
Staff and executive directors costs	300,396	264,581
Remuneration of non-executive directors	167	153
Supplies and services - clinical (excluding drugs costs)	43,531	39,333
Supplies and services - general	4,376	3,265
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	51,531	44,394
Inventories written down	-	106
Consultancy costs	236	379
Establishment	5,655	3,200
Premises	19,090	14,891
Transport (including patient travel)	862	826
Depreciation on property, plant and equipment	13,041	11,241
Amortisation on intangible assets	2,045	2,188
Net impairments	1,162	(397)
Movement in credit loss allowance: contract receivables / contract assets	311	873
Increase/(decrease) in other provisions	(637)	1,157
Fees payable to the external auditor		
audit services- statutory audit	135	78
Internal audit costs	59	60
Clinical negligence	14,002	12,801
Legal fees	775	297
Insurance	538	533
Research and development	4,033	2,956
Education and training	4,658	3,208
Rentals under operating leases	4,125	720
Hospitality	36	15
Losses, ex gratia & special payments	18	8
Other NHS charitable fund resources expended	546	663
Other	1,748	(46)
Total	**475,651**	**409,108**
Of which:		
Related to continuing operations	475,651	409,108
Related to discontinued operations	-	-

Note 6.2 Other auditor remuneration (Group)

	2021/22	2020/21
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	64	-
Total	**64**	**-**

Note 6.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1 million (2020/21: £1 million).

Note 7 Impairment of assets (Group)

	2021/22	2020/21
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	410	-
Abandonment of assets in course of construction	4,947	-
Changes in market price	(4,195)	(397)
Total net impairments charged to operating surplus / deficit	**1,162**	**(397)**
Impairments charged to the revaluation reserve	(836)	2,126
Total net impairments	**326**	**1,729**

Note 8 Employee benefits (Group)

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	232,764	207,188
Social security costs	22,470	19,813
Apprenticeship levy	1,269	977
Employer's contributions to NHS pensions	36,994	34,087
Pension cost - other	192	-
Temporary staff (including agency)	11,888	7,070
NHS charitable funds staff	663	527
Total gross staff costs	**306,240**	**269,662**
Total staff costs	**306,240**	**269,662**
Of which		
Costs capitalised as part of assets	1,892	1,526

Reconciliation of staff costs to the expenditure note

	£000s	£000s
Total staff costs in expenditure note 6.1	300,396	264,581
Add capital staff costs	1,892	1,526
Add research and development staff costs	2,875	2,538
Add education and staff costs	1,077	1,017
Total staff costs note 8	**306,240**	**269,662**

Note 8.1 Retirements due to ill-health (Group)

During 2021/22 there were no early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is 0k (£180k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

Note 10 Operating leases (Group)

Note 10.1 Royal United Hospitals Bath NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Royal United Hospitals Bath NHS Foundation Trust is the lessor.

	2021/22	2020/21
	£000	£000
Operating lease revenue		
Minimum lease receipts	298	281
Total	**298**	**281**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	298	281
Total	**298**	**281**

Note 10.2 Royal United Hospitals Bath NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Royal United Hospitals Bath NHS Foundation Trust is the lessee.

	2021/22	2020/21
	£000	£000
Operating lease expense		
Minimum lease payments	4,125	720
Total	**4,125**	**720**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease payments due:		
- not later than one year;	4,057	720
- later than one year and not later than five years;	10,301	2,880
- later than five years.	4,918	-
Total	**19,276**	**3,600**
Future minimum sublease payments to be received	-	-

Note 11 Finance income (Group)

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

	2021/22	2020/21
	£000	£000
Interest on bank accounts	22	5
Interest income on finance leases	5	-
NHS charitable fund investment income	156	178
Total finance income	**183**	**183**

Note 12.1 Finance expenditure (Group)

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

	2021/22	2020/21
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	157	197
Finance leases	44	31
Interest on late payment of commercial debt	-	1
Total finance costs	**201**	**229**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

	2021/22	2020/21
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	1

Note 13 Other gains / (losses) (Group)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	3	2
Losses on disposal of assets	(121)	(35)
Total gains / (losses) on disposal of assets	**(118)**	**(33)**
Total other gains / (losses)	**(118)**	**(33)**

Note 14 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 £0.0m (2020/21 £0.7m). The Trust's total comprehensive income/(expense) for the period was £3.7m, the Trust also received PDC funding of £22.9m (2020/21 -£1.5 m and £23.2m PDC funding).

