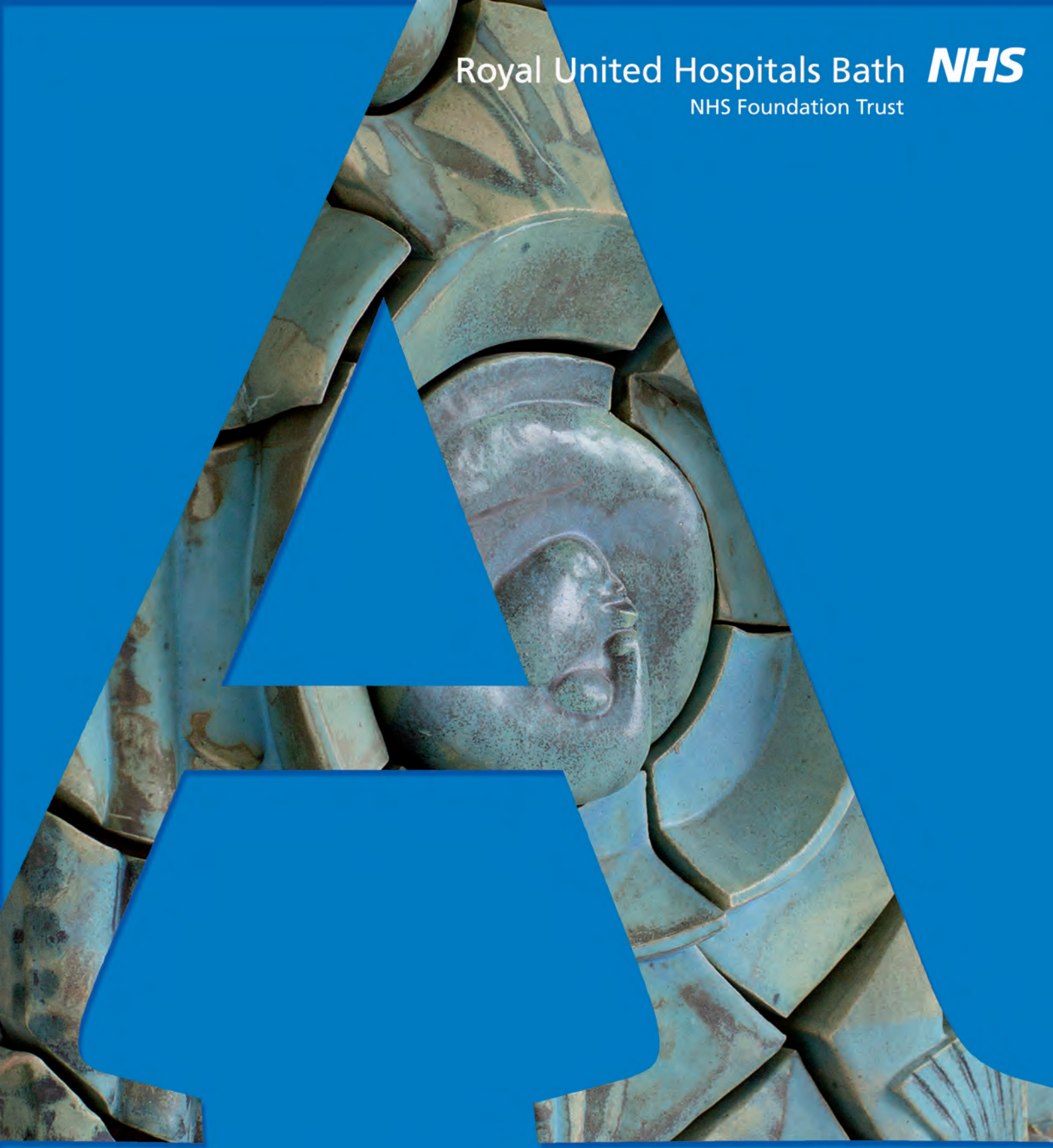
Royal United Hospitals Bath
NHS Foundation Trust

NHS



Annual Report and Accounts

1 November 2014 - 31 March 2015

Royal United Hospitals Bath NHS Foundation Trust

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

Contents

Chairman and Chief Executive's Statement

We are proud to introduce you to our first annual report as an NHS Foundation Trust (FT) in which we share our progress and achievements since authorisation as an FT on 1 November 2014.

During 2014/15 we have built on the successes of the previous year and continued to enhance and develop the services we provide to our patients. Details of the steps we have taken to improve further the quality of care we deliver are outlined in the Quality Accounts from page 91. A flavour of the future direction of travel of our Trust as we establish new partnerships and services within our local community can be found in the Strategic Report from page 9.

Our journey to become a Foundation Trust started in 2008, ending on 1 November 2014 when we were formally authorised by Monitor – the Foundation Trust regulator. During this time, the NHS has seen considerable change, justifiable increases in scrutiny and financial challenge. It has been, on occasions, a difficult path to navigate and we are proud of our staff and Governors for their commitment and dedication in evidencing the safe, high quality, sustainable services we provide to our patients throughout the rigorous foundation trust assessment process.

As a Foundation Trust we have greater freedom to make and take new opportunities. We have worked hard to build a strong platform from which we can further develop our service portfolio and as we build on our partnerships with others, we will be able to provide ever greater care and support to patients and clinicians both within and beyond the walls of the hospital.

We have been working with colleagues at the Royal National Hospital for Rheumatic Diseases (RNHRD) for the last five years, developing plans to provide a sustainable future for its highly regarded portfolio of specialised services. Following authorisation as a Foundation Trust, we were able to put these plans into action and on 1st February 2015, 283 staff from the RNHRD joined the RUH. These teams operate across the Combe Park and RNHRD sites, ensuring that patients can continue to access the right care, in the right place, first time. We now plan to continue to build on the national and international reputation which the RNHRD has developed as a leading provider of high quality, innovative care for patients with long-term rheumatology, pain and fatigue conditions. By combining the RNHRD's enviable specialist research brand and expertise with the RUH's ambitious research agenda, we will create a centre driven by evidence-based clinical excellence and innovation.

The publication of the NHS Five Year Forward View in October 2014 set out a new mandate for greater community engagement and out of hospital care. As a member led organisation, we actively seek the input of patients, carers, members and our Governors in our planning and we encourage their involvement in service developments. This year a highlight of our "see it my way" programme" brought the process of complaints to light in a new and insightful way from the perspective of staff, patients and carers using the medium of drama. The majority of staff attending fed back that the event had impacted the way they now think about complaints. In 2015/16 we will be starting our Patient Empowerment Programme – with the aim of taking this involvement to the next level.

Our dedicated staff proactively seek out ways in which the care we provide can be improved and enhanced. We are delighted to be one of the 12 vanguard Trusts for the national Sign up to Safety campaign, demonstrating our ongoing commitment to continuous improvements in patient safety across our hospitals and within our local health community. We continue to work with colleagues to shape new initiatives to improve patient care, such as our text message reminder service for appointments and sending our letters electronically – meaning that our colleagues receive notification of clinic outcomes more quickly. Our Innovations Panel has also been established this year, enabling investment in smaller scale projects and ideas from front line staff which we know will improve patient care.

The year has not been without its challenges and like most other hospitals, we have experienced growing demand for emergency care which has placed pressure on not only our 'Front Door' services but also waiting times for planned surgery. Local leadership through our System Resilience Group has meant that we have been able to mitigate this pressure with greater partnership working and new initiatives such as our Emergency Surgery Assessment Clinic (ESAC) which has continued to go from strength to strength in providing early assessment to specialist advice and theatre. We have also been delighted that patients have consistently chosen to rate our Emergency Department, through the friends and family test, as amongst the best in the country for patient experience.

We recently received the results of the 2014 NHS Staff Survey, which all staff had the opportunity to participate in. We were pleased to hear from our staff of their positive experience of working at the Trust and that our engagement scores are above the National average. There is a wealth of research to indicate that a happy and engaged workforce is key to high quality care for patients and our work on staff experience and engagement will continue apace in 2015/16; including the roll-out of innovative initiatives such as Schwarz Rounds, a mechanism of peer support for staff experiencing the unique stresses of day-to-day work in a care environment.

The generous support of a range of charities cannot be overlooked. We are particularly grateful to the Bath Cancer Support Group for their generous donation to purchase a PET-CT scanner, enabling us to provide the latest diagnostic services for patients with cancer and to the League of Friends teams, of both the RUH and RNHRD, whose work and tireless volunteers play such an important part in the positive experiences of visitors to our Trust. Not forgetting also our many donors to the Forever Friends Appeal for their continued support of our ambitious Cancer Centre development programme and smaller scale projects across the hospital.

It has been an exciting six months for the Royal United Hospitals Bath NHS Foundation Trust. All our achievements would not have been possible without the hard work and dedication of our staff. We would like to thank them and our wider public for their continued commitment to the Trust and its patients.

Brian Stables,
Chairman

James Scott,
Chief Executive

OUR YEAR


January 2015
ED department scores 9/10 by patients for experience
February
Acquisition of Royal National Hospital for Rheumatic Diseases
March
Visit by Health Secretary who praised staff for their hard work
November
Foundation Trust status achieved
December
Catheter care research project launched
October
Baby Friendly Initiative award from UNICEF
July
CQC scores RUH as one of lowest risk hospitals in country
August
Target reached in Rapid Spread project to prevent pressure ulcers
September
Target met in Sepsis 6 campaign
9
June
Maternity services return to the RUH
May
9 wards awarded gold dementia charter marks
Apr 2014
£110m 5-year plan to build new cancer centre and other buildings

1 Strategic Report

Introduction

The Royal United Hospitals Bath NHS Foundation Trust (RUH) serves a core population of approximately 400,000 patients, in Bath and North East Somerset, Wiltshire and Somerset. The acquisition of the Royal National Hospital for Rheumatic Diseases on 1 February 2015 further expanded its catchment, with patients attending the hospital from other areas of the UK and internationally.

Together our 4,800 employees deliver high quality services from the RUH and RNHRD hospital sites and in local community settings.

Established as an NHS Trust in 1992, the RUH achieved Foundation status in November 2014 – a mark of the governance standards and financial sustainability of the organisation. The principal business of the Trust is the provision of healthcare at a specialist and secondary care level with increasing demand for services provided closer to home and support for those with long-term conditions. Our business model is illustrated below:

Over the past five years, the Trust has transformed elements of the site, using new technologies in modern, purpose-built environments to support improved patient care and outcomes alongside substantial reduction in backlog maintenance. These developments have included a new neonatal intensive support unit, dementia friendly ward design, new lighting across the estate, new pathology and information management and technology buildings.

Over the next five years, this ambitious programme of redevelopment will be continued, providing new pharmacy, therapies and cancer buildings which will further support and enhance care for our patients.

The Trust is regulated by the Care Quality Commission, and was most recently inspected in December 2013 as an NHS Trust, where the inspectors found that the Trust was providing ‘safe, effective care’ for patients. Regular ‘Intelligent Monitoring’ reports, produced by the Care Quality Commission, measure quality and safety indicators across a range of services and areas and the Trust’s staff work hard in a culture of continuous improvement to maintain a position amongst the lowest risk category of Trusts in the country.

Further information can be found in the Quality Accounts from page 91.

Review of 2014/15 – delivery of our strategy

2014/15 was a momentous year for the Trust, characterised by not only achievement of Foundation Trust status in November, but also the successful integration of Wiltshire Maternity Services in June, Diabetic Retinal Screening services in August and the acquisition of the Royal National Hospital for Rheumatic Diseases in February 2015.

Alongside this, the Trust has delivered and developed a wider portfolio of strategic objectives, to ensure the continued provision of the highest quality of care for patients.

1. We will continuously improve the quality of the services we provide, focusing on patient safety, clinical outcomes and patient experience.

Our Quality Report provides greater detail of initiatives delivered in 2014/15, demonstrating our commitment to continuous quality improvement. Highlights include:

Rapid Spread: In April 2015 we implemented a new way of improving care we provide to patients, the initiative was called rapid spread and its aim is to eliminate all avoidable hospital-acquired pressure ulcers. This approach used a systematic twelve-week programme combining proven improvement techniques and evidence-based practice to deliver the outcome of eliminating pressure ulcers quickly. Staff showed real commitment and willingness to take on new ideas and embed change to ensure our patients have an improved experience whilst in our care.

Reducing sepsis in hospital: One of the Trust's Quality Accounts priorities is to further reduce our healthcare associated infection rates with a particular focus on sepsis. Sepsis has a high mortality rate when not detected early, often meaning that patients require treatment in intensive care. We have made real progress in improving early detection of sepsis in the last year, using the 'Sepsis 6' bundle. This is a specific set of six actions for staff to take within an hour of admission to ensure that, where sepsis is suspected, it is identified early and treatment started. Using our learning, we will be working with local health partners to implement the same process across our community.

Patient feedback – Friends and Family Test

We have continued our roll out of the Friends and Family Test across the Trust – incorporating feedback from our outpatients department in the last year. We have also started to roll out the same test to our staff – asking them how likely they would be to recommend treatment at the Trust to a friend or loved one. All the data gathered from patients and staff is included in our regular reviews of wards and clinical areas, supporting ongoing improvements in clinical care.

See it my way

The Trust pioneered the use of face to face patient feedback through its 'See it my way' programme, which has continued to develop in 2014/15. This year, a local drama group presented a 'See it my way' event focused on complaints, highlighting how the complaints process feels from the perspective of a complainant. It was a thought provoking session, with 85% of the 168 staff who attended confirming that it would change the way that they dealt with complaints in the future.

Mortality

The Trust has continued to perform well against the Hospital Standardised Mortality Ratio and Standardised Hospital Mortality Indicator. We have maintained our focus on reviewing in-hospital deaths, ensuring that

learning is disseminated across the organisation.

2. We will demonstrate strong clinical and financial performance, delivering services to national and local standards, moving from process based to outcome based indicators.

Urgent care

We have continued to work with our community colleagues over the last year to deliver system change for urgent care. Within the hospital, we have focused on developing new pathways for patients who do not necessarily need an admission – particularly for older people in our newly established ACE Older People's Unit and in our Emergency Surgery Assessment Clinic (ESAC). These units focus on minimising the length of time patients spend in hospital, whether waiting for assessment and treatment or for surgery, improving their clinical outcomes and experience.

Women and Children's Division

With the successful transfer of maternity services to the Trust in June 2014, we established the new Women and Children's Division giving a greater focus to maternal and paediatric health. Our teams provide care both within the Trust and in our community birth centres in Trowbridge, Chippenham, Paulton, Frome and Shepton Mallet, and we are excited to have them on board as we develop and enhance services for women and children. We have now successfully transferred all maternity care onto our Trust Patient Record system – Millennium – meaning that there is more joined up care for women and their babies across all clinical services across the Trust.

Quality, Innovation, Prevention and Productivity (QIPP)

Our clinical teams have made great progress in developing and delivering new ways of working in 2014/15, improving not only efficiency but also patient experience. Key initiatives include improving patient communications through use of text message reminders and changing the way we provide some of our clinical services. Our Innovations Panel has supported these initiatives with small levels of investment to enable different ways of working to be implemented more quickly.

Trust Electronic Patient Record

As part of our ambition to implement an Electronic Patient Record (EPR) we retendered our Trust Patient Record system in 2014/15. We awarded the contract to Cerner Millennium and our teams are now working with them to implement an upgrade of our patient administration system. This is excellent news for patient care, as the new system will streamline many of our existing processes and will enable clinical teams to spend more time with patients.

Reference Cost Index

Our reference cost for services has remained below 100 across the year. This is a national index that indicates how cost-efficient our services are, and we are pleased that we continue to demonstrate value for money in provision whilst maintaining a focus on delivering the highest quality of service to our patients.

3. We will develop our workforce to support the delivery of our strategy, through optimising skill and profession mix, increasing productivity and delegating local control and authority.

Staff Survey

Following a successful relaunch of our Trust in house publications and a review of how wemaintain continuous communication from Board to ward, our staff engagement score has increased from 3.78 to above national average at 3.82.

Extended roles

We have established a new diabetes case management service with GP colleagues in B&NES. Our Diabetes Consultant works with local GPs to review their diabetic patients, identifying ways in which care can be adjusted to further enhance their care and avoid hospital admissions. This model is in its early stages, and is an important step on our journey to work with secondary care clinicians differently to support patients with complex needs in the community.

Training and development

Training and development remains an intrinsic part of our workforce strategy and we have made great progress in the last year in developing new packages to support all staff. Our RUH Leaders Forum has continued to meet, bringing together clinical and non-clinical leaders from across the Trust to discuss and debate our future strategy.

Schwartz Rounds

We are excited to have implemented Schwartz Rounds at the Trust. The Rounds were developed in Boston, Massachusetts to provide a forum for staff to discuss emotional and social issues raised by patient care, with a focus on the human dimension of medicine. They have been rolled out across a small number of hospitals in England, including the RUH. Research is indicating that the Rounds have a positive impact on how individuals and teams feel about the care they are giving and their confidence to handle challenging non-clinical aspects of care increases, which will further enhance the quality of patient care and safety.

4. We will strengthen our local and national reputation as a provider of quality care, building relationships with patients, staff, members and commissioners through working effectively as part of a system.

Foundation Trust authorisation

Achieving Foundation Trust status in November 2014 was a significant milestone for the organisation. We were the first Trust to be authorised since the publication of the Francis report in February 2013 and teams were rigorously assessed regarding the quality, safety and sustainability of services at the Trust to ensure that we do and can continue to provide high quality, evidence based services for our local population.

As a Foundation Trust, we are now a membership organisation and we have been working closely with our Council of Governors and Governor sub-groups to ensure that we are using feedback from our members in our planning and strategic development. We will be evolving this approach in 2015/16 to ensure that we continue to be responsive to our membership.

Acquisition of the Royal National Hospital for Rheumatic Diseases

Following authorisation as a Foundation Trust, we were able to acquire the Royal National Hospital for Rheumatic Diseases (RNHRD). We have been working with colleagues at the RNHRD for the last 5 years to ensure a sustainable future for valued specialist services and expertise, culminating in the formal transfer on 1st February 2015.

Working with colleagues across our community

The local health community is changing, with the aim being to deliver more care out of hospital. We have been working with commissioners, GPs and community colleagues to deliver and develop new models of care in a range of specialties; for example a more integrated approach to the management of patients which includes diabetes services and working with community colleagues to support a new community continence service. We have also developed closer relationships with our neighbouring Health and Care organisations, continue to support our local Strategic Resilience Group, helped to champion the Wiltshire 100 day challenge (right care, right place, right time), and been involved in the establishment of a new vascular network across the Bath and Bristol area.

PET-CT

We were delighted to be part of the consortium – led by Alliance Medical Ltd – which was successful in its bid to provide PET-CT services across the South of England. This diagnostic test uses the latest radiological technology to identify potential spread of cancer early, meaning that treatment can be more targeted and patient outcomes improved. We would not have been able to participate in this project without the generous donation of the Bath Cancer Support Group which has funded our new, static PET-CT scanner and we are grateful to everyone who has donated money to this cause.

5. We will improve the efficiency of our estate through improved utilisation, functionality and sustainability of our buildings.

Developing the estate

The relocation of both Pathology and IM&T to new builds earlier in the year are an important step on our wider programme of site redevelopment. During the course of the year we have continued to develop more detailed plans for the construction of a new Pharmacy, Therapies Department and Cancer Centre. A range of staff from across the organisation have been involved in this work and there is great enthusiasm for what we are working to achieve.

Alongside engaging with staff, we have also been working with Buro Happold to understand how patients flow through our clinical spaces. We will be using this information to help inform our future building projects.

Overview of performance during 2014/15

Operational Performance

The Trust produces an Integrated Balanced Score Card, which outlines how it is performing under five domains: Caring, Effective, Responsive, Safe and Well led. As the services from the Royal National Hospital for Rheumatic Diseases joined the Trust in February 2015, key reporting metrics are included in the report to the Board. The Trust has performed strongly across cancer and infection targets for the year.

Four-hour performance

Having worked hard to make significant improvements in our processes and to embed innovative new ways of working at the beginning of the year, providing resilience in the wake of catchment expansion following the closure of Frenchay, we faced another difficult winter across the region including the challenge of reduced capacity due to Norovirus.