Note 15.1 Intangible assets - 2021/22

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

Note 15.2 Intangible assets - 2020/21

Group	Software licences	Licences & trademarks	Goodwill	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**1,757**	**13,403**	**-**	**1,281**	**16,441**
Additions	-	934	-	472	**1,406**
Disposals / derecognition	-	(17)	-	-	**(17)**
Valuation / gross cost at 31 March 2021	**1,757**	**14,320**	**-**	**1,753**	**17,830**
Amortisation at 1 April 2020 - as previously stated	**1,540**	**5,454**	**-**	**-**	**6,994**
Provided during the year	94	2,094	-	-	**2,188**
Disposals / derecognition	-	(17)	-	-	**(17)**
Amortisation at 31 March 2021	**1,634**	**7,531**	**-**	**-**	**9,165**
Net book value at 31 March 2021	**123**	**6,789**	**-**	**1,753**	**8,665**
Net book value at 1 April 2020	**217**	**7,949**	**-**	**1,281**	**9,447**

Note 15.3 Intangible assets - 2021/22

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

Note 15.4 Intangible assets - 2020/21

Trust	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**1,757**	**13,403**	**1,281**	**16,441**
Additions	-	934	472	**1,406**
Disposals / derecognition	-	(17)	-	**(17)**
Valuation / gross cost at 31 March 2021	**1,757**	**14,320**	**1,753**	**17,830**
Amortisation at 1 April 2020 - as previously stated	**1,540**	**5,454**	**-**	**6,994**
Provided during the year	94	2,094	-	**2,188**
Disposals / derecognition	-	(17)	-	**(17)**
Amortisation at 31 March 2021	**1,634**	**7,531**	**-**	**9,165**
Net book value at 31 March 2021	**123**	**6,789**	**1,753**	**8,665**
Net book value at 1 April 2020	**217**	**7,949**	**1,281**	**9,447**

Note 16 Business Combinations/Acquisition of Subsidiary

The Trust acquired all the issued share capital of Circle Hospital Bath Limited (subsequently renamed Sulis Hospital Bath Ltd.) on 1 June 2021. Accordingly, the company became a wholly owned subsidiary of the Trust. This requires the Trust to measure the goodwill arising on the acquisition of Sulis in accordance with IFRS 3. Goodwill is the amount by which the consideration paid by the Trust for Sulis exceeds the fair value of the net assets acquired as recognised and measured under IFRS 3. Goodwill has been represented as an intangible asset on the Trust's group balance sheet. The Trust's measurement of the goodwill intangible asset arising on the acquisition of Sulis is:

	£'000
Fair Value of consideration transferred to the seller	1,852
Less: Net Assets acquired on Acquisition	(468)
Excess of consideration over net assets acquired	**1,384**

Sulis loss incurred post accquisition	
Revenue in period	24,624
Expense in period	(24,916)
Loss	**(292)**

Note 17 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. This is the expected future cash flows that the asset in its current condition will produce, discounted to present value using an appropriate discount.

The Trust considers that the FVLCD will always be lower than both the carrying value of the goodwill and the value in use for the Trust. The value in use to the Trust is broader than simply the cashflows of the business as it will also reflect the extent to which the Trust can deploy the service potential of the business.

The Trust believes that there is are clear indicators that the goodwill has been impaired, following post-acquisition analysis of the business, as set out below.

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

Note 18.1 Property, plant and equipment - 2021/22

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

Note 18.2 Property, plant and equipment - 2020/21

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**10,008**	**153,068**	**4,095**	**7,788**	**57,573**	**34**	**11,761**	**1,625**	**245,952**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2020 - restated	**10,008**	**153,068**	**4,095**	**7,788**	**57,573**	**34**	**11,761**	**1,625**	**245,952**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	8,293	12	11,671	7,990	-	3,795	327	**32,088**
Impairments	-	(4,185)	(2)	-	-	-	-	-	**(4,187)**
Reversals of impairments	1,034	1,424	-	-	-	-	-	-	**2,458**
Revaluations	-	(4,133)	(105)	-	-	-	-	-	**(4,238)**
Reclassifications	-	2,629	-	(2,629)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(869)	-	(239)	(22)	**(1,130)**
Valuation/gross cost at 31 March 2021	**11,042**	**157,096**	**4,000**	**16,830**	**64,694**	**34**	**15,317**	**1,930**	**270,943**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**385**	**-**	**-**	**30,528**	**34**	**8,221**	**573**	**39,741**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2020 - restated	**-**	**385**	**-**	**-**	**30,528**	**34**	**8,221**	**573**	**39,741**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	4,578	125	-	4,898	-	1,423	217	**11,241**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(4,497)	(125)	-	-	-	-	-	**(4,622)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(822)	-	(237)	(22)	**(1,081)**
Accumulated depreciation at 31 March 2021	**-**	**466**	**-**	**-**	**34,604**	**34**	**9,407**	**768**	**45,279**
Net book value at 31 March 2021	**11,042**	**156,630**	**4,000**	**16,830**	**30,090**	**-**	**5,910**	**1,162**	**225,664**
Net book value at 1 April 2020	**10,008**	**152,683**	**4,095**	**7,788**	**27,045**	**-**	**3,540**	**1,052**	**206,211**

Note 18.3 Property, plant and equipment financing - 2021/22

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022								
Owned - purchased	12,499	160,547	4,167	26,765	24,660	5,830	1,039	**235,507**
Finance leased	-	-	-	-	1,705	-	-	**1,705**
Owned - donated/granted	-	6,425	-	1,622	2,423	4	42	**10,516**
NBV total at 31 March 2022	**12,499**	**166,972**	**4,167**	**28,387**	**28,788**	**5,834**	**1,081**	**247,728**

Note 18.4 Property, plant and equipment financing - 2020/21

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	11,042	151,113	4,000	15,228	25,217	5,905	1,118	**213,623**
Finance leased	-	-	-	-	2,198	-	-	**2,198**
Owned - donated/granted	-	5,517	-	1,602	2,675	5	44	**9,843**
NBV total at 31 March 2021	**11,042**	**156,630**	**4,000**	**16,830**	**30,090**	**5,910**	**1,162**	**225,664**

Note 18.5 Property, plant and equipment - 2021/22

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

Note 18.6 Property, plant and equipment - 2020/21

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**10,008**	**153,068**	**4,095**	**7,788**	**57,573**	**34**	**11,761**	**1,625**	**245,952**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2020 - restated	**10,008**	**153,068**	**4,095**	**7,788**	**57,573**	**34**	**11,761**	**1,625**	**245,952**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	8,293	12	11,671	7,990	-	3,795	327	32,088
Impairments	-	(4,185)	(2)	-	-	-	-	-	(4,187)
Reversals of impairments	1,034	1,424	-	-	-	-	-	-	2,458
Revaluations	-	(4,133)	(105)	-	-	-	-	-	(4,238)
Reclassifications	-	2,629	-	(2,629)	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(869)	-	(239)	(22)	(1,130)
Valuation/gross cost at 31 March 2021	**11,042**	**157,096**	**4,000**	**16,830**	**64,694**	**34**	**15,317**	**1,930**	**270,943**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**385**	**-**	**-**	**30,528**	**34**	**8,221**	**573**	**39,741**
Prior period adjustments	-	-	-	-	-	-	-	-	-
restated	**-**	**385**	**-**	**-**	**30,528**	**34**	**8,221**	**573**	**39,741**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	4,578	125	-	4,898	-	1,423	217	11,241
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	(4,497)	(125)	-	-	-	-	-	(4,622)
Disposals / derecognition	-	-	-	-	(822)	-	(237)	(22)	(1,081)
Accumulated depreciation at 31 March 2021	**-**	**466**	**-**	**-**	**34,604**	**34**	**9,407**	**768**	**45,279**
Net book value at 31 March 2021	**11,042**	**156,630**	**4,000**	**16,830**	**30,090**	**-**	**5,910**	**1,162**	**225,664**
Net book value at 1 April 2020	**10,008**	**152,683**	**4,095**	**7,788**	**27,045**	**-**	**3,540**	**1,052**	**206,211**

Note 18.7 Property, plant and equipment financing - 2021/22

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022								
Owned - purchased	12,499	160,547	4,167	26,765	24,660	5,830	1,039	235,507
Finance leased	-	-	-	-	1,705	-	-	1,705
Owned - donated / granted	-	6,425	-	1,622	2,423	4	42	10,516
NBV total at 31 March 2022	**12,499**	**166,972**	**4,167**	**28,387**	**28,788**	**5,834**	**1,081**	**247,728**