We have maintained our supportive relationship with the South Western Ambulance Service NHS Foundation Trust (SWAST) and cooperate fully with them to ensure that they reach their patients in good time by making sure no crews are delayed at the ED.

Performance Indicator	Performing	Weighting	Q1	Q2	Q3	Score	Q4	Score
Four hour maximum wait in A&E (All types from April 2014)	95%	1.0	**94.4%**	**94.3%**	**90.6%**	**1**	**85.9%**	**0**
C Diff>= 72 hours post admission (target for year = 37) Cum	37	1.0	3	9	16	0	28	0
RTT - admitted - 90% in 18 weeks all specialties	90%	1.0	90.5%	90.5%	**82.9%**	**1**	**79.0%**	**1**
RTT - non-admitted - 95% in 18 weeks all specialties	95%	1.0	95.7%	95.5%	**92.4%**	**1**	**93.0%**	**1**
RTT - open pathways in 18 weeks	92%	1.0	93.1%	92.4%	92.3%	0	**91.2%**	**0**
31 day diagnosis to first treatment for all cancers	96%	0.5	98.1%	98.2%	98.2%	0	99.4%	0
31 day second or subsequent treatment – surgery	94%	1.0	95.4%	97.8%	99.3%	0	100.0%	0
31 day second or subsequent treatment – drug treatments	96%	1.0	100%	100%	100%	0	100.0%	0
31 day second or subsequent cancer treatment – radiotherapy treatments	94%	1.0	98.8%	99.0%	97.7%	0	100.0%	0
2 week GP referral to 1st outpatient	93%	0.5	94.6%	93.6%	93.5%	0	93.1%	0
2 week GP referral to 1st outpatient - breast symptoms	93%	0.5	95.4%	95.6%	94.8%	0	94.6%	0
62 day referral to treatment from screening	90%	1.0	98.3%	96.1%	93.8%	0	100.0%	0
62 day urgent referral to treatment of all cancers	85%	1.0	98.7%	91.5%	88.6%	0	90.0%	0
Access to healthcare for people with learning disabilities - Trust compliance	n/a	0.5	Yes	Yes	Yes	0	Yes	0
Governance Risk Rating			1	1	3	3	3	3
							Green	

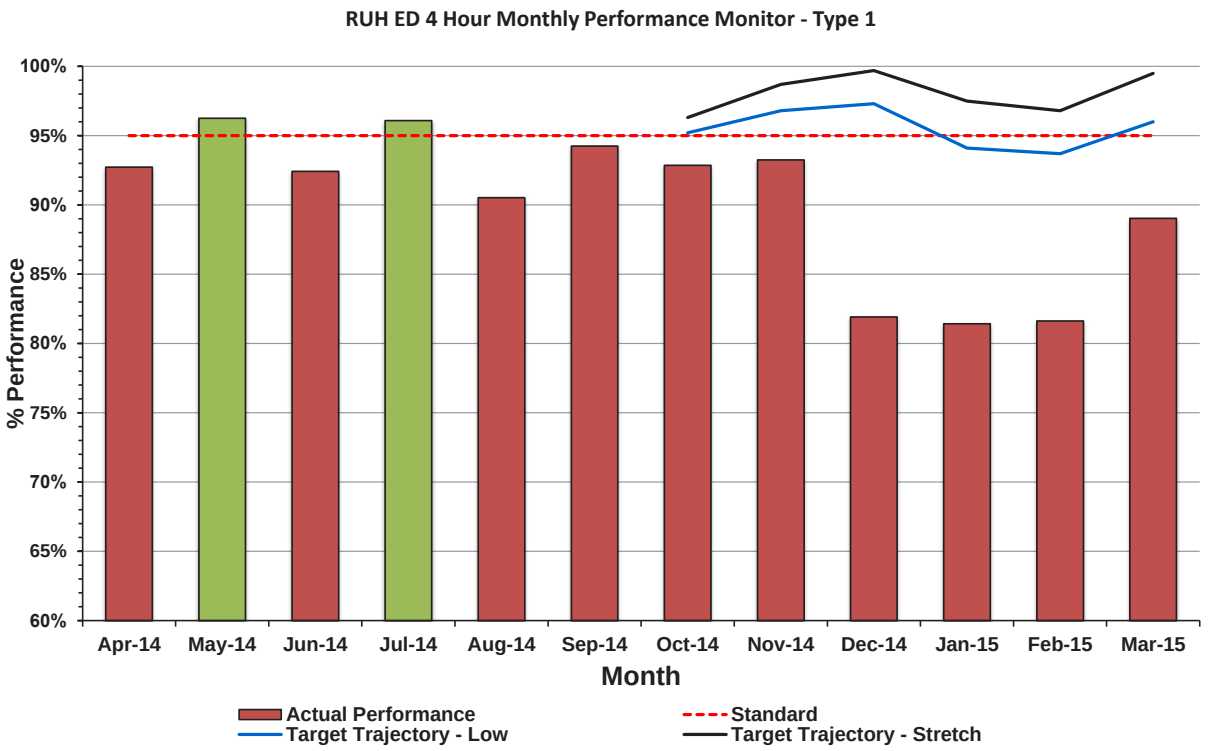
The Urgent Care Improvement Board has identified key issues which we have worked with our Community partners to resolve. This work is ongoing and continues to support improvement across the whole system.

We have focused on three work streams:

Front door – ensuring patients flow freely from the ED to the medical and surgical assessment areas. We have formalised the pathway for patients referred directly by their GP. We have seen a much improved patient experience for patients through Emergency Surgery Ambulatory Care (ESAC), shorter waits, reduced length of stay and high patient satisfaction. We continued to work with the co-located Urgent Care Centre to develop pathways and realise the full potential of the facility. Our focus for 2015/16 is to further develop Ambulatory Emergency Care.

Flow – we have changed the way our site and bed management teams are working, focusing much more on getting patients to the right bed first time. Ward teams have been instrumental in making this happen, ensuring that patients are given the best care in the most appropriate setting by the right teams. We have set up a Discharge Programme Board to support improved flow through the hospital.

Back door - We have worked closely with our Community partners to improve patient discharge. We are working to further improve the delays for patients awaiting onward placement. We have made some progress but there is still a lot to do.



18 weeks RTT

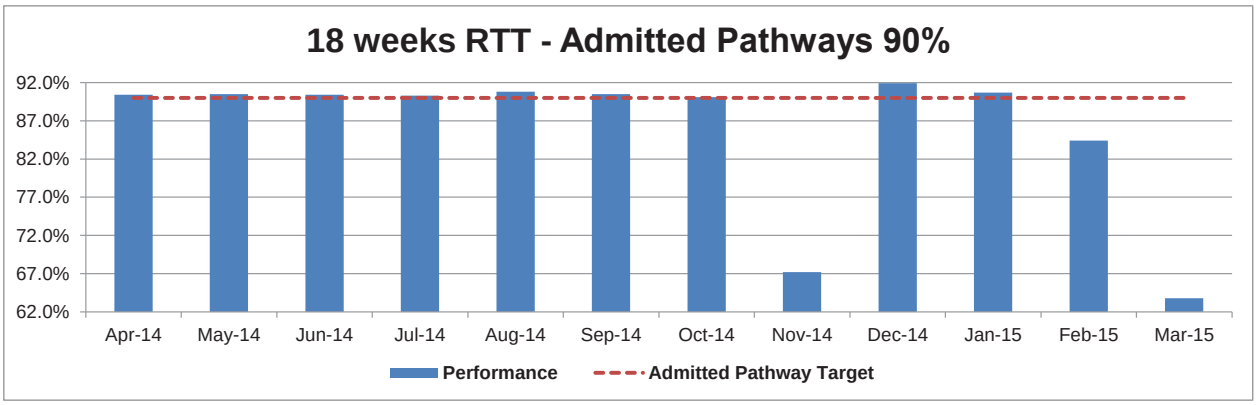
We have maintained delivery of elective care for our patients, managing competing demands of emergency and planned care.

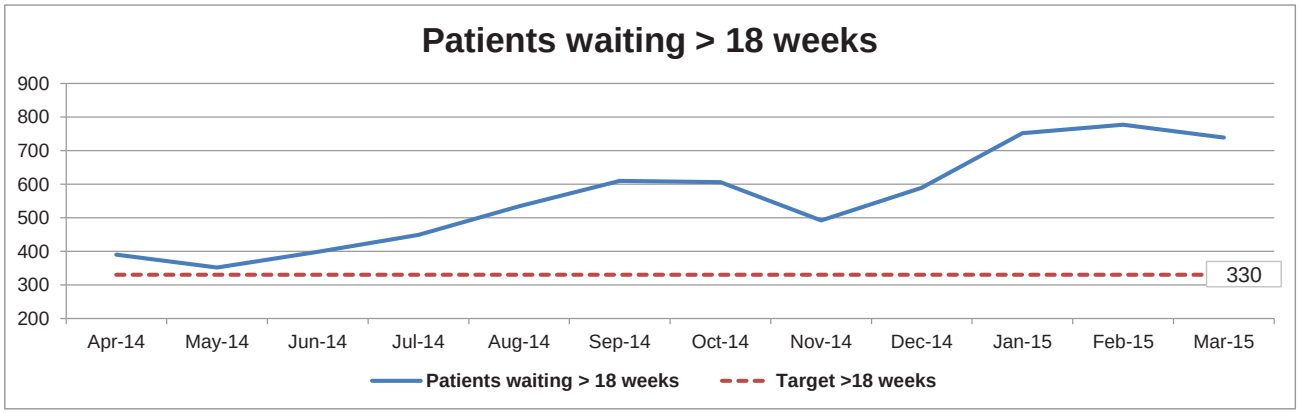
As emergency pressures continued through the winter months, the number of patients waiting more than 18 weeks increased. Although the standard was not achieved in Q4 this was in response to the National initiative to reduce the number of long waiting patients. We have also seen an increase in the levels of in referrals across the Specialties of Dermatology, Gastroenterology, General Surgery, ENT and Oral Surgery.

In response a number of actions were taken:

- Across the year the Trust employed additional consultants across the range of specialties
- Commissioners have put in place robust referral management services to help to manage demand
- The Trust has further developed relationships with alternative providers within the local area, providing greater choice and improved waiting times for our patients.

Looking forward the Trust has plans in place to improve access for patients waiting for routine treatment during Quarter One of 2015/16 in line with National 18 weeks RTT guidance.





We have performed well against the six-week diagnostic maximum wait providing early diagnosis and treatment for our patients. Performance for the period to March 2015 is provided in the following table:

		2014				2015			
Diagnostic Tests within 6 weeks	**Performing (target)**	**Oct**	**Nov**	**Dec**	**Q3**	**Jan**	**Feb**	**Mar**	**Q4**
Performance (%)	<1	0.2	0.2	0.5	0.3	**1.1**	0.9	0.4	0.8

Maternity indicators

The Trust's Integrated Balanced Score Card includes a number of maternity indicators including: Friends and Family Test, Breastfeeding and Smoking at time of delivery, and Midwife-to-Birth ratio. In addition the Trust monitors performance against a further range of measures under the focused headings shown below, which informs discussions with our Commissioners:

- Public Health – focusing on healthy lifestyle in pregnancy
- Mode of birth – monitoring delivery types and numbers supporting national benchmarking
- Maternal indicators – monitoring outcomes of complications at delivery
- Workforce – monitoring training, supervision and midwife staffing.

Since maternity services were transferred to the RUH in June 2014, we have seen improvements in performance particularly around mothers booked within 12 weeks and midwife to birth ratios combined with reductions in emergency caesareans.

We will be focusing going forward on improving rates for mothers initiating breastfeeding, reducing elective caesareans and maintaining focus on staff recruitment.

Financial performance 2014/15

The RUH was granted a licence to operate as a foundation trust on 1 November 2014. This results in two sets of accounts having to be submitted, reflecting each legal entity: an NHS Trust for seven months (1 April 2014-31 October 2014) and an NHS Foundation Trust for five months (1 November 2014 - 31 March 2015).

This report covers the five months from 1 November 2014 to 31 March 2015. This has been a challenging time operationally with an increase in ambulance conveyances, and emergency admissions. This has meant the organisation has been working at the edge of its capacity which in turn brings higher costs. The Trust received some funding for winter resilience but this was not sufficient to account for the reduction in income due to cancellations of elective patients. Therefore for the five month period to March 2015, the Trust is reporting a normalised deficit of £0.8m (excluding impairments, donated income and transfers by absorption).

The 2014/15 financial year was not only characterised by being authorised as a Foundation Trust in November but also by acquiring the assets and services of another foundation trust the Royal National Hospital for Rheumatic Diseases. The latter has had a material impact on the reported surplus of the Trust as it included a gain on the transfer of the acquired assets of £7m, in line with absorption accounting rules in the 2014/15 Annual Reporting Manual. The net transfer of assets from the RNHRD is reflected in both the Statement of Comprehensive Income and the Statement of Financial Position.

The NHS Foundation Trust is the corporate trustee to the RUH Charities. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients and its staff. Therefore the Charity continues to be consolidated within the RUH accounts.

Summary of performance

The main headlines of the financial performance are:

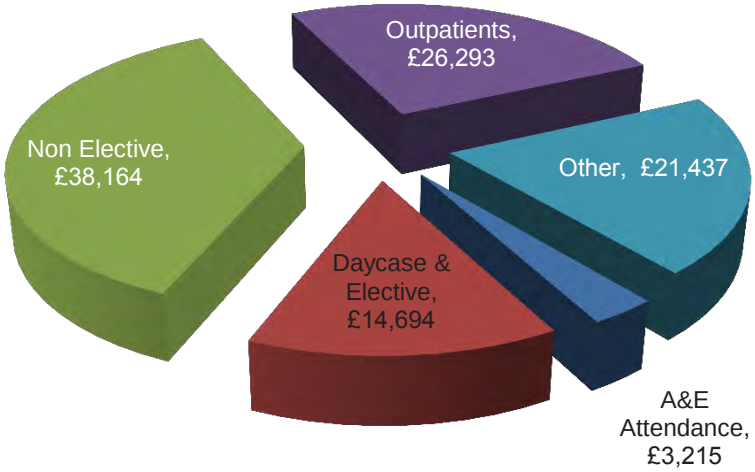
- The underlying “trading” surplus after adjusting for impairment charges, donated income and non-operating transactions is a deficit of £0.8m
- The overall income and expenditure position shows a surplus of £1.3m, but this is after accounting for a number of non-operational items, which are set out in the following table.
- The financial risk rating (Continuity of Service Risk Rating CoSRR) using Monitor's methodology to assess the level of financial risk based on the position as at the end of March 2015 is a 4.

Operating Income	£116.3m
Surplus	£1.3m
Exceptional items included in the surplus:	
Impairments	£5.5m
Donated Income	£0.1m
Transfers from absorption	£7.0m
Charitable Funds	£0.5m
Total Assets	£225.4m
Cash and cash equivalents	£10.7m
Capital investment	£6.4m
Continuity of Service Risk Rating (CoSRR)	4

Operating income

The Trust receives the majority of its income for the delivery of patient care £104m 91%, from the Commissioners of NHS services, predominately, NHS Banes, NHS Wiltshire, NHS Somerset, and NHS England.

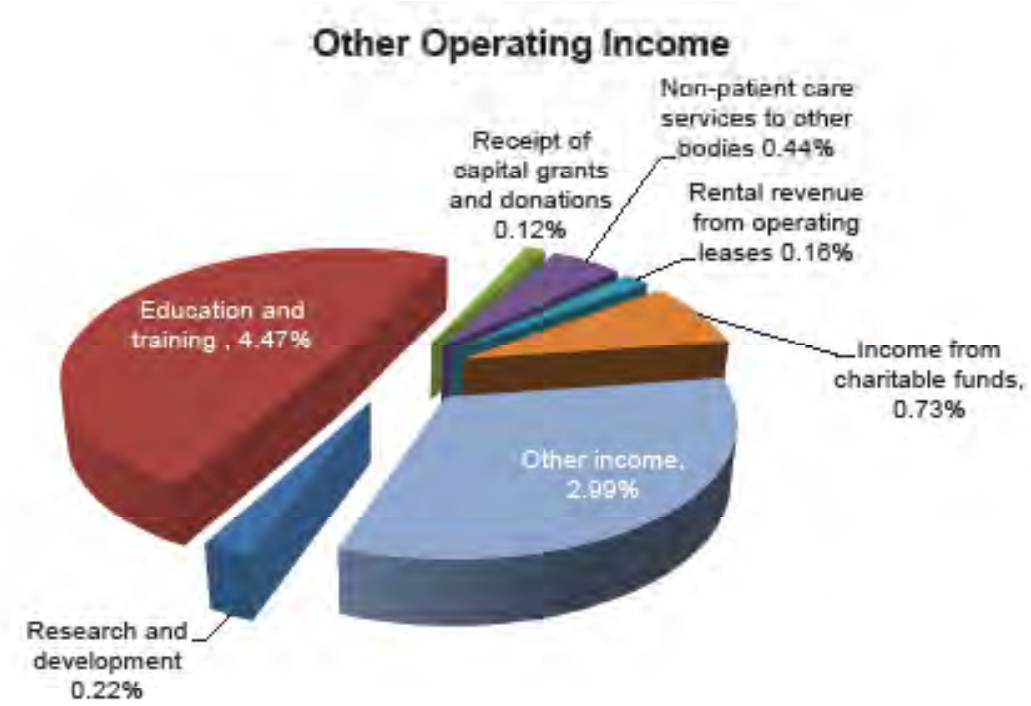
Patient care income Nov 14 - March 15



Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust has met this requirement.

In addition the Trust received £11m for the delivery of non-patient care services, with £5.2m coming from Health Education England to support the costs of providing education and training to NHS staff. Other sources of income include private patients, overseas visitor charges and compensation paid by the NSH injury Cost Recovery scheme to the RUH for treatment costs for patients who have sustained injuries and who receive personal injury compensation.

The following graph sets out the income received for non-patient care income by the Trust over the five months.



Operating expenses

The Trust employs in excess of 4,800 staff and expenditure on pay costs is the single largest item of expenditure for the Trust with £73.2m spent during the five months to March 2015, representing 61% of total operating expenses.

Of the non-pay related expenditure, drugs costs accounts for £12.6m which is 11% of operating expenses, with expenditure on clinical supplies the next biggest item of spend at £11.2m which is 9% of operating expenses.

The graph below sets out the major headings of operating expenses for the Trust.

Capital expenditure investments

The RUH has continued to invest in its estate and equipment with a large capital investment programme in 2014/15.

Capital expenditure totalled £6.4m between November 2014 and March 2015. The table below summarises the main themes of expenditure.

Capital plan	Nov- March Actuals £'000
Estates	1,946
IM&T	1,113
Medical Equipment	1,810
Strategic capital schemes	1,446
Total capital	**6,426**

The biggest schemes have been the building of a new IM&T building which opened in January 2015 and the on-going Electronic Patient Record project. The Trust has also completed the refurbishment of Parry ward, and continued to invest in medical equipment through a rolling replacement programme.

The capital programme was funded by a combination of RUH's internally generated funds, and a loan from the Foundation Trust Financing Facility of £9.9m to fund the Electronic Patient Record project. The loan is for seven years from November 2014, fixed at an interest rate of 1.17%.

Quality Productivity and Efficiency

The Trust has a good record of implementing programmes designed to improve efficiency. In 2014/15 the Trust was required to deliver 11.3m. The amount achieved in the year was £9.7m which was 86%. The delivery of efficiency plans are monitored monthly via the finance and activity report to the Board of Directors.

A look forward

The financial outlook for the NHS as a whole continues to be a difficult one given the continued requirement by the Government to reduce public expenditure. Health spending has been protected, but costs within the sector will continue to rise above the funded levels, due to an ageing population and advances in technologies and treatment options and this provides an ever-increasing financial challenge.

The Trust in acquiring the RNHRD submitted a longer term plan to ensure that patient pathways and services are redesigned to maximise efficiencies whilst continuing to deliver high quality patient care. The programme of change which includes capital redevelopment will not fully be realised until 2017/18. Given this the RUH will be planning for a deficit in 2015/16, however the Trust has secured additional Public Dividend

Capital £2m to cover the structural deficit of the newly acquired services and therefore the Trust maintains a positive cash position.

The Trust will continue to invest in the Trust asset base with investment planned of £31.8m in 2015/16. This will predominately be a new pharmacy building £7m, continued progress against the electronic patient record project £4.8m and installlation of a new PET CT scanning facility. The Trust will continue to make upgrades in clinical facilities including ward and theatre refurbishments, and upkeep of buildings along with new replacement medical equipment.

Going concern

The directors are aware of and actively monitoring the increased challenges facing the Trust in the current economic climate and believe that the strong financial position of the Trust has reported over the last few years has left the Trust well-placed to meet this challenge.

After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Accounting policies

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) agreed with HM Treasury. Consequently the Trust's financial statements have been prepared in accordance with the 2014/15 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Insurance cover

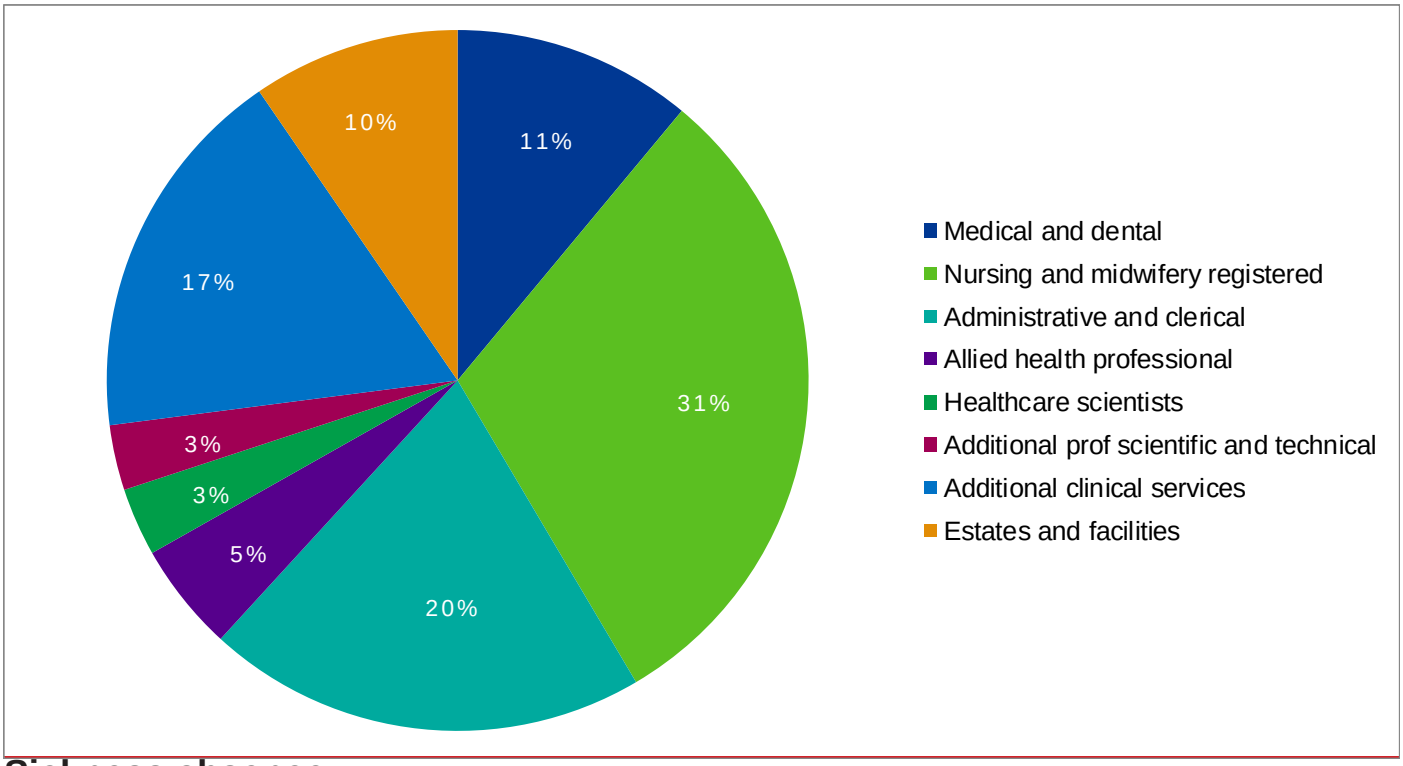
The Trust has insurance cover through the NHS Litigation Authority (NHSLA) to cover the risk of legal action against its directors and officers.

Directors' statement

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware, and the directors have taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Our people

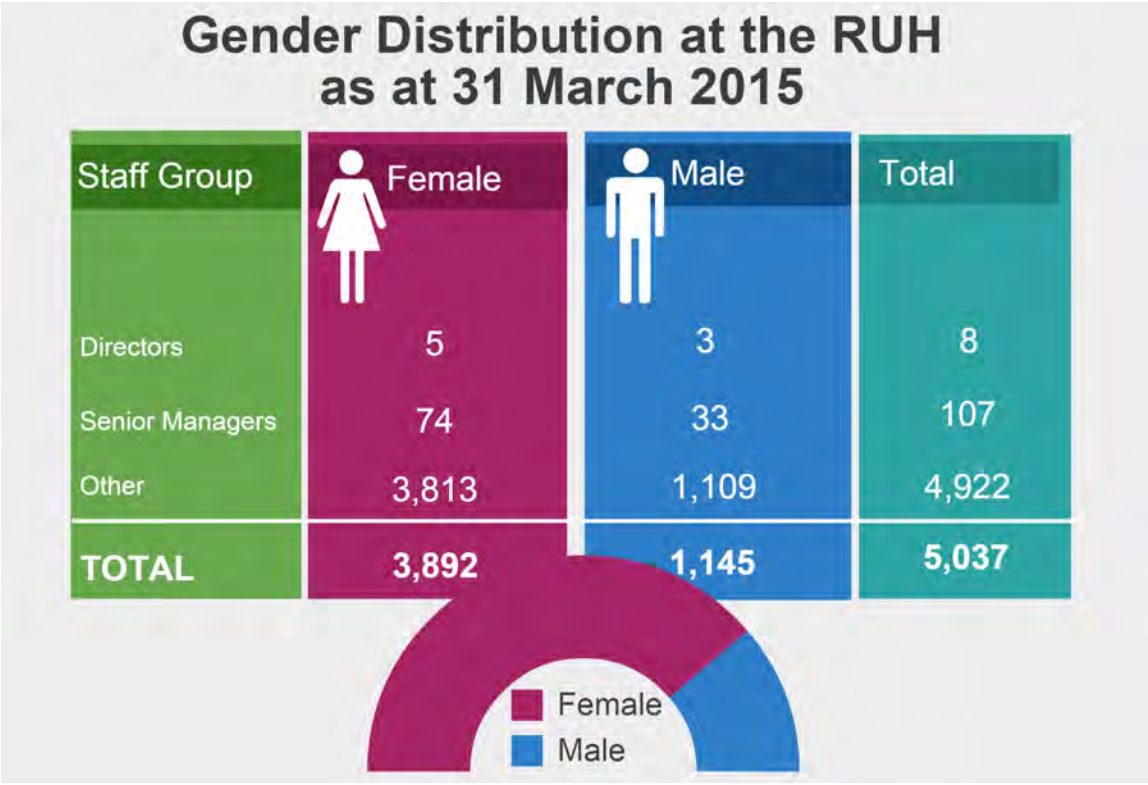
During 2014/15, the average number of people (excluding bank employees) working at the Trust was 4,715.



Sickness absence

The sickness absence rate for 2014/15 was 3.8%. The average number of working days lost to sickness absence was 8.5 (2013/14: 8.5).

Gender analysis



Staff survey

Summary of performance	2014/15		2013/14		Assessment
	RUH	National average	RUH	National average	
Response rate	57%	42%	60%	49%	Highest 20%

Top five ranking scores	2014/15		2013/14		Assessment
	RUH	National average	RUH	National average	
Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	21%	26%	27%	27%	Improvement
Percentage of staff suffering work-related stress in last 12 months	32%	37%	37%	36%	Improvement
Percentage of staff receiving job-relevant training, learning or development in last 12 months	84%	81%	82%	81%	Improvement
Percentage of staff believing the trust provides equal opportunities for career progression or promotion	91%	87%	88%	88%	Improvement
Staff job satisfaction	3.68	3.60	3.63	3.61	Improvement

Bottom five ranking scores	2014/15		2013/14		Assessment
	RUH	National average	RUH	National average	
Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	20%	14%	19%	14%	Deterioration
Percentage of staff witnessing potentially harmful errors, near-misses or incidents in last month	38%	34%	36%	33%	Deterioration
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	31%	29%	32%	28%	Improvement
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	88%	90%	89%	90%	Improvement
Work pressure felt by staff	3.15	3.07	3.23	3.04	Improvement

The key areas of improvement between 2013/14 and 2014/15 are:

- Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell (reduced from 27% to 21%).
- Percentage of staff suffering work related stress in last 12 months (reduced from 37% to 32%).
- Percentage of staff receiving health and safety training in last 12 months (increased from 68% to 75%).
- Work pressure felt by staff (reduced from 3.23 to 3.15).
- Percentage of staff having equality and diversity training in last 12 months (increased from 60% to 68%).

Actions supporting the staff survey

Overall there has been a significant improvement in the Staff Survey results this year for the RUH.

This improvement is a reflection of the hard work and effort that has been put in place throughout 2014 to improve communication and staff engagement, during what has been a year of significant organisational change and operational challenges.

In 2014/15 the Trust focused on actions in five areas, developed following analysis of staff views, governor views, staff survey results and a review of the literature on staff engagement, namely:

- Embed continuous quality improvement
- Embed Service Line Management
- Improve leadership and management development
- Increase Continuing and Personal & Professional Development opportunities
- Continue improving communication.

Staff engagement

The Trust monitors staff engagement using the key indicators in the annual NHS Staff Survey, and the Friends and Family Test (FFT) for Staff results. Over the past three years the Trust engagement score, as evidenced in the NHS Staff Survey, has improved from 3.63 in 2012 to 3.82 in 2014.

The national average score for acute trusts in 2014 was 3.74 which means that the RUH score was above (better than) average when compared with similar trusts.

There are areas where we need to do further work to improve staff experience particularly in the areas of work pressure, staff both witnessing and reporting potentially harmful errors, near misses or incidents, non-clinical staff feeling secure to raise concerns about unsafe clinical practice, and staff experiencing physical violence and or harassment, bullying or abuse from patients, relatives or the public.

Over the forthcoming year, the Staff Engagement Steering Group will provide strategic leadership to the work across the whole trust, to improve staff experience including staff engagement. The steering group is developing a three-year engagement plan which has six work streams. The focus for year one (2015/16) will be:

Vision, mission and values: The Trust will formulate a new vision and mission. It will co-create a new set of values with staff, patients and stakeholders. It will take time to fully involve managers and leaders in the process of communicating the vision and mission and developing the values. This will provide firm foundations for embedding the values.

Hear it my Way: The Trust will build on the work it has begun using executive patient safety visits, Schwartz Rounds, listening events and focus groups to understand the staff experience. Although the Trust is in the top 20% for its staff engagement score, drill down analysis has highlighted departments where engagement is poor. These areas will be a priority for this work stream.

The Trust will focus its listening events on the areas identified following analysis of the 2014 survey.

Organisational wide / Area Specific: A cross-section of staff will be invited to share their experience and to identify priority actions to address concerns in the following areas:

- Training and Development for support staff (Agenda for Change Bands 1-4)

- Work pressure
- Staff both witnessing and reporting potentially harmful errors
- Near misses or incidents, non-clinical staff feeling secure to raise concerns about unsafe clinical practice
- Staff experiencing physical violence and or harassment, bullying or abuse from patients, relatives or the public.

Ward / Department level: Staff Survey Team Reports will be shared with teams and discussed at team meetings; the output will be departmental / ward level action plans.

In addition, the Trust will identify best practice so that it can be celebrated and built upon. The Trust will introduce a 'Back to the Floor' campaign to enable managers to hear and see what if feels like at the 'sharp end' and what makes the most difference for patients.

Teams: The importance of effective team working within and across teams is well documented. The Trust will increase its internal capacity to provide a programme of teambuilding; initially the focus will be on those teams who are impacted by RUH/ RNHRD integration. In the longer term the focus will be on enabling teams to work effectively across functional, departmental, ward and organisational boundaries.

Leaders and managers: The Trust will build on the success of internally provided leadership programmes for senior staff (for example Service Line Management Development and Leading for Quality) by reviewing provision for entry level leaders. The Trust will focus on putting in place a process to identify aspiring ward Sisters /Charge Nurses and Matrons. Leadership development activities will be priorities for this group to secure a talent pipeline for the future.

A 'Leading for Values' master class will be developed and delivered. This will build the motivation, skills and confidence of senior leaders helping them to role-model the values, make informed choices about how they behave and to manage attitude and behaviour in their teams.

Experience it my way: The Trust will formalise opportunities for staff to experience and learn from their colleagues. Initially the focus will be on individuals working in newly integrated teams as a result of the Trust's acquisition of the RNHRD.

However there is a need to extend this work beyond organisational boundaries to enable individuals and teams to recognise the importance of adopting a health community mind-set for the benefit of patients.

This approach will increase appreciation and co-operation amongst individuals and teams as well as across organisational boundaries. The Trust will achieve this by developing opportunities for secondments and shadowing with well-defined outcomes.

Service Improvement: The Trust has a dedicated service improvement team. Service improvement is an integral module of Trust leadership programmes. In response to feedback from clinical leaders the Trust is exploring the viability of implementing a dedicated service development task force model. In addition, the Trust has supported two senior clinical members of staff to attend a 'train the trainer' programme with the aim of training 40 people to take forward service improvement over the next year.

Social, community and human rights issues

All Trust policies and procedures were based on national employment legislation, adhered to the NHS constitution staff pledges and contained an equality and diversity impact assessment – to ensure upholding of social, community and human rights principles. During 2014/15 the Trust had no social, community or human rights violation issues.

Environmental matters and sustainability

To allow comparison with previous years, this section covers the period 1st April 2014-31 March 2015. In the last year the Estates & Capital Projects teams have successfully completed a number of major projects which have brought real benefits for staff and patients at the hospital. The year started off with the opening of the new Urgent Care Centre adjacent to the Emergency Department which has enabled the provision of a new walk-in service which was officially opened by Sir Bruce Keogh in July 2014. Other major projects complete in year include:

- Opening of the new £13m pathology laboratory and mortuary
- Major refurbishment of Parry Ward was completed in August 2014
- The new Friends coffee shop was opened in October by Mary Berry
- A new landscaped garden for Combe Ward which was funded earlier in the year by the Department of Health.
- In December the new £2.5m office block for the IT & Medical Records teams opened.

Apart from these major capital buildings, we have invested heavily during the year in the electrical infrastructure, installing a new standby generator to protect the central area of the hospital and the new pathology laboratory. As it is remotely operated, it allows the Trust to generate electricity for sale to the grid. We have also upgraded wards and public spaces and provided ten additional bed spaces on site, including four en-suite rooms in the older persons unit. The cardiac ward has been fitted with new windows, flooring and has been re-decorated throughout. In the Princess Anne Wing the maternity ward has benefited from the creation of a bereavement suite which was funded from Department of Health monies.

The intention is to spend our limited resources wisely in order to improve the environment based on a priority list and risk assessments.

The major capital resource activity this year has been spent in planning the new pharmacy department which represents Phase One of our major development programme named ‘Fit for the Future’. The planning application for the pharmacy was approved just before Easter, enabling the start on site to be in the Summer of 2015. The new pharmacy will be located in the former P3 car park and will include five aseptic suites, thus future proofing it for the manufacture of radiotherapy, chemotherapy and gene therapy drugs. The new unit is located adjacent to the main clinical areas of the hospital and will improve the effectiveness of this service.

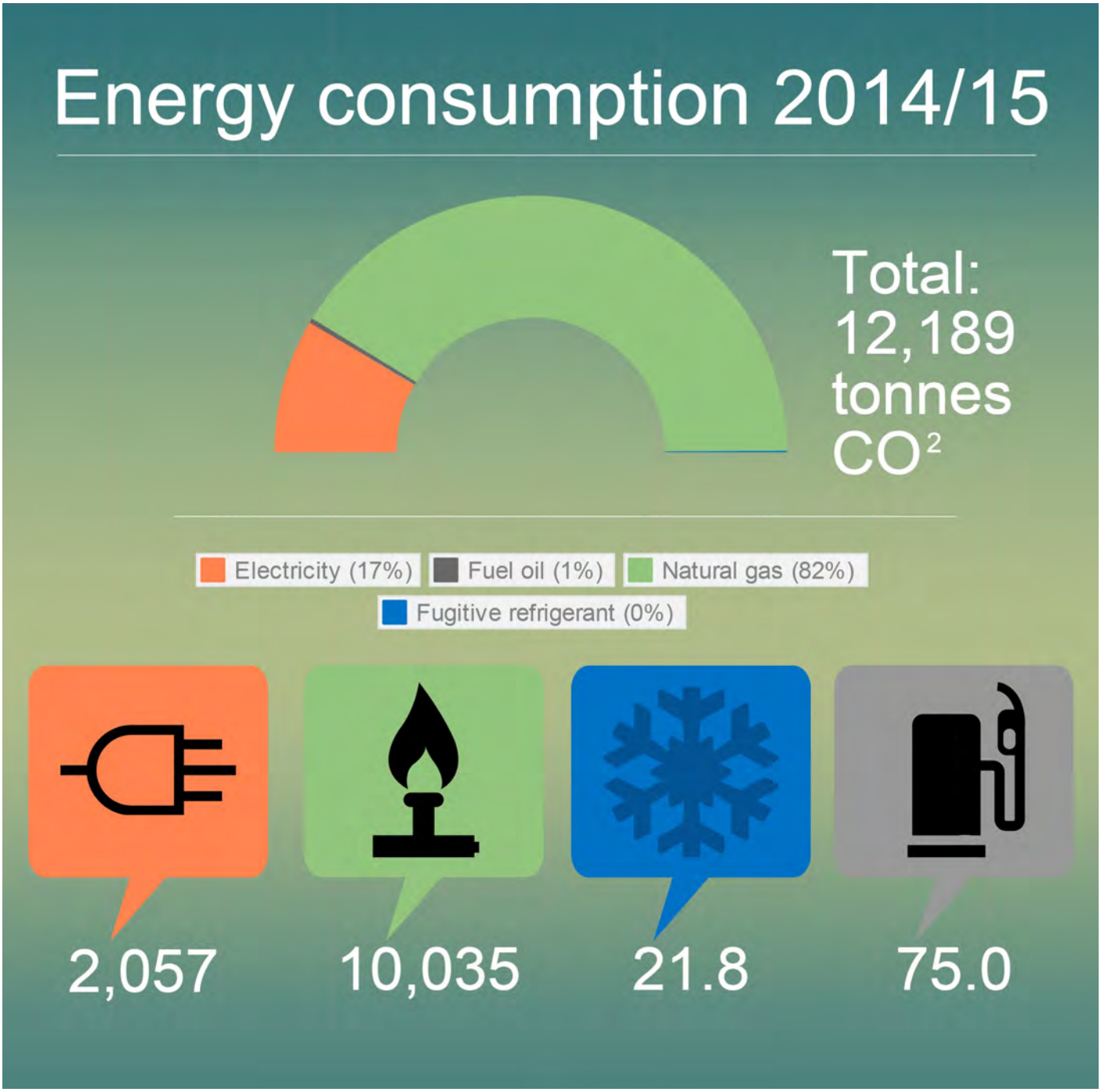
The space released by the old pharmacy will allow us to construct new facilities for our therapies teams and RNHRD services. Plans are also in place to design the new Cancer building which will be the culmination of our estates strategy for the North part of our site.

We are able to report a reduction in our backlog maintenance liability of £10m. We are therefore on track to virtually eliminate this figure by the end of the development programme.

The sustainability agenda in 2014/15

Alongside the Capital Development Plan the Estates & Facilities Division has been targeting investment to improve our sustainability performance. Examples are given below:

- A new Combined Heat and Power (CHP) engine within the new boiler house saved the Trust an estimated £415,000 in 2014.
- We have been awarded funding to install an absorption chiller to convert summer heat from the CHP unit into cooling for the planned new pharmacy building.