Note 18.8 Property, plant and equipment financing - 2020/21

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	11,042	151,113	4,000	15,228	25,217	5,905	1,118	**213,623**
Finance leased	-	-	-	-	2,198	-	-	**2,198**
arrangements	-	-	-	-	-	-	-	**-**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	**-**
Owned - donated/granted	-	5,517	-	1,602	2,675	5	44	**9,843**
NBV total at 31 March 2021	**11,042**	**156,630**	**4,000**	**16,830**	**30,090**	**5,910**	**1,162**	**225,664**

Note 19 Donations of property, plant and equipment

The Trust received donations from which assets were purchased to the value of £1.3m (£0.8m 2020/21).

The donations were made up as follows:

- £0.6m cash donation from Royal United Hospital Bath Charitable Funds for the Breast Unit extension works and equipment, the donation was restricted to the Breast Unit .
- £0.1m cash donation from Royal United Hospital Bath Charitable Funds towards the costs of the new Cancer Centre which is under construction, the donation was restircted to the Cancer Centre.
- £0.1m from Royal United Hospital Bath Charitable Fund to fund various medical equipment.
- £0.4m relates to the donation of COVID Loan equipment by the DHSC.
- £0.1m cash grant from an external organisations towards the purchase of a new medical equipment.

Note 20 Revaluations of property, plant and equipment

The Trust's policy is to complete a full revaluation at least every five years realting to Land and Buildings, with a desktop review every three years. Gerald Eve, who are members of the Royal Institute of Chartered Surveyors and are independent of the Trust, undertook a desktop valuation using indices of the Trust's land and buildings as at 31 March 2021. The last full revaluation was undertaken as at 31 March 2020. The valuations were carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1).

The total net impairment charged to the accounts is £1.1m of which £4.7m relates to expenditure previously charged to capital, these have now been expensed in line with changes to the programme. There was also a reversal of an impairment of £4.1m following a desktop valuation of land, buildings and dwellings as at 31 March 2022 following a valuation carried out by Gerald Eve in line with Trust’s policy.

Further impairments of £0.41m related to Sulis goodwill based on value in use and a further £0.23m related to capital assets under construction where the project is no longer expected to complete.

Note 21 Heritage Assets

The Trust hold a number of art works. The art is across a variety of mediums and have either been donated or transferred from the acquisition of The Royal National Hospital for Rheumatic Diseases in 2015.

These assets are not operational and are not held to deliver front line services or back office functions. Therefore the assets will not be recognised in the statement of financial position.

The assets were last valued in 2015 for insurance purposes. The Trust has not obtained up to date valuations, as the cost will not be commensurate with the benefits to users of the financial statements.

The art works are held at various locations across the Trust site and a small number have been loaned to the Bath Medical Museum. The art collection is managed by the Art & Design Manager.

Note 22 Investments in associates and joint ventures

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**-**	**-**	**-**	**-**
Share of Other Comprehensive Income	56	-	-	**-**
Carrying value at 31 March	**56**	**-**	**-**	**-**

Note 23 Other investments / financial assets (non-current)

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**9,324**	**7,932**	**-**	**-**
Adjustment for Charity investments following audit	6	16		
Carrying value at 1 April - restated	**9,330**	**7,948**	**-**	**-**
At start of period for new FTs	-	-		
Acquisitions in year	104	127	3,241	-
Movement in fair value through OCI	723	1,249	-	-
Carrying value at 31 March	**10,157**	**9,324**	**3,241**	**-**

Note 24 Disclosure of interests in other entities

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

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

The clinical services provided to Wiltshire are procured mainly from Great Western Hospitals NHS Foundation Trust, with other small service provision, both clinical and corporate, received from Salisbury NHS Foundation Trust and the Royal United Hospitals Bath NHS Foundation Trust on a contract basis.