- Retrofitting the majority of the hospital's lighting with LED units has greatly improved the ambience of our buildings and saved an estimated £210,000-£250,000 per annum.
- A new Environment Champions Toolkit has been developed and launched which will support future engagements with staff, helping them reduce their environmental impact, providing user feedback and reducing costs.
- The re-use and recycling system 'any takers' has been moved from an email distribution list to a website which will foster greater uptake.
- We have worked with the B&NES Council team to promote sustainable transport and have invited them to engage with our staff through their transport roadshows.
- We have also agreed a deal with the City Car Club to place two new hybrid cars on site for business and personal use. This will assist greatly with journeys to and from our expanding community services, i.e. maternity birthing centres and the RNHRD.

- The salary sacrifice Cycle Scheme processed 94 bicycles in 2014, saving staff an average of £240 each and the RUH £9,731 in National Insurance costs.
- We have adopted the 'Next Bikes' scheme which works in the same way as London's 'Boris Bikes', siting a station outside our main entrance that allows for better cycling connectivity with the city, bus and train stations.
- There has been increased use of our Park & Ride scheme from Odd Down, which we subsidise.
- Investments were made to enable waste segregation during transport on site and a new waste manual is under development which will better support staff in reducing the amount of waste they produce and in safely managing that which is unavoidable.
- Improved heating controls have been installed in the on-site accommodation blocks, the West ward area, Bath and Wessex House, the Oasis Centre, and Theatres 9A and 9B.
- A five-year partnership with Avon Wildlife Trust has been initiated to proactively manage biodiversity during new building projects at the site and to maximise crossover with the charity's health and well-being projects that promote the health benefits of enjoying the outdoors and nature.
- There have also been significant investments in staff capacity with the appointment of a Compliance and Sustainability Manager and Compliance and Sustainability Analyst.

Energy consumption

Historic data on the consumption of finite resources is given below. Total energy consumption has been effectively flat; this represents significant progress. Energy demand has not increased while the new pathology laboratory has been added. Furthermore, switches in the demand profile between gas and electricity represent progress. Gas is a much lower CO2 fuel and is also significantly cheaper per unit. Increased availability of the CHP (combined heat and power engine) allowed increased gas consumption: 54.2GWh compared to 45.5GWh previously. This allowed us to reduce imported electricity to 3.4GWh, down from 11.0GWh in the previous year. Due to the points raised above, plus reduced energy unit prices, although usage remained flat, costs dropped significantly to £2.15m, compared to £2.55m in the previous year. Total tonnes CO2 equivalent emitted also reduced from 14,140 to 12,189 tonnes.

Energy and CO^2 emissions		2012/13	2013/14	Apr 14-Oct 14*	Nov 14-Mar 15*	Total 2014/15
Non-financial indicators (tonnes CO2)	**Total**	**14,727**	**14,140**	**6,273**	**5,916**	**12,189**
	Electricity	6,141	6,309	1,201	856	2,057
	Natural gas	8,270	7,503	5,021	5,013	10,035
	Fuel oil	62	74	36.2	38.8	75
	Fugitive refrigerant	254	254	14.2	7.6	21.8
Related energy consumptions (millions kWh)	**Total**	**56.1**	**57.5**	**29.3**	**28.5**	**57.9**
	Electricity	11.3	11.0	2.1	1.3	3.4
	Natural gas	44.5	45.5	27.1	27.1	54.2
	Fuel oil	0.3	1.0	0.13	0.14	0.3
Financial indicator (£k)	**Total**	**2,526**	**2,554**	**1,125**	**1,023**	**2,148**
	Electricity	993	1,012	312	185	496
	Natural gas	1,516	1,485	804	828	1,632
	Fuel oil	17	57	10	10	20

Changes in the waste management practices at the hospital have resulted in an increased scope of report-

ing when compared to the previous year, giving an increase on 2013/14 tonnages, but approximately flat performance when compared to 2012/13. Improvements to the waste management performance of the hospital will be driven by the release of a new waste manual in 2015/16.

Waste production		2012/13	2013/14	Apr 14 - Oct 14*	Nov 14 - Mar 15*	Total 2014/15
Non-financial indicators (tonnes)	**Total Waste**	**1,364**	**1,213**	**804**	**554**	**1,358**
	Incinerated	145	161	95	75	170
	Alternative treatment	202	265	142	129	272
	Landfill	640	638	369	239	609
	Recycled	353	149	198	110	308
Financial indicators (£k)	**Total Waste Disposal Cost**	**330**	**265**	**199**	**147**	**346**
	Incinerated	104	72	54	43	97
	Alternative treatment	91	74	50	45	95
	Landfill	91	91	73	47	119
	Recycled	56	27	23	13	36

Finally, water consumption has increased in 2014/15 due to known leaks and increased intensity of new hospital processes that have been introduced. The water leaks are being addressed through a rolling programme of pipework investigation and replacement. Targets for water conservation will be included in the sustainability strategy refresh of 2015/16.

Water usage		2012/13	2013/14	Apr 14 - Oct 14*	Nov 14 - Mar 15*	Total 2014/2015
Non-Financial Indicator ('000m³)	Water Consumption	173	206	131	89	220
Financial Indicator (£k)	Water Supply Costs	303	367	271	129	400
	Sewerage Costs	N/A	163	120	58	178

The projects and data listed above demonstrate the commitment of the RUH to improving our sustainability performance.

In 2015/16 we will review our sustainability objective to 'improve the efficiency of our estate through improved utilisation, functionality and sustainability of our buildings.' The aim is to update this objective with performance targets that align with national sustainability targets. We also plan to formalise our sustainability management and reporting system, selecting and implementing an internationally recognised management system. These two initiatives will enable us to develop a ten year sustainability strategy for the organisation which will involve setting specific performance targets that align with UK policy.

Our future strategy

The Trust serves a mixed urban and rural population. Overall life expectancy across our local area is either the same or above the national average. Whilst this is an indicator of good overall health and wellbeing amongst the Trust's population, it also reflects the increasing numbers of older age patients we serve. This group of patients typically have higher numbers of long term conditions and require greater input from a range of health, social care and voluntary sector organisations to enable them to look after themselves. This presents both operational and economic challenges; we are working closely with colleagues across our wider health and social care community to deliver care in an integrated way to improve quality and experience for patients and to reduce duplication across the wider community.

The Trust now proveds maternity services and, whilst the current birth rate is not expected to rise, it is anticipated that – in line with national trends – the number of older age mothers and those with other health and wellbeing needs that could affect their pregnancy (eg obesity, diabetes, mental health needs) will increase. This will result in a larger proportion of mothers potentially requiring hospital based maternity care.

The NHS Five Year Forward View (Department of Health, October 2014) and the Dalton Review (Department of Health, December 2014) set out ambitious plans for the future delivery of services. They both focus on the provision of joined-up care, so services are easier to navigate, duplication is reduced and patients have faster access to the right care, in the right place, first time. Across our local community, our commissioners are already developing strategies to achieve this and we are working with them to understand the impact on hospital services and how we can work differently, together.

We are now in the final phase of our business model and strategy that underpinned the original Integrated Business Plan which we submitted to Monitor as part of our Foundation Trust application. In 2015/16 it will be timely to review and refresh our Trust vision, strategy and values taking account of the developments in year and changing environment. We have already started work on our new strategic plan, taking into account national and local changes.

Our Board of Directors has discussed three broad ambitions for our Trust:

System Leader – acting as a leader and catalyst of change in our local health community, working with colleagues across health and social care to ensure that we are providing the right care for our patients, first time and developing a strong reputation for innovation and research.

A hospital without walls – working in partneship with others to remove barriers to seamless care and, where possible, delivering services in community settings, meaning that patients do not have to travel for treatment and can benefit from a more joined up approach to healthcare provision.

Provider of Choice – continuing to deliver and develop ever safer and higher quality care for our patients, as demonstrated through feedback from patient experience, consistently strong performance metrics, 'outstanding' CQC ratings, strong market share performance, innovation in care provision and access to the latest treatments and techniques.

During the coming year, we will be continuing our journey and developing further detail in our plans to deliver against these ambitions over the longer term. The following table provides an overview of how we will do this, based on our agreed operational plan:

Strategic Aim	Supporting Strategies
System Leader	**Quality strategy – leading quality improvement across our local community through:** • Sign up to Safety • Extending Rapid Spread programme into our community • Delivering our Quality Accounts priorities **Supporting operational delivery through:** • Improving discharge to support patient flow across the community using new models such as Discharge to Assess • Developing new models of care across our community **Enabling our workforce through:** • Leading workforce change across our local community, ensuring that our staff have the right skills and values to deliver care now and in the future • Developing our innovations model, staff engagement skills to support ever greater frontline leadership.
Hospital without walls	**Expanding our services to:** • Increase clinics in community settings, promoting care closer to home • Develop new models of integrated care with community partners • Integrate services with those of the RNHRD **Enhancing our workforce to:** • Develop new roles operating across organisational boundaries to provide more seamless care for patients • Support staff in delivering new models of care through skills development and training
Provider of Choice	**Improve patient experience through:** • Roll out of the Patient Empowerment Programme • Reviewing our Patient and Carer strategy • Improving catering and cleaning • Implementation of the Electronic Patient Record **Improving our environment through:** • Redeveloping the RUH site, constructing new Pharmacy, Therapies and Cancer buildings and improving car parking • Increasing capacity in pressured services **Enabling our staff to provide excellent care through:** • Engaging our workforce, supporting ongoing recruitment and retention • Promoting health and wellbeing at work to enable staff to perform their roles to a high standard

Principal risks and uncertainties

The Trust faces a number of operational, strategic and financial risks. Principal risks facing the Trust in 2014/15 are outlined in the Annual Governance Statement on page 172. Key challenges and risks facing the Trust in 2015/16 include:

- Supporting and delivering greater integration in service provision between primary, community, secondary and social care
- Creation of a dynamic bed base that is able to provide concurrent capacity for both elective and non-elective services
- Constructing clinical environments that are fit for purpose and reflect the quality of service provision
- Continuing to develop a workforce that is able to meet the changing needs of an increasingly older population, across organisational boundaries
- Capacity across the health system to manage the increasing challenge of patients with long term conditions
- Increasing financial and operational challenges across the local health system

James Scott
Chief Executive
Royal United Hospitals Bath NHS Foundation Trust

27 May 2015

2 Directors' Report

This report is prepared in accordance with the NHS Foundation Trust Code of Governance and the NHS Foundation Trust annual reporting manual 2015/15 published in March 2015.

Directors of the Trust

The following Directors were appointed to the membership of the Board of Directors on 6 November 2014 following authorisation as an NHS foundation trust on 1 November 2014:

Name	Role	Term of Office (for Non-Executive Directors)
Brian Stables	Trust Chairman	Current term of office ends on 31/03/2016
Michael Earp	Non-Executive Director	Term of office ends on 31/10/2015*
Joanna Hole	Non-Executive Director	Current term of office ends on 31/10/2015*
Moira Brennan	Non-Executive Director	Current term of office ends on 31/01/2016
Nigel Sullivan	Non-Executive Director	Current term of office ends on 31/07/2016
Nick Hood	Non-Executive Director	Current term of office ends on 31/07/2016
James Scott	Chief Executive	
Sarah Truelove	Deputy Chief Executive and Director of Finance	
Tim Craft	Medical Director	
Francesca Thompson	Chief Operating Officer	
Helen Blanchard	Director of Nursing and Midwifery	
Claire Buchanan	Director of Human Resources**	
Jocelyn Foster	Commercial Director**	
Howard Jones	Director of Estates and Facilities**	

** The unexpired terms of office for Michael Earp and Joanna Hole were less than 12 months in duration and therefore their terms of office have been extended to 12 months from the date of authorisation in line with the NHS Foundation Trust's Constitution.*

***Non-Voting Members*

Upon authorisation as an NHS foundation trust on 1 November 2014, the Council of Governors appointed the Trust Chairman and Non-Executive Directors in accordance with the Trust's Constitution in relation to the appointment of the first NHS Foundation Trust Chairman and Non-Executive Directors. All future Chairs and Non-Executive Directors will be appointed for a three-year term of office and will be eligible to be considered for re-appointment for another three year term of office, subject to the Chairman confirming to the Council of Governors that following a formal performance evaluation process, the performance of the individual proposed for re-appointment continues to be effective. Any term beyond six years (eg, two

three-year terms) will be subject to rigorous review, and should take into account the need for progressive refreshing of the board. The Trust considers each of the listed Non-Executive Directors to be independent. Further details about the Board of Directors can be found on pages 42-57 of the annual report.

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.

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.

Disclosures

Better Payment Practice Code

The national "better payment practice code" requires the Trust to aim to pay all valid invoices within 30 days of receipt or the due date – whichever is the later.

Cost Allocation and charging requirements

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Investments

The Trust made no investments through joint ventures or subsidiary companies and no other financial investments were made. No financial assistance was given by the Trust.

Charitable funds

All charitable fund expenditure is classed as granted to the hospital from its charities. Items over £5,000 are capitalised, where appropriate, and included in the Trust's closing non-current assets on its Statement of Financial Position. The Charitable Funds Annual Report and Accounts for 2014/15 is published separately and is available from the Trust upon request.

Following the acquisition of the Royal National Hospital for Rheumatic Diseases (RNHRD) NHS foundation trust on 1 February 2015, RNHRD charitable funds are now a linked charity to the Trust's Charitable Funds as approved by the Charities Commission.

Political donations

The Trust has made no political donations during the financial year.

Important events since balance sheet date

There are no important events since the balance sheet date that are likely to have a material impact on both the Trust and financial statements for the five months ending 31 March 2015.

Future developments

The annual report has been prepared during a time of significant transformation for the NHS. The economic challenges facing the health economy will require new ways of working and greater levels of collaboration with partners to ensure the long term clinical, operational and financial sustainability of the Trust.

During 2015/16, the Trust will continue its work to integrate the RNHRD services. More information about future strategy can be found in the Strategic Report on page 30.

Employment issues

The Trust's Equality and Diversity policy and a variety of other supporting policies are the cornerstone of its approach to equality of employment opportunity. We recognise our responsibility to provide (as far as is reasonably practicable) job security of all employees.

Our policies ensure full and fair consideration of applications for employment made by disabled persons, having regard to their particular aptitudes and abilities; for continuing the employment of, and for arranging appropriate training for, employees who have become disabled personsduring the period; and for the training, career development and promotion of disabled 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

Recruitment and selection, promotion, transfer, training, discipline and grievance and all terms and conditions of employment: As a Trust, we recognise the important role we must play as an active and socially responsible member of the local community and that our patients, clients and staff represent the community we serve.

We know that having a committed and motivated workforce depends on staff feeling that they are treated with fairness, respect and dignity and that they have equal opportunities for self-development. We want to ensure that our staff are not discriminated against, or harassed, on the grounds of their ethnic origin, physical or mental ability, gender, age, religious beliefs or sexual orientation. Equally, if this happens, we want staff to feel confident about using our policies to raise concerns and to have them addressed.

A number of actions have been undertaken in the financial year to provide employees systematically with information on matters of concern to them as employees; consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests; encourage the involvement of employees in the Trust's performance; and achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the Trust.

The Trust has formal consultation arrangements through the joint staff consultative and negotiating committee to provide information to staff, consult them through their designated local representatives and take their views into account. The Trust also uses a variety of regular forms of communication to secure engagement with staff:

- Pay-slip bulletin – information pertinent to everyone (corporate development, employment issues etc) circulated to every member of staff with their monthly pay-slip;
- Intranet – Staff can access policies and procedures, patient information, an on-line telephone directory and up-to-date news about the Trust, including finance reports, performance reports and minutes from key meetings such as the council of governors and board of directors;
- Email briefings – Intheweek, an email newsletter sent to all staff every Monday via their individual NHS email accounts, on a variety of subjects affecting the Trust – from departmental moves to briefings on clinical issues
- All staff email – used to share critical information
- Team Brief – a newsletter shared with managers across the Trust containing information to be shared in team meetings
- Open Staff Meetings – held monthly to provide staff with the opportunity to find out about what is going on in the hospital;
- Staff magazine – @RUHBath is a colourful newspaper published once a month, packed full of news from around the Trust and with a focus on staff and the roles they play in the organisation;
- Posters, leaflets, reports – produced specifically for staff
- Twitter – the Trust has its our own private Twitter account which all staff can request to join in
- Membership magazine – Insight Magazine is distributed to all community and staff members of the Trust every quarter and updates the Trust's membership on service developments, proposals and plans
- The Bright Ideas & Innovation programme to support and empower staff to put forward and implement ideas for innovation and service improvement
- Publication of our new Workforce Strategy, which sets out how we will attract, recruit and retain appropriately skilled, qualified and experienced staff who share our values, demonstrate our agreed behaviours and who will deliver safe, compassionate, excellent care.

Significant activities in the field of research and development

In 2014/15 research activity has remained high in the RUH. Now that the RUH has acquired the RNHRD, the research activity has increased significantly. The total number of studies in the RUH for year was 258, of which 70% was portfolio activity. With the joining, the total becomes 328 of which 68% is portfolio. The total number of portfolio patients recruited at the RUH was 757 and the RNHRD was 558, giving a total of 1315. This number of studies and patients means that the combined research activity makes the combined hospital one of the top medium sized acute hospitals in terms of research studies carried out. A significant amount of activity has been carried out in aligning and combining the research structures of both sites of the new hospital. Now that acquisition has occurred, both sites can use the good practise and different cultures to further grow research, and involve more and more patients in the research process. There is strong evidence that a research active hospital has much better and safer overall patient care.

Branches outside the UK

The Trust has no branches outside the UK.

Financial risk management

There are no branches of the RUH outside of the UK, and there was no exposure to the Trust associated with financial instruments.

Accounting policies for pensions and other retirement benefits are set out in note 1.3 to the accounts and details of senior employees' remuneration can be found on page 87 of the remuneration report.

Register of interests

Details of company directorships and other significant interests of the Trust board can be found on pages 48 to 54. The Trust's Governors are also required to comply with the Trust's Code of Conduct and declare any interests that may result in a potential conflict of interest in their role as a Governor of the Trust. The Register is held and maintained by the Membership & Governance Manager and is available to the public via the following methods:

	RUH Membership Office (C27) Royal United Hospitals Bath NHS Foundation Trust Combe Park Bath BA1 3NG
	RUHmembership@nhs.net
	01225 821299 or 01225 826288

Enhanced quality governance reporting

The Board takes clear responsibility for ensuring the quality and safety of services provided by the Trust and has in place robust structures and reporting mechanisms to ensure that quality priorities are identified, monitored and where our performance is below what we expect, that remedial action is taken to improve services.

In April 2014, prior to achieving Foundation Trust status, the Board undertook a self-assessment of its quality governance framework, identifying areas of good practice and areas for development. The Trust also commissioned KPMG to undertake an external audit of the assessment and provided the Trust with a detailed report which informed our action plan focussing on areas that required improvement. This has been monitored by the Trust's Quality Board throughout the year. An annual self-assessment will take place against Monitor's Quality Governance Framework in April 2015. This will ensure that our governance structures are fit for purpose. It is the role of the Clinical and Non Clinical Governance Committees to 'test' our systems and processes in order to assure the Trust that we have robust systems in place for monitoring quality and safety.

We also have a Ward and Outpatient Accreditation programme which uses key performance indicators

(KPIs) to measure the quality and safety of the services provided at individual department level. This is undertaken through analysis of data and observations of care.

Furthermore our Executive patient safety walkabouts are an opportunity for staff to engage with Board members in relation to patient safety and quality and raise any concerns. Our programme of visits by Commissioners and Healthwatch representatives provides an external perspective. In addition, patients and their families/carers have the opportunity to feed back on the quality of care we provide through the Friends and Family Test (FFT) and through patient surveys. We use this information to make changes to the services and care we provide.

Our Trust scorecard is based on the Care Quality Commission domains and our ward dashboards allow for the triangulation of data and information flows from ward to board.

As an NHS Foundation Trust, the RUH will continue to put quality first in developing its services and improving patient care. The Trust has performed well against a wide range of clinical indicators and outcomes, including our own quality goals to improve care for patients with Sepsis and Diabetes. We have made significant reductions in the number of hospital acquired pressure ulcers and our mortality rates remain below the national average. We have performed well against each of the Care Quality Commission domains of providing safe, effective, caring, responsive and well led services and against Monitor's risk assessment framework.

We want to make sure that we work in partnership with patients and their family members and this has been demonstrated in a number of ways throughout the year.

To support improvements in the way in which we handle complaints we invited members of the public who had previously raised concerns to join our staff at a number of workshops to review the process of complaints particularly focussing on the emotions and experiences of all those involved. The result of the workshop was to produce a play 'See it My Way' that was performed to over 200 staff and will be used for training.

At our 'Caring for You' evening on the subject of nutrition, many of our members had the opportunity to sample the food that was being served on the wards that night. The event was highly successful and the feedback given on the taste, texture and appearance of the food was valuable. Feedback from patients through the Friends and Family Test (FFT) cards on the hospital food has allowed us to make improvements to the meal service we provide and this has been evidenced by positive feedback and improvements in the Picker inpatient survey.

We are delighted that our patients and their carers rated our Emergency department in the top five in the country in response to the FFT question 'would you recommend the hospital to your family and friends'. At the end of March 2015, we had the highest FFT inpatient score for the year. Our ward accreditation programme is underway and will ensure that wards across the hospital deliver the same high standards of care.

We are pleased to have met over 90% of our CQUIN targets this year and are making good progress towards agreeing CQUIN goals with our Commissioners for the coming year. More details on this can be found in our Quality Accounts.

In the coming year, we will launch our 'Patient Empowerment programme'. This three-to-five year programme will support a cultural change ensuring that all hospital services are developed to support the patients' needs and ensure that they are involved in any service redesign from the outset.
This will include a review of our patient and carer information.

More information on our performance against key health targets can be found on page 131 onwards. Progress towards targets as agreed with local commissioners (CQUIN) is on page 152 while information on our new complaints process is on page 105.

Stakeholder relations

As the direction of travel for the health service shifts towards more integrated care provision, the Trust continues to develop and expand its partnerships and alliances with other local organisations. Key partnerships that have been developed in the last year include:

Partnerships with NHS colleagues

We have continued to expand and develop our partnerships with GP colleagues across our community – both in terms of providing more care and in planning services. This year, we have established a joint diabetes clinic with GP colleagues in Bath – working with them to plan care for patients with diabetes and reducing the number of hospital appointments patients may need. We are now working with our GP commissioning colleagues to roll this 'case management' approach out more widely across our community.

As part of our work with colleagues in Somerset, we have co-sponsored the development of care hubs across Mendip. These care hubs bring together GPs, community health and mental health colleagues and hospital staff to plan care for those patients with greatest need. These patients often have a range of illnesses, and need careful management to ensure that where possible hospital admissions can be avoided and treatment in the community provided. This is an exciting step forward on a longer journey of transformation for Somerset patients, and we will continue to work with colleagues to progress this further in 2015/16.

We continue to work with GP commissioning colleagues through our Clinical Commissioning Board, developing joint strategies to improve the care of patients through new ways of working. Through the System Resilience Group, we have put in place a range of initiatives to reduce demand, including working with community and voluntary sector colleagues. This has been successful in helping to manage demand and improve the quality of care provided for patients.

Through the acquisition of the Royal National Hospital for Rheumatic Diseases, we jointly established a Local Health Economy Forum between the Trust and our Clinical Commissioning Groups. This Forum was responsible for the strategic oversight of the transaction from a health community perspective, and was instrumental in ensuring a smooth acquisition and transfer of service on 1 February 2015. We would like to thank our commissioning colleagues for their support and input to this process.

During 2015/16 we anticipate that our local commissioners will review the current provision of community services. To prepare for this we have been working closely with colleagues across a range of organisations, helping to support a new, more integrated approach to care.

Links with patient bodies
Healthwatch is a key partner for the Trust, and we have engaged with our local Healthwatch organisations in the last year both through the acquisition of the RNHRD and also more broadly to support ongoing engagement activity. Healthwatch will be a key stakeholder in our Patient Empowerment Programme and we are excited to be continuing to work with them as a partner in the coming year.

Private providers

A range of private partnerships are in place to support the continued delivery of high quality, accessible services for our patients. These include:

- A new partnership with Alliance Medical Ltd to provide PET-CT services at the Trust
- Partnerships with BMI Healthcare, Care UK, Circle (Bath) to provide additional surgical capacity during periods of peak demand

- Cerner continue to support the ongoing development of the Electronic Patient Record across the Trust
- Bath and North East Somerset Doctors Urgent Care Ltd (part of the Vocare Group) to support the ongoing provision of a high quality Urgent Care Centre adjacent to our Trust Emergency Department.

Third sector partnerships

To support our strategic ambitions, we recognise the need to work more closely with, and harness the significant experience and expertise of the third sector. We have expanded and developed our partnerships in the last year, and will continue to do so as we further develop new models of care locally. Key partnership work in year has included:

- Dorothy House Hospice – supporting an integrated approach to care for patients at the end of their life
- Red Cross – providing a night sitting service, enabling patients to be discharged home with support rather than remaining in the hospital without medical need
- Macmillan – a key partner in the development of the Cancer Centre at the Trust and services provided at the Royal National Hospital for Rheumatic Diseases
- Research Institute for Care of the Elderly (RICE) with whom we work closely to support continued research into dementia and input into our Dementia Strategy
- Bath Institute for Rheumatic Diseases (BIRD) – consolidating our immunology services into a single service at the Trust, with staff successfully transferring from BIRD to the Trust in January 2015.
- Bath Cancer Support Group – supporting through capital investment the purchase of the Trust PET-CT scanner
- League of Friends of the RUH and RNHRD whose volunteers work tirelessly for patient and visitor benefit and who have funded improvements to ward areas across the Trust.
- Forever Friends Appeal – providing capital funds for the redevelopment of the Trust site as well as a range of smaller scale projects to improve the fabric and function of services

Council partnerships

The Trust's stakeholder governors include representation from Wiltshire and Bath and North East Somerset Councils, and the Health and Wellbeing Board in Wiltshire.

Academic Health Science Network and links with further education

The Trust hosts the West of England Academic Health Science Network driving new initiatives in patient safety and quality improvement through this relationship. This has included active involvement in the Pre-CePT project to reduce the risks of Cerebral Palsy in preterm labour.

The Trust has an active Research and Development Department, and already works with colleagues from the University of Bath to deliver integrated research programmes. The acquisition of the Royal National Hospital for Rheumatic Diseases has further expanded our research and development portfolio and through this, our links with the University of Bristol and the University of the West of England.

3 Governance of the Trust

Introduction

The Trust's Constitution came into effect on 1 November 2014 when the Trust was authorised as an NHS Foundation Trust. A small number of changes were made to the Constitution after 1 November 2014 to incorporate changes to the Model Election Rules to allow electronic voting for public governors and the deletion of the section on the nomination process for non-executive directors because the process was more fully set out in the Terms of Reference for the Council of Governors Nominations and Remuneration Committee. The Constitution was further amended to reflect the acquisition of the Royal National Hospital for Rheumatic Diseases on 1 February 2015.

Role of the Board of Directors

The Board of Directors is collectively responsible 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 governance as set out in the Monitor 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 the resources are used in the most appropriate way;
- Providing leadership of 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, 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;
- 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 monthly (with the exception of August) with provision to hold extraordinary meetings as and when required. The Board of Directors has a formal schedule of matters specifically reserved of its decision. This includes approving strategy, business plans and budgets, regulations and control, annual report and monitoring how the strategy is 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

Board meetings follow a formal agenda which is ordered under the headings of:

- Quality, patient safety, effectiveness and experience;
- Operational performance and use of resources;
- Corporate governance, risk and regulatory; and
- Strategy and business planning and improvement.

The Board of Directors have 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. On-going development is provided collectively by the monthly Board Seminars and Away Days and individual training needs are assessed through the appraisal process. All directors attend regional and national events.

The Board of Directors develops its understanding of the view of Governors and Members through a variety of mechanisms. This includes:

- attendance by Executive Directors and Non-Executive Directors at Council of Governors meetings;
- attendance at joint Board and Council away day events;
- participation in meetings involving Members, such as at the Annual Members Meeting, the Members *Caring for You* events;
- Executive Director attendance at Governor Constituency meetings.

Appointment of the Board of Directors post authorisation as an NHS Foundation Trust

Following authorisation as an NHS Foundation Trust on 1 November 2014, the Council of Governors held their inaugural meeting on 6 November 2014 and formally appointed the Chairman, Brian Stables, a Vice Chairman, Michael Earp and Moira Brennan, Joanna Hole, Nicholas Hood and Nigel Sullivan as Non-Executive Directors. A Committee of Directors (comprising the Chief Executive, Chairman and Non-Executive Directors) met on the same day and formally appointed the Executive Directors.

The first meeting of the Board of Directors post authorisation appointed the Vice Chairman, Michael Earp as the Senior Independent Director, in consultation with the Council of Governors. Going forward, the Council of Governors' Nominations and Remuneration Committee comprising the Chairman, Senior Independent Director, Public Governors, one Stakeholder Governor, one Staff Governor with support from the Director of Human Resources and Chief Executive will be responsible for recommending to the Council of Governors the appointment, re-appointment, dismissal and setting the remuneration of the Chairman and Non-Executive Directors in accordance with the Trust's Constitution.

The Council of Governors Nominations and Remuneration Committee met on 5th March 2015 to discuss the recruitment process to appoint a new Non-Executive Director to replace Michael Earp, Non-Executive Director when his term of office ended on 31 October 2015. The Committee approved the appointment of an external recruitment agency to assist the Trust with the recruitment and selection process.

The Board of Directors' Nominations and Remuneration Committee, comprising the Chairman and Non-Executive Directors assisted by the Chief Executive and the Director of Human Resources is responsible for appointing the chief executive and executive directors and for determining their terms and conditions, including remuneration.

Chairman

The Chairman is responsible for ensuring that the Board of Directors focuses on the strategic development of the Trust and for ensuring 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.

Non-Executive Directors

Executive Directors are responsible for the day to day operational management of the Trust. Non-Executive Directors share the corporate responsibility for ensuring that the Trust is run efficiently, economically and effectively. Non-Executive Directors use their expertise 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 for a three year term of office. A non-executive director can be re-appointed 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. 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 Chairman, satisfactory performance and the needs of the board of Directors. In any event, a non-executive director's term of office will not exceed nine years.

The Chairman and 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 Chairman 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

Directors' summary biographies are set out on pages 48-54. These describe the skills, experience and expertise of each director.

There is a clear separation of the roles of the Chairman and the Chief Executive. The Board of Directors approved the respective roles of the Chairman and the Chief Executive at its first meeting post authorisation as an NHS foundation trust. The document is published on the Trust's public website.

All of the Non-Executive Directors of the Trust are considered to be independent in accordance with Monitor's NHS Foundation Trust Code of Governance. The Board considers that the Non-Executive Directors bring a wide range of business, commercial and financial knowledge required for the successful direction of the Trust. The Board of Directors confirmed the statement of non-executive directors independence at its meeting on 6 November 2014 (the first meeting post authorisation as an NHS Foundation Trust).

The balance, completeness and appropriateness of the Board of Directors is reviewed at least annually to ensure its effectiveness. In 2014/15 this was undertaken as part of the Board Governance Assurance Framework and Quality Governance Framework review processes as required by Monitor's NHS foundation trust assessment process. At the present time, the Board is satisfied as to its balance, completeness and appropriateness and will continue to keep these matters under review in consultation with the Council of Governors.

The Board of Directors and the Council of Governors work closely together in the best interests of the Trust.

Detailed below is a summary of the key roles and responsibilities of both the Board of Directors and the Council of Governors.

The Board of Directors and the Council of Governors held a joint away day in December 2014 to discuss business planning.

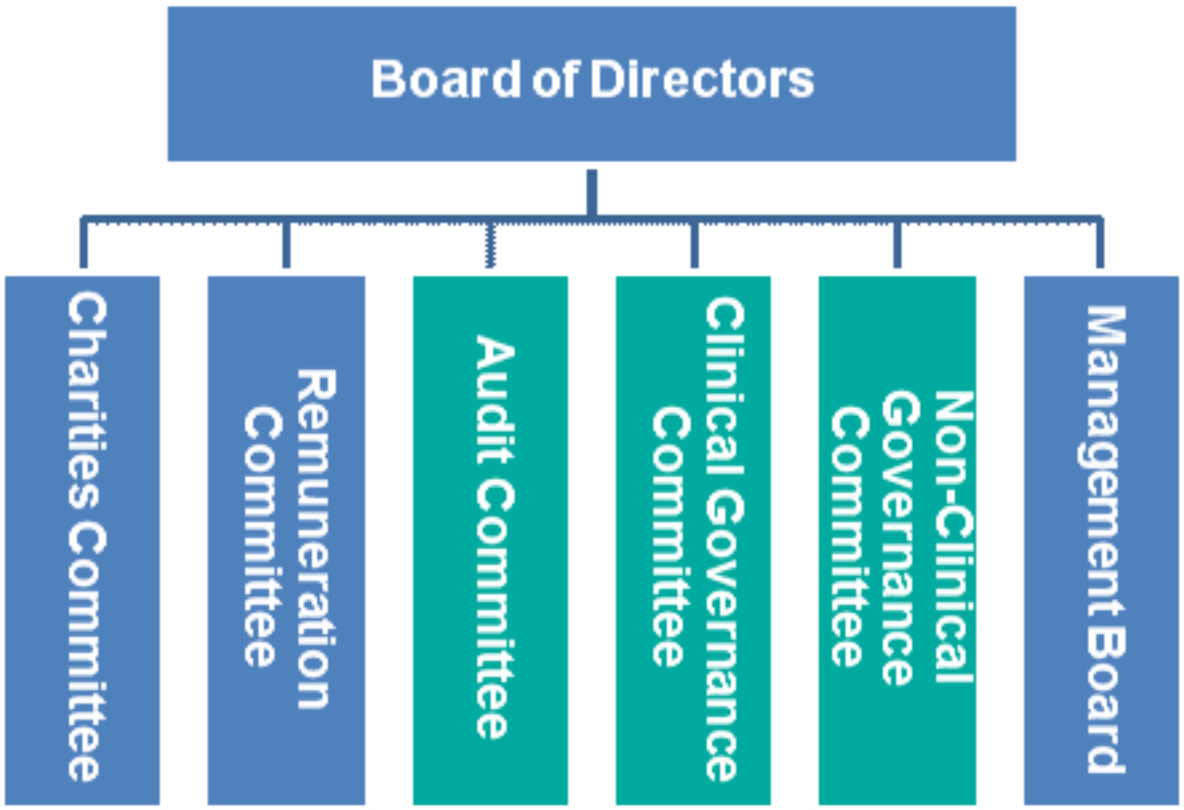
Board development

Evaluation of the Chairman's performance is led by the Senior Independent Director under the auspices of the Council of Governors' Nominations and Remuneration Committee. The Council of Governors' Nominations and Remuneration Committee is also responsible for evaluating the performance of the Non-Executive Directors. The Chief Executive's performance is evaluated by the Chairman. 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. The away days 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 held after each Board meeting on a range of topical issues. Individual directors attend a range of formal and informal training and networking events as part of their on-going development.

Board committees

The Board of Directors has the following Committees:



The Board of Directors has delegated responsibilities to these committees to undertake specified activities and provide assurance to the Board of Directors. The Committees provide the Board of Directors with a written report of their proceedings. A summary of each committee's role is set out below:

Management Board

The Management Board 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 organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives.

Audit Committee

The Audit Committee is chaired by Moira Brennan, Non-Executive Director. The Audit Committee is responsible for:

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

Since authorisation as an NHS foundation trust, in addition to the standing items of business, the Audit Committee has reviewed how risk management is embedded within the Estates and Facilities division; the governance systems and processes of the Women and Children's division (which was established in June 2014 when responsibility for maternity services transferred to the Trust; the Royal National Hospital for Rheumatic Diseases (RNHRD) audit requirements post-acquisition; and capital process review arrangements.

Non-Clinical Governance Committee

The NCGC is chaired by Joanna Hole, Non-Executive Director. The Non-Clinical Governance Committee (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, environment and equipment, health and safety, workforce, reputation management, information governance, business continuity and other non-clinical areas as may be identified.

Clinical Governance Committee

The Clinical Governance Committee is chaired by Michael Earp, Non-Executive Director. The Committee 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 incident management and reporting, quality improvement, compliance with the Care Quality Commission's standards, medical records, patient experience, research and development and maintaining clinical competence.

Joint Committee Meetings

The Non-Clinical Governance Committee and Clinical Governance Committee hold six monthly joint meetings to seek assurance of key systems and processes which impact on both non-clinical and clinical areas. For example, the March 2015 meeting considered the process for storing and retrieving medical records; progress made in implementing the electronic patient record programme; and the Trust's Quality, Innovation, Productivity and Prevention Programme (QIPP) processes.

Board of Directors Nominations and Remuneration Committee

The Board of Directors Nominations and Remuneration Committee is chaired by Brian Stables, Chairman. The Committee's key roles and responsibilities are to appoint the Chief Executive and the Executive Directors and to determine the appropriate employment and remuneration and terms of employment for the Chief Executive and Executive Directors.

The Charities Committee

The Charities Committee is chaired by an Independent Trustee.
The Royal United Hospital Charitable Fund was formed under a Deed dated 10 September 1996 as amended by a Supplemental Deed dated 9 December 2009. It is registered with the Charity Commission in England and Wales (Registered number 1058323) ("the Charity").

Following the acquisition of the RNHRD on 1 February 2015, the RNHRD charitable funds are now a linked charity of the RUH.

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 ("Trustees") 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 70 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, focussed on principal Campaigns agreed with the Charities Committee and the Corporate Trustee.

Whilst the Charities Committee is a formal subcommittee 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, reporting to the Full Corporate Trustee of the Charity Annual Report and Accounts and a separate charity strategy.

Commercial Transactions Steering Group

The Commercial Transactions Steering Group is chaired by the Chief Executive. The Board of Directors established this committee in September 2014 to provide scrutiny and assurance of aspects of tenders and other significant transactions as delegated by the Board of Directors.

It was responsible for overseeing the RNHRD acquisition transaction on behalf of the Board of Directors and approved the business transfer agreement between the RNHRD and the RUH.