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

Note 25 Analysis of Charitable Fund Reserves

	31 March 2022 £000	31 March 2021 £000
Unrestricted funds:		
Unrestricted income funds	2,548	1,948
Restricted funds:		
Other restricted income funds	11,088	10,717
	13,636	**12,665**

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 26 Inventories

	Group & Trust		Trust	
	31 March 2022 £000	31 March 2021 £000	31 March 2022 £000	31 March 2021 £000
Drugs	722	540	660	540
Consumables	4,937	3,595	3,789	3,595
Energy	132	101	132	101
Total inventories	**5,791**	**4,236**	**4,581**	**4,236**

Inventories recognised in expenses for the year were £60,117k (2020/21: £65,460k). Write-down of inventories recognised as expenses for the year were £0k (2020/21: £106k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £1,677k of items purchased by DHSC (2020/21: £6,245k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 27.1 Receivables

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Contract receivables	9,854	14,963	7,170	14,963
Capital receivables	-	-	69	49
Allowance for impaired contract receivables / assets	(1,183)	(988)	(1,024)	(988)
Deposits and advances	23	23	28	23
Prepayments (non-PFI)	2,845	2,750	2,368	2,750
Finance lease receivables	-	-	109	-
PDC dividend receivable	95	65	95	65
VAT receivable	-	604	(4)	604
Other receivables	232	53	217	53
NHS charitable funds receivables	521	1,278	-	-
Total current receivables	**12,387**	**18,748**	**9,028**	**17,519**
Non-current				
Contract assets	1,962	1,600	1,655	1,600
Allowance for other impaired receivables	(369)	(296)	(369)	(296)
Finance lease receivables	-	-	442	-
Other receivables	1,034	997	1,034	997
NHS charitable funds receivables	-	400	-	-
Total non-current receivables	**2,627**	**2,701**	**2,762**	**2,301**
Of which receivable from NHS and DHSC group bodies:				
Current	6,118	12,532	4,913	14,406
Non-current	1,034	997	1,034	371

Note 27.2 Allowances for credit losses - 2021/22

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

Note 27.3 Allowances for credit losses - 2020/21

	Group	Trust
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 Apr 2020 - as previously stated	**541**	**541**
Transfers by absorption	-	-
New allowances arising	966	966
Changes in existing allowances	9	9
Reversals of allowances	(102)	(102)
Utilisation of allowances (write offs)	(130)	(130)
Allowances as at 31 Mar 2021	**1,284**	**1,284**

Note 28 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	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
At 1 April	**30,297**	**15,512**	**28,275**	**13,512**
Net change in year	22,854	14,785	20,267	14,763
At 31 March	**53,151**	**30,297**	**48,542**	**28,275**
Broken down into:				
Cash at commercial banks and in hand	1,649	80	4	2
Cash with the Government Banking Service	51,502	30,217	48,538	28,273
Total cash and cash equivalents as in SoFP	**53,151**	**30,297**	**48,542**	**28,275**
Total cash and cash equivalents as in SoCF	**53,151**	**30,297**	**48,542**	**28,275**

Note 29 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.

	Trust only	
	31 March 2022	31 March 2021
	£000	£000
Bank balances	8	9
Monies on deposit	-	-
Total third party assets	**8**	**9**

Note 29 Trade and other payables

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Trade payables	2,104	415	1,432	415
Capital payables	3,929	6,633	3,929	6,633
Accruals	36,328	22,294	34,918	22,294
Social security costs	5,873	5,233	5,873	5,233
VAT payables	35	49	91	49
Other payables	7,412	6,200	6,266	6,200
NHS charitable funds: trade and other payables	135	310	-	-
Total current trade and other payables	**55,816**	**41,134**	**52,509**	**40,824**
Of which payables from NHS and DHSC group bodies:				
Current	4,858	3,569	5525	3,569
Non-current	-	-	-	

Note 30 Early retirements in NHS payables above

There are no early retirement in the payables stated above

Note 31 Other liabilities

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	6,717	5,056	5,221	5,056
Total other current liabilities	**6,717**	**5,056**	**5,221**	**5,056**

Note 32.1 Borrowings

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Loans from DHSC	351	3,016	351	3,016
Obligations under finance leases	554	488	495	488
Total current borrowings	**905**	**3,504**	**846**	**3,504**
Non-current				
Loans from DHSC	5,476	5,789	5,476	5,789
Obligations under finance leases	1,532	1,680	1,185	1,680
Total non-current borrowings	**7,008**	**7,469**	**6,661**	**7,469**

The DHSC is unsecured, . Interest rates applied by DHSC can be found on the National Loan Fund website.