The Board of Directors Summary Biographies

Chair

Brian Stables
Chair
Appointed:
1 April 2010

Relevant experience

- Previously a Foundation Trust Network Board Member and Trustee
- Previously Non-Executive Director and Vice Chairman of NHS Wiltshire. Chairman of NHS Wiltshire Provider Services Committee
- Director and owner, Profex Associates Ltd
- Member of the Supervisory Board, SC Rolast SA (2003 – 2007)
- Director, Avon Automotive Hose Systems, Avon Rubber plc. (1998 – 2002)
- Mentor, Great Western Enterprise

Qualifications

- Fellow of the Chartered Institute of Management Accountants (FCMA)
- Master of Business Administration (MBA, University of Bath)
- Associate of Trinity College of Music, London (ATCL)

Declared interests

- Director of Profex Associates Ltd - Management Consultancy
- Associate Lecturer, Open University, Mary Seacole Programme
- Trustee, Wiltshire Air Ambulance Charitable Trust
- Wife works part time at Apetito in Trowbridge (Apetito is a food supplier for the RUH)
- Trustee, Wiltshire MIND

Non-Executive Directors

Michael Earp
Non-Executive Director, Vice Chairman, Senior Independent Director
Appointed:
1 December 2004

Relevant experience

- 2001 – Manager of own residential property business and part-time management consultancy
- 2000 – Chief Executive Officer, Fly on the Wall.com Limited – internet video (a precursor to YouTube)
- 1999 – Managing Director, Woodmansterne Publications Limited – greetings card publisher
- 1987 – Managing Director, The Andrew Brownsword Collection – greetings card publisher
- 1985 – Deputy Managing Director of Bonham's – Fine Art Auctioneers & Valuers

Qualifications

- HND in Business Studies (Oxford Brookes)
- Graduate of Chartered Institute of Marketing
- Past Associate of Chartered Institute of Secretaries and Administrators

Committees and other roles

- Vice Chairman of the Trust
- Remuneration Committee
- Audit Committee
- Chairman of the Clinical Governance Committee
- 'Quality' Champion

Declared interests

- None

Moira Brennan
Non-Executive Director
Appointed:
1 February 2008

Relevant experience

- Present – Trustee of the Royal Mail Senior Executive Pension Plan
- 2003 – Royal Mail, held a number of roles including Finance Director of Logistics, Finance Director of West Territory, Financial Controller and Director of Strategic Finance
- 1999 – Finance Director of AstraZeneca UK
- 1998 – Finance Director of Zeneca Australia and New Zealand
- 1995 – International Tax Manager, Zeneca
- 1986-1995 – Chartered Accountant and Chartered Tax adviser, Arthur Andersen

Qualifications

- BSc (Hons) Degree in Business Administration
- Fellow of the Institute of chartered Accountants in England and Wales
- Committees and other roles:
- Remuneration Committee
- Chair of the Audit Committee
- Charities Committee
- Foundation Trust Steering Group
- Whistle Blowing Contact, Sustainability champion

Declared interests

- Bathampton Parish Councillor
- Treasurer of Bathampton Village Hall
- Trustee of St John's

Joanna Hole
Non-Executive Director
Appointed:
1 April 2011

Relevant experience

- 2008-2010 Ministry of Defence Whitehall, Head of Safety, Sustainable Development & Continuity (civilian and military)
- 2006-07 Ministry of Defence Whitehall Director of Business Continuity (civilian)
- 2003 – Ministry of Defence Whitehall Deputy Director HR Development Framework (civilian)
- 2001 – Assistant Director Estate Strategy Defence Logistics Organisation 1999-2001 Head of Secretariat Defence Logistics Organisation
- Prior to 2000, held a number of senior management roles within the Ministry of Defence: delivering business strategy and support, HR policy and career management, Ministerial and Parliamentary business, national and international procurement policy, training management/delivery, and secondment as Material Manager at a major Royal Navy Dockyard

Qualifications

- Cranfield University School of Management,
- Defence Strategic Leadership and Strategic Management Programmes (2007 and 2008 respectively)
- Ashridge Higher Management Training Programme (1998)

Committees and other roles

- Chairman of the Non-Clinical Governance Committee
- Foundation Trust Steering Group
- Non Clinical Governance Committee

Declared interests

- None

Nigel Sullivan
Non-Executive Director
Appointed:
1 August 2012

Relevant experience
- Group HR Director, Talk Talk Group plc
- Group HR Director and Executive Director, Wincanton plc 2002- 2010
- Audit Committee, Wincanton plc 2008-1010
- Pension Scheme Wincanton plc, Trustee Director 2002 – 2010
- Divisional HR Director Rover Group , Nortel, Marconi 1997 – 2002
- Board Member CBI West 2008- 2010

Qualifications
- Bachelor of Science (Honours, University of Bradford)
- Post Graduate Diploma in Personnel Management (Leeds Business School)
- Pension Management Institute Trustee Qualifications

Committees and other roles
- Non-Clinical Governance Committee
- Remuneration Committee

Declared interests
- Director of West Four Apartments Company Ltd

Nicholas Hood
Non-Executive Director
Appointed:
1 August 2012

Relevant experience
- Present - @Bristol, Life Vice-President
- 2005-present – First Group Strategic Advisory Board
- 2001-present – Walk-the-Walk, Chairman
- 1990-present – WWF, Ambassador then Fellow
- 2000-2012 – Brewin Dolphin plc. Deputy Chairman
- 1998-2003 – MHIT plc, Chairman
- 1998-2003 – QHIT plc, Director
- 1994-1997 – APV plc, Director
- 1992-2012 – Member of HRH the Prince of Wales Council for the Duchy of Cornwall
- 1992-1998 – CU Environmental Trust Director
- 1990-1992 – National Westminster Bank, Director western board
- 1988-2007 – Winterthur Life UK Ltd, Director then Chairman
- 1987-1993 – Bremhill Industries plc, Director
- 1989-1999 – Wessex Water plc, Chairman
- 1987-1989 – Wessex Water Authority, Chairman

Qualifications
- Honorary Doctorate, MBA, University of West of England
- Honorary Fellow of the Institution of Water and Environmental Management

Committees and other roles
- Remuneration Committee
- Clinical Governance Committee
- Safeguarding Champion

Declared interests
- None

Executive Directors (voting)

James Scott
Chief Executive
Appointed:
1 June 2007

Relevant experience

- 2007 – Chief Executive
- 1999 – Chief Executive of Yeovil Hospital, a wave 1A NHS Foundation Trust
- Director of Operations, Chase Farm Hospital
- Held a number of senior roles in London hospitals such as St Mary's Paddington and Hammersmith

Qualifications

- BA (Hons) in History
- Diploma in Health Services Management

Declared interests

- Vice Chair and Company Director of the West of England Academic Health Science Network

Sarah Truelove
Director of Finance & Deputy Chief Executive
Appointed:
June 2013

Relevant experience

- 2009-2013 – Director of Finance and Deputy Chief Executive, Gloucestershire Hospitals NHS Foundation Trust
- 2006-2009 – Director of Finance Gloucestershire PCT
- 1993-2006 – Held a number of senior roles in commissioning and acute hospitals

Qualifications

- BA (Hons) in politics
- Member of the Chartered Institute of Public Finance and Accountancy

Declared interests

- Married to the Chief Finance Officer for Wiltshire Clinical Commissioning Group
- School Governor – The Corsham School

Tim Craft
Medical Director
Appointed:
August 2010

Relevant experience

- 2010 to date – Medical Director, Royal United Hospital Bath NHS Trust
- 2003-2010 – Deputy Medical Director
- Chair of the Speciality Division
- Clinical Director of Operations
- 1994-1999 – Clinical Director of Anaesthesia and Critical Care Medicine
- 1994 to date Consultant in Anaesthesia and Critical Care Medicine

Qualifications

- MB BS (London), FRCA 1983
- Health Foundation Leadership Fellow 2004-2005

Declared interests

- Director and shareholder of Anaesthetic Medical Systems (AMS) Ltd.
- Director and shareholder of 10 Bar Ltd

Francesca Thompson
Chief Operating Officer
Appointed:
September 2006

Relevant experience

- 2006 – Director of Nursing, Royal United Hospital Bath NHS Trust
- 2003 – Board Director of Nursing, Great Western Hospitals NHS Foundation Trust

Qualifications

- DIPC. Registered Nurse
- Registered Midwife (lapsed)
- Fellow of Improvement Faculty NHS Institute for Innovation and Improvement.
- MSc Social Sciences, University of Southampton 1996

Declared interests

- Daughter is registered with the Trust's Temporary Bank Staff

Helen Blanchard
Director of Nursing
Appointed:
August 2013

Relevant experience

- September 2007 - July 2013 – Chief Nursing Officer and Director of Infection Prevention and Control, Worcestershire Acute Hospitals NHS Trust
- May 2004 - September 2007 – Director of Nursing and Quality, Hereford County Hospitals NHS Trust
- 1997-2004 – Held a number of senior nursing and midwifery roles in Acute Trusts

Qualifications

- Registered General Nurse
- District Nurse
- Lecturer/practice educator
- MSc Nursing Studies

Declared interests

- None

Executive Directors (non-voting)

Claire Buchanan
Director of Human Resources
Appointed:
October 2013

Relevant experience

- 2012-2013 Acting Director of Workforce and OD University Hospitals Bristol NHS Foundation Trust
- 2008-2012 Deputy Director of Workforce and OD University Hospitals Bristol NHS Foundation Trust
- 1998-2008 various Senior HR positions, United Bristol Healthcare NHS Trust

Qualifications

- MA Human Resource management
- Chartered Fellow of the Institute of Personnel and Development

Declared interests

- None

Jocelyn Foster
Commercial Director
Appointed:
July 2012

Relevant experience:

- 2012 – Commercial Director, Royal United Hospital Bath NHS Trust
- 2011 – Director of Business Strategy, Kent County Council
- 2008 – Strategy Director (Parcelforce), Royal Mail
- 2006 – Strategic and Corporate Development Director, Leicestershire Partnership NHS Trust
- Public and private sector experience in business strategy, planning, transformation and new business development

Qualifications

- Chartered Marketer
- MBA
- DPhil Oxon
- BSc (Hons) Biological Sciences

Declared interests

- Chair of Trustees, Apex Works (Charitable organisation in Leicester providing services to support disadvantaged and marginalised individuals in Leicester into work)
- Complaints Panellist – Dental Complaints Service – Private Complaints Resolution Service
- Trustee of the Disabilities Trust (a national organisation providing brain injury rehabilitation, autism and physical disability services)
- Non-Executive director and shareholder of Veloscient Ltd (An organisation developing a platform to facilitate structured data capture).

Howard Jones
Director of Estates and Facilities
Appointed:
November 2008

Relevant experience:

- 2008 – Director of Estates and Facilities, Royal United Hospital Bath NHS Trust
- Director of Estates and Facilities, East Kent Hospitals NHS Foundation Trust.

Qualifications

- B Eng (Hons) MSc C Eng MCIBSE FIHEEM
- Chartered Engineer, Degree in Environmental Engineering
- MSc in Corporate Real Estate Management.

Declared interests

- None

Contact with the Directors

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

Board of Directors and Council of Governors

The Chairman also chairs the Council of Governor meetings. This is a unique position which ensures that there is effective communication between the Board and the Council. Governors are invited to discuss strategic issues in detail at the Council of Governors meetings and advise the Chairman of their views. The Chairman ensures their views are considered at the Board of Directors meetings as part of the decision-making process.

Governors are invited to attend Public Board of Directors meetings and Non-Executive and Executive Directors are in attendance at Council of Governors meeting. Informal joint meetings between the directors and the governors are held twice a year.

Where a dispute between the Council of Governors and the Board of Directors occurs, in the first instance the Chairman would endeavour to resolve the dispute. Should the Chairman be unable to resolve the dispute, the Senior Independent Director and Lead Governor would jointly try and resolve the dispute. Should the Senior Independent Director and the Lead Governor not be able to resolve the matter, the Board of Directors, pursuant to section 15(2) of Schedule 7 of the 2006 Act, would decide the disputed matter.

Board of Directors Membership and Attendance – 1 November 2014-31 March 2015

Name	Position	Board of Directors	Audit Committee	Non-clinical Governance Committee	Clinical Governance Committee
Brian Stables	Chairman	6/6			
Michael Earp	Deputy Chairman and Senior Independent Director	6/6	2/2		3/3
Moira Brennan	Non-executive Director	5/6	2/2		
Joanna Hole	Non-executive Director	4/6	2/2	2/2	
Nicholas Hood	Non-executive Director	4/6			1/3
Nigel Sullivan	Non-executive Director	5/6		0/2	
James Scott	Chief Executive	6/6			
Sarah Truelove	Deputy Chief Executive and Director of Finance	6/6	2/2		
Helen Blanchard	Director of Nursing and Midwifery	4/6			2/3
Claire Buchanan	Director of Human Resources	6/6		2/2	
Tim Craft	Medical Director	3/6			3/3
Jocelyn Foster	Commercial Director	5/6		2/2	
Howard Jones	Director of Estates and Facilities	6/6		2/2	
Francesca Thompson	Chief Operating Officer	6/6		1/2	

Notes

X/Y = number of meetings attended out of the total number possible

= Director is not a committee member

Board of Directors Membership and Attendance contd

Name	Position	Nominations and Remuneration*	Commercial Transactions Steering Group	Charities Committee
Brian Stables	Chairman		2/2	2/2
Mihcael Earp	Deputy Chairman and Senior Independent Direcotr			
Moira Brennan	Non-executive Director		1/2	1/2
Joanna Hole	Non-executive Director			
Nicholas Hood	Non-executive Director			
Nigel Sullivan	Non-executive Director			
James Scott	Chief Executive		2/2	
Sarah Truelove	Deputy Chief Executive and Director of Finance		2/2	2/2
Helen Blanchard	Director of Nursing and Midwifery			0/2
Claire Buchanan	Director of Human Resources		2/2	
Tim Craft	Medical Director			
Jocelyn Foster	Commercial Director		2/2	2/2
Howard Jones	Director of Estates and Facilities			
Francesca Thompson	Chief Operating Officer			

Notes

X/Y = number of meetings attended out of the total number possible

= Director is not a committee member

= The Nominations and Remuneration Committee did not meet during the period of this annual report

4 Foundation Trust Membership

Being an NHS Foundation Trust means that we are a membership-led organisation that has a duty to be responsive to and meet the needs of our local community. We are accountable to our members who are represented by an elected Council of Governors. The Royal United Hospitals Bath NHS Foundation Trust is made of public and staff members.

Members are able to:

- Have a say over how services at the RUH are run
- Provide feedback based on personal experiences as well as those of family and friends
- Come to special Members' events to gain an insight into the hospital's activities
- Vote for the public governors who will represent the members and hold the hospital to account
- Take responsibility for shaping the services provided by the RUH now and in the future
- Receive copies of Insight, the hospital's quarterly magazine.

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 twelve months are automatically registered as members unless they choose to opt out. Staff members are represented by five governors. Staff from the RNHRD automatically transferred to the RUH membership upon acquisition, in line with conditions outlined above.

How many members do we have?

The table below highlights the Trust's actual and target public membership figures for 31 March 2015:

Category	Actual 31 March 2015	Target 31 March 2015
Public	9,072	8,000
Staff	4,796	4,500
Total	13,868	12,500

Constituency breakdown	As at 31 March 2015
City of Bath	1,964
North-East Somerset	1.649
Mendip	1,005
North Wiltshire	1,470
South Wiltshire	1,791
Rest of England and Wales	1,193
Staff	4,796

Membership size and movements		
Public constituency	**Last year (2014/15)**	**Next year 2015/16 (predicted)**
At year start (1 April 2014)	7,303	9,072
New members	2,064	1,228
Members leaving	295	300
At 31 March 2015	9,072	10,000
Staff constituency	**Last year (2014/15)**	**Next year 2015/16 (predicted)**
At year start (1 April 2014)	3,676	4,796
New members	1,335	600
Members leaving	215	600
At 31 March 2015	4,796	4,796

Public Constituency	Number of members	Eligible membership
AGE		
0-16	28	152,009
17-21	620	48,192
22+	7,502	570,574
ETHNICITY		
White	7,749	728,501
Mixed	45	9,462
Asian or Asian British	113	11,684
Black or Black British	61	4,764
Other	23	1,865
Unknown	1,081	n/a
SOCIO-ECONOMIC GROUPING		
AB	2,700	60,698
C1	2,649	69,365
C2	1,813	48,403
DE	1,814	45,242
Unknown	96	n/a
GENDER		
Male	3,261	380,174
Female	5,784	390,601
Unknown	27	n/a

Developing a representative membership

The Board of Directors and the Council of Governors are committed to growing the Trust's membership and for ensuring that the membership is representative of the local community served by the Trust. The Council of Governors' Membership and Outreach Working Group regularly reviews membership data and develops action plans for targeted membership recruitment activity to increase membership amongst particular groups or localities if membership is unrepresentative.

A further Membership Development Strategy has been developed by the Membership & Governance Manager in conjunction with the Governor Membership and Outreach Working Group. The working group was developed to support the Trust in growing and developing its membership, developing methods of communication and engagement with the members and the local community including hard to reach and underrepresented groups and to ensure that the Council of Governors and the Trust takes account of the views of its membership.

The Membership Development strategy sets out objectives to develop further 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 primary objectives are as follows:

- To create an engaged and supportive membership, representative of the public and stakeholders in our area.
- To inform members of the health landscape and provide them with the information to access services and make the best health choices.
- To enable members to influence the services the Trust offers them and hold the Board to account for the delivery of those services.
- To develop the infrastructure and processes to enable efficient and effective dialogue between the Trust Board and its members.

Engaging with members

The Trust has 9,072 local people registered as members of the Trust, and a further 4,796 staff members. This is an audience of almost 13,686 people to seek views and opinions from. Responsibility for developing member engagement falls to the Council of Governors Membership and Outreach working group.

The Trust has implemented a number of feedback mechanisms to ensure regular engagement and communication with members, these include:

- Members' quarterly newsletter – Insight
- E-communications
- Caring for You events
- Governor Constituency meetings
- Online surveys
- Annual Members Meeting

During the course of their time in shadow form, Governors have been developing ideas on how to engage with and listen to their constituents. The Mendip and North Wiltshire Governors have embarked on a great

piece of work to engage with their members and have been hosting Governor Constituency meetings to seek the views of their constituents.

Caring for You Events

Our Caring for You events are designed exclusively for our members and give our members and the public the opportunity to step behind the scenes and understand more about the work of the hospital and how it supports the health and wellbeing of the local communities.

Past events have included tours of the operating theatres, talks on surviving cancer, men's health, food and nutrition and many more. The aim of the events is to give members a view of the hospital from a different perspective, in order to help them connect more closely with the work the hospital.

Royal National Hospital for Rheumatic Diseases (RNHRD)

The Chairmen of RNHRD and RUH Bath sent a joint letter encouraging existing members of RNHRD to become members of the RUH. We had a good response, and welcomed over 650 members from RNHRD to RUH membership.

In order to facilitate an ongoing relationship between the RUH and RNHRD Stakeholder Governors, Brian Stables, Chairman, contacted all RNHRD Stakeholder Governors to explore levels of interest and any opportunities for future involvement in some of the key issues surrounding the integration and development of the acquired RNHRD services.

Council of Governors

Composition, roles and responsibilities

When Parliament created NHS foundation trusts, it gave them independence from central government and a governance structure designed to ensure that people from the communities served by NHS foundation trusts can take part in governing their local trust. All NHS Foundation Trusts are required to have a Council of Governors, comprising elected Public and Staff Governors and appointed Stakeholder Governors.

The Council of Governors is chaired by the Trust Chairman, Brian Stables. Governors at the Royal United Hospitals Bath are the direct link between the NHS Foundation Trust's members and the Trust. The Council of Governors' prime role is to represent the interests and views of Trust 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 Governors have a number of important responsibilities to perform and are expected to act in the best interests of the Trust. The Council of Governors would be expected to inform Monitor if it believed that the Trust was at risk of breaching its provider licence.

The statutory powers and duties of the Council of Governors include:

- Appoint and, if appropriate, remove the Chairman and other Non-Executive Directors;
- Determine the remuneration and allowances and other terms and conditions of office of the Chairman and other Non-Executive Directors;
- Approve the appointment of the Chief Executive;
- Approve and, if appropriate, remove the NHS Foundation Trust's Auditors;
- Receive the NHS Foundation Trust's annual accounts, any report from the auditor on them, and the annual report;
- Approve changes to the Trust's Constitution (a joint responsibility with the Board of Directors)
- Approve any proposal by the Trust to enter into a significant transaction;
- Approve any application by the Trust to enter into a merger, acquisition, separation or dissolution;
- Approve any proposed increase of more than 5% of total income in the amount of the Trust's income attributable to activities other than the provision of goods and services for the purposes of the health service in England;
- 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 Secretary of State recommended that our NHS FT application could proceed to Monitor in 2012, this meant that we were able to begin the election process to elect our first-ever Council of Governors on Monday 20th August 2012. Eleven Public and five Staff Governors were elected by our members to represent the member's views. Five Stakeholder Governors were also appointed from our partner organisations.

As the RUH was not licensed as an NHS Foundation Trust on the date the Governor elections were announced, our Governors began their role immediately, but in shadow form. The Shadow Governors undertook a comprehensive training and development programme to ensure that they understood the Trust as well as their statutory duties. The Shadow Governors continued in their roles until the Trust gained its NHS Foundation Trust licence on 1 November 2014.

Register of Governors

The Council of Governors held its first formal meeting on 6 November 2014, and the register of Governors was confirmed as follows:

Name	Constituency	Term of Office ends
Public Governors		
Amanda Buss	City of Bath	31 October 2017
Dominic Tristram	City of Bath	31 October 2016
Helen Rogers	North East Somerset	31 October 2017
Nick Houlton	North East Somerset	31 October 2016
Michael Welton	Somerset (Mendip)	31 October 2017
Ian Bynoe	Somerset (Mendip)	31 October 2016
Jan Taylor	North Wiltshire	31 October 2017
Adrian Bligh	North Wiltshire	31 October 2016
Jane Shaw	South Wiltshire	31 October 2017
Phil Morris	South Wiltshire	31 October 2016
Bill Aiken	Rest of England & Wales	31 October 2017
Staff Governors		
Elizabeth Brown	Staff	31 October 2017
Julian Hunt	Staff	31 October 2017
Hassan El-Wakeel	Staff	31 October 2017
Michael Coupe	Staff	31 October 2016
Sharon Manhi	Staff	31 October 2016
Stakeholder Governors (appointed)		
Dr Ian Orpen	BaNES CCG	31 October 2017
Cllr Simon Allen*	BaNES Council	31 October 2017
Dr Stephen Rowlands	Wiltshire CCG	31 October 2017
Cllr Keith Humphries	Wiltshire Council	31 October 2017
Mark Humphriss	University of Bath	31 October 2016

* In March 2015, Cllr Simon Allen stood down and Katie Hall stepped in as an interim Stakeholder Governor.

During the Council of Governors meeting held on 4th December 2014, the Chairman announced that following the completion of a voting process, Ian Bynoe had been elected as the Lead Governor for the Council of Governors for a one-year tenure.

Public Governors

Bill Aiken
Rest of England and Wales

Adrian Bligh
North Wiltshire

Amanda Buss
City of Bath

Ian Bynoe
Mendip

Nick Houlton
North East Somerset

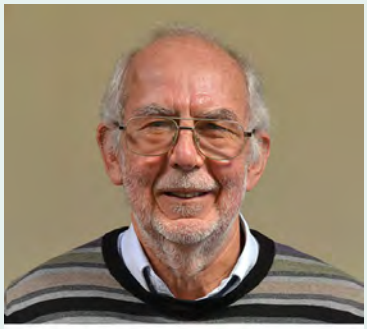
Phil Morris
South Wiltshire

Helen Rogers
North East Somerset

Jane Shaw
South Wiltshire

Jan Taylor
North Wiltshire

Dominic Tristram
City of Bath



Mike Welton
Mendip

Staff Governors

Liz Brown
Emergency Department Doctor

Mike Coupe
Consultant in Anaesthesia

Hassan El-Wakeel
Associate Specialist Surgeon

Julian Hunt
Consultant Nurse, ITU

Sharon Manhi
Head of Quality Improvement

Stakeholder Governors

Councillor Simon Allen
BaNES Council

Councillor Keith Humphries
Wiltshire Council

Mark Humphriss
University of Bath

Dr Ian Orpen
Chair, BaNES CCG

Dr Stephen Rowlands
Chair, Wiltshire CCG

Link with the Board of Directors

The Council of Governors holds the Board of Directors to account for the performance of the Trust. This increases the level of local accountability in public services. The Council of Governors is required to advise the Board of Directors regarding future plans and strategies and the monitoring of performance against the Trust's strategic direction. Through contact with members and the public at events such as constituency meetings, Caring for You, the Annual General Meeting and through other engagement activities, Governors have an opportunity to listen to members and the public and to represent their views on a wide range of matters relating to the Trust's forward plans, priorities and strategies.

The Board of Directors uses a variety of methods to ensure that they take account of, and understand, the views expressed by Governors (including the period when the governors were in shadow form) and the members. The Council of Governors is chaired by the Chairman and these meetings are always attended by the Chief Executive and other Executive Directors and Non-Executive Directors. The Chief Operating Officer presents the standing item on Operational Performance Assurance and the Director of Finance presents the standing item on Financial Performance Assurance. Other Executive Directors present reports relating to their directorates. The Governors have opportunity to question Executive Directors. There is also a programme of update reports from the Non-Executive Director Chairs of the Assurance Committees.

Membership of the Council of Governors working groups on Quality and Strategy and Business Planning include both an Executive and Non-Executive Lead. The Membership and Outreach Working Group has an Executive Lead.

The Board of Directors and Council of Governors also hold joint away day events to provide an opportunity for informal discussions. Although meetings of the Board of Directors are held in public and Governors can and do attend, the Chairman writes to all Governors after every Board of Directors meeting setting out a summary of the key items discussed at the meeting and the decisions taken within both the public and the private meetings and responds to any questions or concerns that Governors may have.

In the event of a dispute between the Council of Governors and the Board of Directors, in the first instance the Chairman would endeavour to resolve the dispute. If the Chairman was not able to resolve the dispute, the Senior Independent Director and Lead Governor would jointly attempt to resolve the dispute. Should the Senior Independent Director and Lead Governor not be able to resolve dispute, the Board of Directors, pursuant to section 15(2) of Schedule 7 of the 2006 Act would decide the disputed matter.

Council of Governor Meetings

The Council of Governors have met on the following occasions:

- Thursday 6th November 2014 – inaugural meeting
- Thursday 4th December 2014 – scheduled meeting
- Thursday 18th December 2014 – extraordinary meeting
- Tuesday 3rd March – scheduled meeting

The following table summarises Governor attendance at Council of Governor meetings 1 November 2014 – 31 March 2015:

Name	Constituency	Attendance
Public Governors		
Amanda Buss	City of Bath	4 of 4
Dominic Tristram	City of Bath	3 of 4
Helen Rogers	North East Somerset	2 of 4
Nick Houlton	North East Somerset	4 of 4
Michael Welton	Somerset (Mendip)	4 of 4
Ian Bynoe	Somerset (Mendip)	4 of 4
Jan Taylor	North Wiltshire	4 of 4
Adrian Bligh	North Wiltshire	4 of 4
Jane Shaw	South Wiltshire	3 of 4
Phil Morris	South Wiltshire	4 of 4
Bill Aiken	Rest of England & Wales	3 of 4
Staff Governors		
Elizabeth Brown	Staff	4 of 4
Julian Hunt	Staff	3 of 4
Hassan El-Wakeel	Staff	3 of 4
Michael Coupe	Staff	4 of 4
Sharon Manhi	Staff	4 of 4
Stakeholder Governors (appointed)		
Dr Ian Orpen	BaNES CCG	2 of 4
Cllr Simon Allen	BaNES Council	0 of 3
Cllr Katie Hall	BaNES Council	1 of 1
Dr Stephen Rowlands	Wiltshire CCG	1 of 4
Cllr Keith Humphries	Wiltshire Council	3 of 4
Mark Humphriss	University of Bath	2 of 4

The following table summarises Board of Director attendance at Council of Governor meetings 1 November 2014 – 31 March 2015:

Name	Title	Attendance
Executive Directors		
Helen Blanchard	Director of Nursing & Midwifery	3 of 4
Claire Buchanan	Director of Human Resources	4 of 4
Tim Craft	Medical Director	0 of 4
Joss Foster	Commercial Director	4 of 4
Howard Jones	Director of Estates & Facilities	4 of 4
James Scott	Chief Executive	3 of 4
Sarah Truelove	Deputy Chief Executive	3 of 4
Francesca Thompson	Chief Operating Officer	3 of 4
Non-Executive Directors		
Moira Brennan	Non-Executive Director	3 of 4
Michael Earp	Senior Independent Director	4 of 4
Joanna Hole	Non-Executive Director	3 of 4
Nick Hood	Non-Executive Director	2 of 4
Nigel Sullivan	Non-Executive Director	0 of 4

Acquisition of the Royal National Hospital for Rheumatic Diseases

The Council of Governors held an extraordinary meeting on 18 December 2014 to consider the Statutory Transaction of the Acquisition of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust by the Royal United Hospitals Bath NHS Foundation Trust. All of the 15 Governors present at the meeting voted unanimously in favour of the acquisition and resolved that the Board of Directors had followed an appropriate process in deciding to undertake the transaction and that the Board of Directors had taken account of the interests of the members of the Trust in its process in approving the Transaction. The Council of Governors also agreed that the Transaction would promote the success of the Trust so as to maximise the benefits for the Members of the Trust as a whole and for the public.

Council of Governors Nominations and Remuneration Committee

The role of the Nominations and Remuneration Committee is to:

- Oversee the recruitment of the Chairman and other Non-Executive Directors
- Review and make recommendations to the Council of Governors on the remuneration of the Chairman and other Non-Executive Directors
- Conduct the appraisal of the Chairman
- Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Non-Executive Directors and make recommendations to the Council with regard to any changes;
- Give full consideration to and make plans for succession planning for the Non-Executive Directors taking into account the challenges and opportunities facing the foundation trust and the skills and expertise needed on the Board of Directors in the future;
- Carry out other functions as may be determined by the Council of Governors from time to time.

The Committee does not have decision-making powers, but will make recommendations for the approval of the full Council of Governors. The Committee is chaired by the Trust Chairman, Brian Stables.
The Council of Governors Nominations and Remuneration Committee held its first meeting on 6 November 2014. The Council of Governors meeting on 4 December 2014 agreed to extend the membership to include a Staff Governor. Membership of the Committee is:

Name	Title
Brian Stables	Chairman
Adrian Bligh	Public Governor, North Wiltshire
Jan Taylor	Public Governor, North Wiltshire
Michael Welton	Public Governor, Somerset (Mendip)
Amanda Buss	Public Governor, City of Bath
Liz Brown	Staff Governor
Mark Humphriss	Stakeholder Governor, University of Bath
Michael Earp	Senior Independent Director

Governor working groups

Governors continue to fulfil both their statutory and non-statutory duties through established working groups which they have chosen to establish. Governor working groups are supported by the Membership & Governance Manager, and include an Executive and a Non-Executive Director lead.

The Working groups which have been developed are:

- Governor Strategy & Business Planning Working Group

- Governor Quality Working Group
- Governor Membership & Outreach Working Group

Governor Strategy & Business Planning Working Group

The role of the Strategy & Business Planning Working Group is:

- To contribute and add value to the medium and long-term vision and strategic direction of the Trust
- To ensure Membership interests are represented in the strategic planning process
- To develop an understanding of the strategy and business planning processes of the Trust
- To ensure the Council of Governors views are taken into consideration when setting the strategic direction of the Trust and the annual business planning process, Five Year Integrated Business Plan and supporting strategies.
- To act in an advisory capacity when the Board of Directors has to make challenging or difficult decisions which affect the strategic direction of the Trust
- To work with the Council of Governors to ensure that membership views are obtained on future business planning priorities.
- To give progress reports to the Council of Governors at full meetings of the Council.
- To report to the Council of Governors the views of the Working Group on the implementation of business plans.

The Committee is chaired by Helen Rogers, Public Governor for North East Somerset, and its meetings are also attended by:

- Jocelyn Foster, Commercial Director
- Nick Hood, Non-Executive Director
- Jane Rowland, Head of Business Development

The working group does not have decision-making powers, but will make recommendations for the approval of the full Council of Governors. The Strategy & Business Planning Working Group held its first meeting on 16 May 2013. Membership of the Committee is as follows:

Name	Title
Helen Rogers	Public Governor, North East Somerset
Bill Aiken	Public Governor, Rest of England & Wales
Adrian Bligh	Public Governor, North Wiltshire
Jan Taylor	Public Governor, North Wiltshire
Michael Welton	Public Governor, Somerset (Mendip)
Phil Morris	Public Governor, South Wiltshire
Amanda Buss	Public Governor, City of Bath
Michael Coupe	Staff Governor
Sharon Manhi	Staff Governor
Dr Ian Orpen	Stakeholder Governor, BaNES CCG
Cllr Simon Allen	Stakeholder Governor, BaNES Council
Cllr Keith Humphries	Stakeholder Governor, Wiltshire Council
Joss Foster	Commercial Director
Nick Hood	Non-Executive Director

Governor Quality Working Group

The role of the Governor Quality Working Group is:

- To identify issues affecting Quality, including patient experience, patient safety and clinical outcomes;
- To develop an understanding of the Quality priorities of the Trust;
- To advise the Council of Governors in contributing to setting the Quality Accounts priorities;
- To liaise with the Governors Membership Working Group to ensure that membership views are obtained on the Quality Accounts priorities and issues arising;
- To give progress reports to the Council of Governors at full meetings of the Council.

The Committee is chaired by Jan Taylor, Public Governor for North Wiltshire, and its meetings are also attended by:

- Helen Blanchard, Director of Nursing and Midwifery
- Mary Lewis, Deputy Director of Nursing, Quality and Patient Safety - (Deputises for Helen Blanchard)
- Michael Earp, Senior Independent Director

The working group does not have decision-making powers, but will make recommendations for the approval of the full Council of Governors. The Quality Working Group held its first meeting on 16 May 2013. Membership of the Committee is as follows:

Name	Title
Jan Taylor	Public Governor, North Wiltshire
Dominic Tristram	Public Governor, City of Bath
Amanda Buss	Public Governor, City of Bath
Nick Houlton	Public Governor, North East Somerset
Ian Bynoe	Public Governor, Somerset (Mendip)
Jane Shaw	Public Governor, South Wiltshire
Phil Morris	Public Governor, South Wiltshire
Elizabeth Brown	Staff Governor
Julian Hunt	Staff Governor
Hassan El-Wakeel	Staff Governor
Helen Blanchard	Director of Nursing and Midwifery
Michael Earp	Senior Independent Director

Governor Membership & Outreach Working Group

The role of the Governor Membership & Outreach Working Group is to:

- act in an advisory capacity ensuring that the Council of Governors and the Trust takes account of the views of its membership;
- assist in the development and review of the Membership & Engagement Strategy and plan;
- formulate initiatives for membership recruitment;
- advise, explore and develop methods of communication and engagement with the members and the local community including hard to reach and underrepresented groups and suggest actions;

- monitor the membership profile with respect to age, gender, ethnicity and area of residence in order to ensure a representative membership;
- receive reports on membership recruitment and activities;
- monitor the brand image of the Trust in the local community and advise on the public image of the Trust.

The Committee is chaired by Adrian Bligh, Public Governor for North Wiltshire, and its meetings are also attended by:

- Jocelyn Foster, Commercial Director
- Roxy Poultney, Membership & Governance Manager
- Julie Hill, Trust Board Secretary

The Membership & Outreach Working Group held its first meeting on 20 November 2013. Membership of the Committee is as follows:

Name	Title
Adrian Bligh	Public Governor, North Wiltshire
Bill Aiken	Public Governor, Rest of England & Wales
Phil Morris	Public Governor, South Wiltshire
Jan Taylor	Public Governor, North Wiltshire
Michael Welton	Public Governor, Somerset (Mendip)
Sharon Manhi	Staff Governor
Hassan El-Wakeel	Staff Governor
Cllr Keith Humphries	Stakeholder Governor, Wiltshire Council
Jocelyn Foster	Commercial Director
Roxy Poultney	Membership & Governance Manager
Julie Hill	Trust Board Secretary

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

	RUH Membership Office (C27) Royal United Hospitals Bath NHS Foundation Trust Combe Park Bath BA1 3NG
	RUHmembership@nhs.net
	01225 821299 or 01225 826288

NHS Foundation Trust Code of Governance

NHS Foundation Trusts in their annual reports are required to disclose information relating to the Code's requirements. For each item below, the information, its reference in the Code of Governance and its location within the Annual Report are shown. The reference "ARM" indicates a requirement not of the Code of Governance, but of the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

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

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.	Section on Board of Directors (page 42)
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.	Section on Board of Directors Membership and Attendance 1 November 2014-31 March 2015 (page 56)
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.	Section on Members and Governors (page 58)
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.	Section on Council of Governors attendance (page 67)
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.	Section on Board of Directors (page 35)
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.	Section on Directors' Summary Biographies (pages 48-54)
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.	Section on Directors' Report (page 34)

Ref No	Code Provision	Annual Report and Accounts Section
B.2.10	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.	Section on Remuneration Committee (page 68)
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.	Section on Remuneration Committee (page 68)
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.	Section on Board of Directors' Summary Biographies (pages 48-54)
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.	Section on Council of Governors (page 62)
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.	Section on governance (page 42)
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.	The Trust did not commission an external evaluation of the board during the period of the Annual Report.

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 (page 172)
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 (page 172)
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 (page 172)
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.	N/A
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 explanation of how auditor objectivity and independence are safeguarded.	Section on governance (page 42)
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.	N/A

Ref No	Code Provision	Annual Report and Accounts Section
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 Section (page 71)
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 Section (page 42)
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.	Council of Governors Section (page 62)
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.	Membership Section (page 58)
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, 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.	Council of Governors and Board of Directors Section (pages 48-54 and page 62)

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	Narrative in the Code	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 a monthly operational performance scorecard.
A.1.6	The board should report on its approach clinical governance.	Confirmed: the Trust undertakes an annual Quality Governance Assurance Framework review. This was externally audited in 2014/15. The Annual Quality Accounts also provides details of the Trust's approach to clinical governance.
A.1.7	The chief executive as the accounting officer should follow the procedure set out by Monitor 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 January 2015 to reflect the acquisition of the RNHRD. 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.
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 was updated in November 2015 to reflect 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 the NHSLA. 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 Chairman and Chief Executive are compliant with this provision. The Trust's Chairman meets the independence criteria.

Code Ref	Narrative in the Code	RUH Compliance
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 Chairman is the Senior Independent Director. He was appointed at the first meeting of the Board of Directors post authorisation as an NHS foundation trust, in consultation with the Council of Governors.
A.4.2	The chairperson should hold meetings with the non- executive directors	Confirmed: the Trust Chairman 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 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 is in line 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 will be kept under review.
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. The Trust holds joint away day sessions for governors and the Board of Directors.
A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns.	Confirmed: The Trust has a Board of Directors and Council of Governors 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.
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 Chairman and non-executive directors is set out in the Trust's NHS Foundation Trust's Constitution.

Code Ref	Narrative in the Code	RUH Compliance
A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties.	Confirmed: The Trust is fully compliant with this provision.
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 fully compliant with this provision. The Chairman and other Non-Executive Directors confirmed their independence at the first Board of Directors meeting post authorisation on 6 November 2014.
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 fully compliant with 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 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: Members of the Board of Directors confirmed that they met the requirements of the new statutory Fit and Proper Persons Test at the October 2014 meeting. Governors have confirmed that they meet the requirements of the Fit and Proper Persons as set out in Monitor's Provider Licence.
B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.	Confirmed: Both the Board of Directors and Council of Governors Nominations and Remuneration Committees' Terms of Reference include this requirement.
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.
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: A meeting of the Council of Governors Nominations and Remuneration Committee has been scheduled to discuss the process for appointing a new Non-Executive Director. The Committee will be supported by the Director of Human Resources.
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.

Code Ref	Narrative in the Code	RUH Compliance
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: The Annual Report sets out the Council of Governors role in confirming the appointments of the Trust Chairman and Non-Executive Directors post authorisation as an NHS Foundation Trust.
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 set out in Trust's NHS Foundation Trust's Nominations and Remuneration Committee's 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.
B.5.1	The board and the council 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 respective functions.
B.5.2	The board and in particular non-executive directors, may reasonably 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.	Confirmed: The Board of Directors' minutes provide evidence of executive and non-executive directors' challenge. In addition, the Board of Directors' assurance committees provide the opportunity to test systems and processes in more detail and to confirm a level of assurance.
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 provisional advice as and when appropriate.
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 Chairman.

Code Ref	Narrative in the Code	RUH Compliance
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.
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.	Partially compliant: The Governors were appointed to their formal role in November 2014. The Chair meets with governors on a one to one basis to discuss their performance. The Chair lead the assessment of the collective performance of the Council of Governors later in the year.
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 attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	Confirmed: The Trust's NHS Foundation Trust Constitution sets out the criteria and process for removing a governor.
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 Chairman (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.
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 and Annual Quality Accounts Reports are presented to the Annual Members Meeting and are available from the Trust's website.

Code Ref	Narrative in the Code	RUH Compliance
C.1.4	a) The board of directors must notify Monitor 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 reputation and standing of the NHS foundation trust. b) The board of directors must notify Monitor 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.	Confirmed: The Board of Directors is aware of this requirement.
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.	Confirmed: The Council of Governors received a paper on their role in re-appointing and removing external auditors at their first formal meeting on 6 November 2014.
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 is aware of this requirement.
C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	Confirmed: The Trust's Chairman is aware of this requirement and will inform Monitor if and when appropriate.
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 reporting and control, clinical quality, patient safety or other matters.	Confirmed: The Audit Committee receives regular reports from the Trust's Counter Fraud Service. The Non-Clinical Governance Committee has provided assurance to the Board of Directors on the Trust's Raising Concerns Policy.