Note 32.2 Reconciliation of liabilities arising from financing activities (Group)

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

Group - 2020/21	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2020	**11,771**	**2,652**	**14,423**
Cash movements:			
Financing cash flows - payments and receipts of principal	(2,958)	(483)	**(3,441)**
Financing cash flows - payments of interest	(208)	(31)	**(239)**
Non-cash movements:			
Application of effective interest rate	200	30	**230**
Carrying value at 31 March 2021	**8,805**	**2,168**	**10,973**

Note 32.3 Reconciliation of liabilities arising from financing activities

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

Trust - 2020/21	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2020	11,771	2,652	**14,423**
Cash movements:			
Financing cash flows - payments of interest	(2,958)	(483)	**(3,441)**
Non-cash movements:			
Change in effective interest rate	200	30	**230**
Carrying value at 31 March 2021	**9,013**	**2,199**	**11,212**

Note 33 Finance leases

Note 33.1 Royal United Hospitals Bath NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Gross lease liabilities	**2,171**	**2,232**	**1,720**	**2,232**
of which liabilities are due:				
- not later than one year;	586	513	513	513
- later than one year and not later than five years;	1,585	1,670	1,207	1,670
- later than five years.	-	49		49
Finance charges allocated to future periods	(85)	(64)	(40)	(64)
Net lease liabilities	**2,086**	**2,168**	**1,680**	**2,168**
of which payable:				
- not later than one year;	554	488	495	488
- later than one year and not later than five years;	1,532	1,631	1,185	1,631
- later than five years.	-	49		49

Note 34.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2021	**701**	**44**	**1,058**	**1,803**
Arising during the year	293	(17)	37	**313**
Utilised during the year	(90)	-	-	**(90)**
At 31 March 2022	**904**	**27**	**1,095**	**2,026**
Expected timing of cash flows:				
- not later than one year;	82	27	61	**170**
- later than one year and not later than five years;	328	-	-	**328**
- later than five years.	494	-	1,034	**1,528**
Total	**904**	**27**	**1,095**	**2,026**

Note 34.2 Provisions for liabilities and charges analysis (Trust)

Trust	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2021	**701**	**44**	**1,058**	**1,803**
Arising during the year	97	(17)	37	**117**
Utilised during the year	(90)	-	-	**(90)**
At 31 March 2022	**708**	**27**	**1,095**	**1,830**
Expected timing of cash flows:				
- not later than one year;	82	27	61	**170**
- later than one year and not later than five years;	328	-	-	**328**
- later than five years.	494	-	1,034	**1,528**
Total	**904**	**27**	**1,095**	**2,026**

Pensions - early departure costs
Early retirement costs and injury benefit payments for staff, based on the information provided by NHS Pensions. The amounts and timings of the cash flows are accurate for the life of the claimant. Timings of payment are due over the life of the claimants.

Other legal claims
Litigation claims against the Trust that are being handled by NHS Litigation Authority. The provision is based on the information provided by NHS Litigation Authority. The timing of future and actual amounts remain uncertain until the claims are settled.

Other
Other provisions have been made in relation to employment issues. The amounts are estimates based on known risks and saleries and are therefore inherently uncertain.

Note 34.3 Clinical negligence liabilities

At 31 March 2022, £318,056k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal United Hospitals Bath NHS Foundation Trust (31 March 2021: £151,682k).

Note 35 Contingent assets and liabilities

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	23	17	23	17
Gross value of contingent liabilities	**23**	**17**	**23**	**17**
Amounts recoverable against liabilities	-	-		
Net value of contingent liabilities	**23**	**17**	**23**	**17**
Net value of contingent assets	**-**	**-**		

NHS Resolution claims
Contingent liabilities are the legal claims under the liability to third parties and property expenses administered by the NHS Resolution (formerly NHS Litigation Authority). The Trust has not identified any contingent assets in 2021/22 (nil in 2020/21).

Other
The Trust has a contract with a third party to store, process and securely destroy records. The Trust is in the process of a detailed review to ascertain the number of records this relates to . At this point in time the Trust is unable to quantify reliably the number of records this relates to. therefore is disclosing a contingent liability

Note 36 Contractual capital commitments

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Property, plant and equipment	30,975	8,484	30,975	8,484
Intangible assets	153	328	153	328
Total	**31,128**	**8,812**	**31,128**	**8,812**

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
Because the majority of the Trust's income comes from other public sector bodies, it has low exposure to credit risk. The maximum exposures as at 31 March 2022 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 2022	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	11,530	-	**11,530**
Cash and cash equivalents	49,989	-	**49,989**
Consolidated NHS Charitable fund financial assets	3,683	10,157	**13,840**
Total at 31 March 2022	**65,202**	**10,157**	**75,359**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	16,329	-	**16,329**
Cash and cash equivalents	28,275	-	**28,275**
Consolidated NHS Charitable fund financial assets	3,700	9,324	**13,024**
Total at 31 March 2021	**48,304**	**9,324**	**57,628**

Note 37.3 Carrying values of financial assets (Trust)

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

The Charitable Fund elected to classify equity instruments as fair value through OCI on initial recognition; the carrying value of these designated assets are £10.1m, (£9.3m in 2020/21).

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	16,329	-	**16,329**
Cash and cash equivalents	28,275	-	**28,275**
Total at 31 March 2021	**44,604**	**-**	**44,604**

Note 37.4 Carrying values of financial liabilities (Group)

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

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	8,805	**8,805**
Obligations under finance leases	2,168	**2,168**
Trade and other payables excluding non financial liabilities	35,542	**35,542**
Total at 31 March 2021	**46,515**	**46,515**

Note 37.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	5,827	**5,827**
Obligations under finance leases	1,680	**1,680**
Trade and other payables excluding non financial liabilities	46,601	**46,601**
Provisions under contract	2,026	**2,026**
Total at 31 March 2022	**56,134**	**56,134**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	8,805	**8,805**
Obligations under finance leases	2,168	**2,168**
Trade and other payables excluding non financial liabilities	35,852	**35,852**
Total at 31 March 2021	**46,825**	**46,825**

Note 38 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 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
In one year or less	52,978	39,190	49,405	39,190
In more than one year but not more than five years	3,303	3,417	3,303	3,417
In more than five years	4,927	5,394	4,927	5,394
Total	**61,208**	**48,002**	**57,635**	**48,002**

Note 39 Losses and special payments

	2021/22		2020/21	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	-	-	1	1
Bad debts and claims abandoned	3	7	-	-
Stores losses and damage to property	1	-	-	-
Total losses	**4**	**7**	**1**	**1**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	-
Ex-gratia payments	25	637	28	456
Total special payments	**25**	**637**	**29**	**456**
Total losses and special payments	**29**	**644**	**30**	**457**
Compensation payments received		-		-

Note 40 Gifts

	2021/22		2020/21	
Group and trust	**Total number**	**Total value**	**Total number**	**Total value**
	Number	**£000**	**Number**	**£000**
Gifts made	-	-	74	29

Note 41 Related parties

During the year none of the Department of Health Ministers, Royal United Hospitals Bath NHS Foundation Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Royal United Hospitals Bath NHS Foundation Trust.

The Department of Health is regarded as a related party. During the 12 month period to 31 March 2022, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

CCGs
NHS Bath and North East Somerset, Swindon and Wiltshire CCG
NHS Somerset CCG
NHS Bristol, North Somerset and South Gloucestershire CCG
NHS Gloucestershire CCG

NHS England Organisations
NHS England - Central Specialised Commissioning Hub
NHS England - South West Regional Office
NHS England - South West Specialised Commissioning Hub
NHS England - South East Regional Office
NHS England - Wessex Specialised Commissioning Hub
NHS England - Midlands Regional Office

NHS Trusts and Foundation Trusts
University Hospitals Bristol and Weston NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
North Bristol NHS Trust
Salisbury NHS Foundation Trust
Avon and Wiltshire Mental Health Partnership NHS Trust
Somerset Partnership NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust

Other Agencies
Health Education England
Department Of Health
Bath and North East Somerset Council
Wiltshire Unitary Authority
Welsh Assembly Government (including all other Welsh Health Bodies)
Public Health England
NHS Litigation Authority
NHS Blood and Transplant (excluding Bio products Laboratory)

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Her Majesty's Revenue and Customs in relation to Value Added Tax, National Insurance Contributions and Income Taxes.

The Trust has also received revenue and capital payments from the Royal United Hospital Bath NHS Trust Charitable Funds, for which the Trust Board acts as Corporate Trustee. In 2021-22 the Trust received £0.65m from the Charity towards the Breast Unit expansion. The audited accounts of the Charitable Funds are available at www.ruh.nhs.uk.

The Trust is an equal partner in Wiltshire Health and Care LLP, the Trust received payment of £0.1m in respect to the provision of Financial Services to the partnership for 2021-22.

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

Note 42 Events after the reporting date

No events after the reporting date have been identified.