Code Ref	Narrative in the Code	RUH Compliance
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 detailed 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 determined the remuneration of the Chairman and other Non-Executive Directors after taking account the time commitment and responsibilities of their roles.
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 include this provision.
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 took account of external benchmarking data as part of their work in determining the level of remuneration for the Chairman and other Non-Executive Directors.
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 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 receive advance notice of the Trust Board agenda and papers and are invited to contact the Chairman if they have any comments and or questions.
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 fully meets this requirement.
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 fully meets this requirement.

Regulatory ratings

The Trust is regulated by Monitor. Monitor uses risk ratings to assess whether or not we are meeting the commitments we have made as an NHS Foundation Trust to run our services effectively. For finance, the Trust is measured against Monitor's continuity of service rating which is focussed on liquidity and capital service capacity as set out in Monitor's Risk Assessment Framework. The continuity of service risk rating is scored 1-4. The Trust achieved a risk rating of 4.

Monitor's governance risk rating is based predominantly on the Trust's plans for ensuring compliance with its Provider Licence. The governance rating is determined by an assessment of governance elements which are:

- Performance against national outcomes and access requirements;
- CQC judgements;
- Third party reports (eg external regulators such as the Health and Safety Executive);
- Quality governance indicators; and
- Continuity of service rating.

The governance risk rating is on a narrative rating scale from red to green, with green being the lowest risk.

NHS Foundation Trusts are responsible for supplying Monitor with the information which forms the basis for their governance rating. In particular, they are responsible for self-certification on a quarterly basis on areas of governance and for supplying any required exception reports.

Monitor Risk ratings 1 November 2014 to 31 March 2015

	Annual Plan 2014/15 forecast	Q1 actual	Q2 actual	Q3 actual	Q4 actual
Financial Risk (Continuity of Service Risk Rating)	4			4	4
Governance Risk Rating	**Green**			**Green**	**Green**

Care Quality Commission (CQC)

At 31 March 2015, the Trust had been placed by the CQC's Intelligent Monitoring Report in band 6, the lowest category of risk.

5 Remuneration report

Annual statement on remuneration

This report details how the remuneration of senior managers in 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 Trust'. The Trust deems this to be the executive and non-executive members of the Board of Directors.

Remuneration of the Chief Executive and Executive Directors

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 issues concerning remuneration.

The Nominations and Remuneration Committee is chaired by the Trust Chairman 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, including pensions, 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 of Human Resources are in attendance at meetings of the Committee to provide advice, but are not present during any discussions relating to their own remuneration. The Committee did not receive any external advice.

The Board of Directors Nominations and Remuneration Committee did not meet during the period of this annual report.

Senior Managers' remuneration policy

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

The pay, terms and conditions for the Medical Director are driven by his Consultant Contract and therefore by Medical Terms and Conditions albeit that an additional payment is made which reflects the additional responsibilities for the role of Medical Director. The Medical Director is eligible to apply for discretionary performance related pay under Medical Terms and Conditions but is excluded from eligibility for the Directors' Bonus Payments Scheme.

The remuneration of the Chief Executive and Executive Directors (with the exception of the Medical Director) is determined by the Board of Directors Nominations and Remuneration Committee taking into account market levels, key skills, performance and responsibilities.

In reviewing remuneration, 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 wider NHS and the individual director's level of experience and development of the role.

Performance assessment of Chief Executive and Executive Directors

Individual performance is reviewed through the Trust's appraisal process to evaluate the extent to which the Chief Executive and Executive Directors have met their objectives and contributed to the delivery of the Trust's strategic objectives. The annual review comprises, where applicable, a cost of living uplift 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.

Remuneration of the Chairman and Non-Executive Directors

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

The Committee first met on 6th November 2014 to consider the remuneration of the Trust Chairman and other Non-Executive Directors. The Committee reviewed national NHS Trust Chairman and Non-Executive Directors remuneration benchmarking data and agreed to recommend to the Council of Governors that the level of remuneration for the Trust Chairman and the Non-Executive Directors should be in line with similar sized NHS foundation trusts in the South West region. The Committee recommended the following remuneration for non-executive directors:

a) Basis Non-Executive Directors remuneration: £12,500 per annum
b) Chair of the Audit Committee: £14,000 per annum
c) Senior Independent Director: £14,000 per annum
d) Chairs of the Non-Clinical and Clinical Governance Committees: An additional allowance of £1,000

The Committee recommended that the remuneration of the Trust Chairman should be set at £47,500 per annum.

The Committee's recommendation was approved by the Council of Governors on 6 November 2014.

Annual report on remuneration

Service contracts

Name	Role	Appointed/ Re-appointed	Current length of term	Notice period
Brian Stables	Trust Chairman	01-Apr-2010 Re-appointed 01-Apr-2014	Current term of office ends on 31/03/2016	3 months
Michael Earp	Non-Executive Director	01-Dec-2004 Re-appointed 01-Dec-2008 Re-appointed 01-Dec 2012	Term of office ends on 31/10/2015*	3 months
Joanna Hole	Non-Executive Director	01-Apr-2011	Current term of office ends on 31/10/2015*	3 months
Moira Brennan	Non-Executive Director	01-Feb-2008 Re-appointed 01-Feb-2012	Current term of office ends on 31/01/2016	3 months

Name	Role	Appointed/ Re-appointed	Current length of term	Notice period
Nigel Sullivan	Non-Executive Director	01-Aug-2012	Current term of office ends on 31/07/2016	3 months
Nick Hood	Non-Executive Director	01-Aug-2012	Current term of office ends on 31/07/2016	3 months
James Scott	Chief Executive	01-Jun-2007	N/A	6 months
Sarah Truelove	Deputy Chief Executive and Director of Finance	24-Jun-2013	N/A	6 months
Tim Craft	Medical Director	01-Aug-2010	N/A	6 months
Francesca Thompson	Chief Operating Officer	25-Sep-2006	N/A	6 months
Helen Blanchard	Director of Nursing and Midwifery	27-Aug-2013	N/A	6 months
Claire Buchanan	Director of Human Resources*	07-Oct-2013	N/A	6 months
Jocelyn Foster	Commercial Director*	30-Jul-2012	N/A	6 months
Howard Jones	Director of Estates and Facilities*	03-Nov-2008	N/A	6 months

** Indicates non-voting members of the Board of Directors*

In accordance with the Trust's constitution, the chairman and non-executive directors were formally appointed by the Council of Governors on 6 November 2014, following authorisation as an NHS foundation trust on 1 November 2014.

Director and governor expenses

Information regarding director and governor expenses during the reporting period are outlined below:

Directors' expenses

No taxable expenses were paid to any executive or non-executive during the reporting period.

Governors' expenses

Governors are not remunerated, but are entitled to claim expenses for costs incurred while undertaking duties for the Trust as a governor (e.g. travel expenses to attend Council of Governors meetings). A total of £873 was paid as expenses to seven Governors in the period from 1 November 2014 to 31 March 2015. 22 Governors were on the council during this period.

Payments to past senior managers

No payments or awards were made to past senior managers during the period from 1 November 2014 to 31 March 2015.

Directors' Remuneration

Remuneration in relation to the five months to 31 March 2015

Name	Title	Salary & Fees (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
James Scott	Chief Executive	70-75		60-62.5	135-140
Sarah Truelove	Deputy Chief Executive & Director of Finance	55-60			55-60
Helen Blanchard	Director of Nursing	50-55		25-27.5	80-85
Tim Craft	Medical Director	15-20	50-55	17.5-20	90-95
Francesca Thompson	Chief Operating Officer	45-50		5-7.5	55-60
Claire Buchanan	Director of Human Resources	40-45		10-12.5	50-55
Howard Jones	Director of Estates and Facilities	40-45		0	40-45
Jocelyn Foster	Commercial Director	40-45		5-7.5	50-55
Brian Stables	Chairman	15-20		0	15-20
Moira Brenan	Non-Executive Director	5-10		0	5-10
Michael Earp	Non-Executive Director	5-10		0	5-10
Joanna Hole	Non-Executive Director	5-10		0	5-10
Nicholas Hood	Non-Executive Director	5-10		0	5-10
Nigel Sullivan	Non-Executive Director	5-10		0	5-10

No director received taxable benefits.

No long term performance related benefits were paid to directors.

No annual performance related bonus was paid during the reported period.

Tim Craft's substantive appointment is as a medical consultant. His remuneration is therefore split between his responsibilities as medicat director (salary) and his substantive appointments.

Howard Jones has reached retirement age. Therefore the calculation of increase in pension-related benefits is not applicable.

Pensions Disclosure

Name	Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)
		£000			
James Scott	Chief Executive	2.5-5	7.5-10	65-70	200-205
Helen Blanchard	Director of Nursing	0-2.5	2.5-5	30-35	95-100
Tim Craft	Medical Director	0-2.5	2.5-5	70--75	210-215
Francesca Thompson	Chief Operating Officer	0-2.5	0-2.5	30-35	100-105
Claire Buchanan	Director of Human Resources	0-2.5	0-2.5	25-30	95-100
Jocelyn Foster	Commercial Director	0-2.5	0-2.5	5-10	15-20

Name	Title	Cash Equivalent Transfer Value at 1 Nov 2014	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 Mar 2015	Employer's contribution to NHS pension
James Scott	Chief Executive	1,284,957	62,413	1,347,369	60,154
Helen Blanchard	Director of Nursing	597,267	27,228	624,495	26,591
Tim Craft	Medical Director	1,400,647	63,894	1,464,541	18,156
Francesca Thompson	Chief Operating Officer	719,397	34,954	754,351	6,798
Claire Buchanan	Director of Human Resources	470,906	26,068	496,975	10,050
Jocelyn Foster	Commercial Director	96,064	9,328	105,393	6,648

There are no payments for loss of office for senior managers during the reporting period.

There are no payments to past senior managers during the period that have not been reported in previous remuneration reports published by the Royal United Hospital Bath NHS Trust.

Fair Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Royal United Hospitals Bath NHS Foundation Trust in the five months to 31 March 2015 was £175,000-£180,000 (2014-15 to 31 October: £180,000-£185,000). This was 6.6 times (2014-15 to 31 October: 6.5) the median remuneration of the workforce, which was £26,822 (2014-15 to 31 October: £28,173). In the five months to 31 March 2015, four (2014-15 to 31 October: two) employees received remuneration in excess of the highest-paid director.

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

	As at 31 October 2014	As at 31 March 2015
Band of Highest Paid Director's Total Remuneration (£'000)	180-185	175-180
Median Total Remuneration (£)	28,173	26,822
Ratio	6.5	6.6

The provisions for compensation for early retirement and redundancy are as set out in Section 16 of the Agenda for Change: NHS Terms and Conditions of Service Handbook. No payments for loss of office were approved either by the Remuneration Committee or the Trust Board in the reporting period.

Off-payroll arrangements

Number of existing engagements as of 31 March 2015 of which:	
No. that have existed for less than one year at time of reporting:	0
No. that have existed for between one and two years at time of reporting:	0
No. that have existed for between two and three years at time of reporting:	0
No. that have existed for between three and four years at time of reporting:	0
No. that have existed for four or more years at time of reporting:	2

All off-payroll engagements were subject to a risk based assessment as to whether assurance is required and that the individual is paying the right amount of tax and, where necessary that assurance has been sought.

There were no off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 November 2014 and 31 March 2015.

James Scott
Chief Executive and Accounting Officer
27 May 2015

Royal United Hospitals Bath NHS
NHS Foundation Trust

2014/15

Quality Accounts

incorporating the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

Contents

1 Our commitment to quality – the Chief Executive's view

I am pleased to introduce our Quality Accounts for 2014/15, highlighting the achievements and aspirations we have on quality of patient care and experience.

This report demonstrates that the RUH has a huge amount to be proud of and that our commitment to placing our patients at the heart of everything we do is improving quality across the Trust. It is a great testament to our staff that the Care Quality Commission has given us a risk rating of 6. The scale is 1-6 where 1 indicates the highest risk and 6 the lowest.

Whilst we are proud of the improvements that have enhanced our patients' experience with us, and this extends to their families, carers and visitors to the hospital, we do need to address some areas where we have not made sufficient progress. Notably, like most hospitals across England, we have not consistently achieved the four-hour access target for emergency patients. Therefore we have been streamlining our internal processes and are working closely with our health and social care partners in the community to improve the timeliness and safety of emergency care. The areas for improvement are covered in more detail in this report.

We listen to what our patients, carers, members, and our staff tell us is important to them and, as a result, we are now proud to report 97% of patients who complete the 'Friends and Family' test say that they would recommend our hospitals to friends and family. In fact, at the height of the winter pressures our emergency department was the most highly recommended in England with 98% of patients saying they would recommend it to friends and family.

I am also delighted that we have been able to integrate the quality report for the RNHRD, which the RUH acquired on 1 February 2015.

The views of our local health and social care partners, and national requirements, are also taken into account to help shape our approach to improving services and to delivering the best possible care to the communities and individuals whose care and treatment is entrusted to us.

We want you to know that the quality of care we provide is very important to us. Our patients should have confidence that they are in the best hands when they are being cared for by us.

High quality care, safety and patient experience are the key principles that drive our hospitals and continued improvements in these vital areas will remain our priority.

To the best of my knowledge the information in the Quality Report is accurate.

James Scott
Chief Executive and Accounting Officer
27 May 2015

2 Our approach to quality

We want to ensure that patient safety and service quality are at the heart of everything we do; with our staff being proud to provide safe, high quality personal care to every patient, every time. In 2014 the Trust Board of Directors agreed a new two year Quality Strategy which outlines our approach that we want to see all staff working to improve quality. The emphasis is on ensuring that our patients have the best clinical outcomes, delivered with compassion, in a safe environment, resulting in the best possible patient experience. Our strategy was developed with staff and patient representatives and builds on our strengths and complements our quality and safety infrastructure. It also addresses areas where we know that we need to improve, such as the roll out of quality improvement training to more staff across the organisation. Within the strategy, we outline our priorities over the next two years and how we plan to deliver improvements.

The four key objectives are to:

1. Make improvement part of our everyday work
2. Empower and support staff
3. Use information as a tool for change
4. Support innovation and celebrate success.

What are Quality Accounts for?

Quality Accounts are annual reports to the public about the quality of services that providers of healthcare deliver. They also show how they are performing against key standards and targets, and they explain their plans for improvement. Quality Accounts allow:

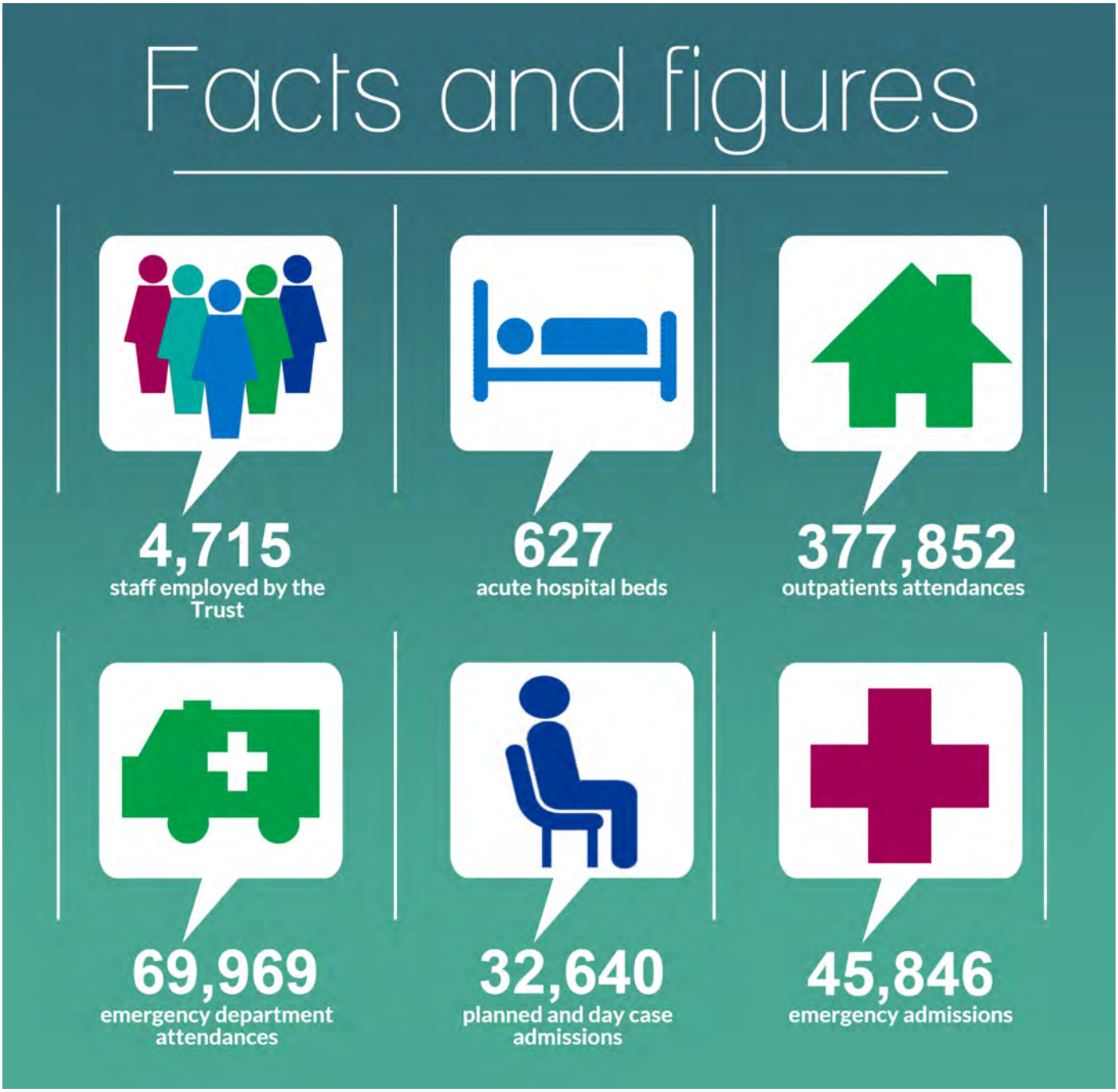
- Patients and their carers to make well-informed choices about who they would like to provide their healthcare
- NHS Foundation Trust Governors, Members and the public to hold providers to account for the quality of services they provide
- Boards of NHS Providers to report what improvements they have made to services and what their priorities are for the following year.

How do we improve Quality?

Quality of care is about being safe, clinically effective and providing a positive patient experience. It is everyone's business and all staff have a part to play in delivering the quality strategy. We have made some great improvements in terms of the quality of care we provide; however we know that we must continually strive to do better. Our staff are the foundation for all that we do and we encourage them to share in improvement activity no matter how big or small, whether it is at a team or at an organisational level. The results of this year's staff survey shows that 71% of staff 'feel able to contribute towards improvements at work' compared to the national average for acute Trusts of 68%.

About Royal United Hospitals Bath NHS Foundation Trust

We are proud to care for the people of Bath and the surrounding towns and villages in North East Somerset and Western Wiltshire in providing treatment and care for a catchment population of around 500,000 people and a comprehensive range of acute services including medicine and surgery, services for women and children, accident and emergency services, and diagnostic and clinical support services.



In June 2014, we won the bid to provide maternity services for the next three years. Prior to this the services were managed by different NHS organisations. As well as running maternity services from the hospital's own Princess Anne Wing, the RUH has also taken on the running of maternity services across the community in units at Frome, Paulton, Trowbridge, Chippenham and Shepton Mallet.

We had more great news later in the year when on 1st November 2014, we celebrated becoming a Foundation Trust. We were the first hospital to be authorised as an NHS Foundation Trust by the health regulator, Monitor in sixteen months. This was a momentous day for our hospital, our patients and the community we serve. Achieving NHS Foundation Trust status was recognition of the high quality services and safe care that the hospital provides.

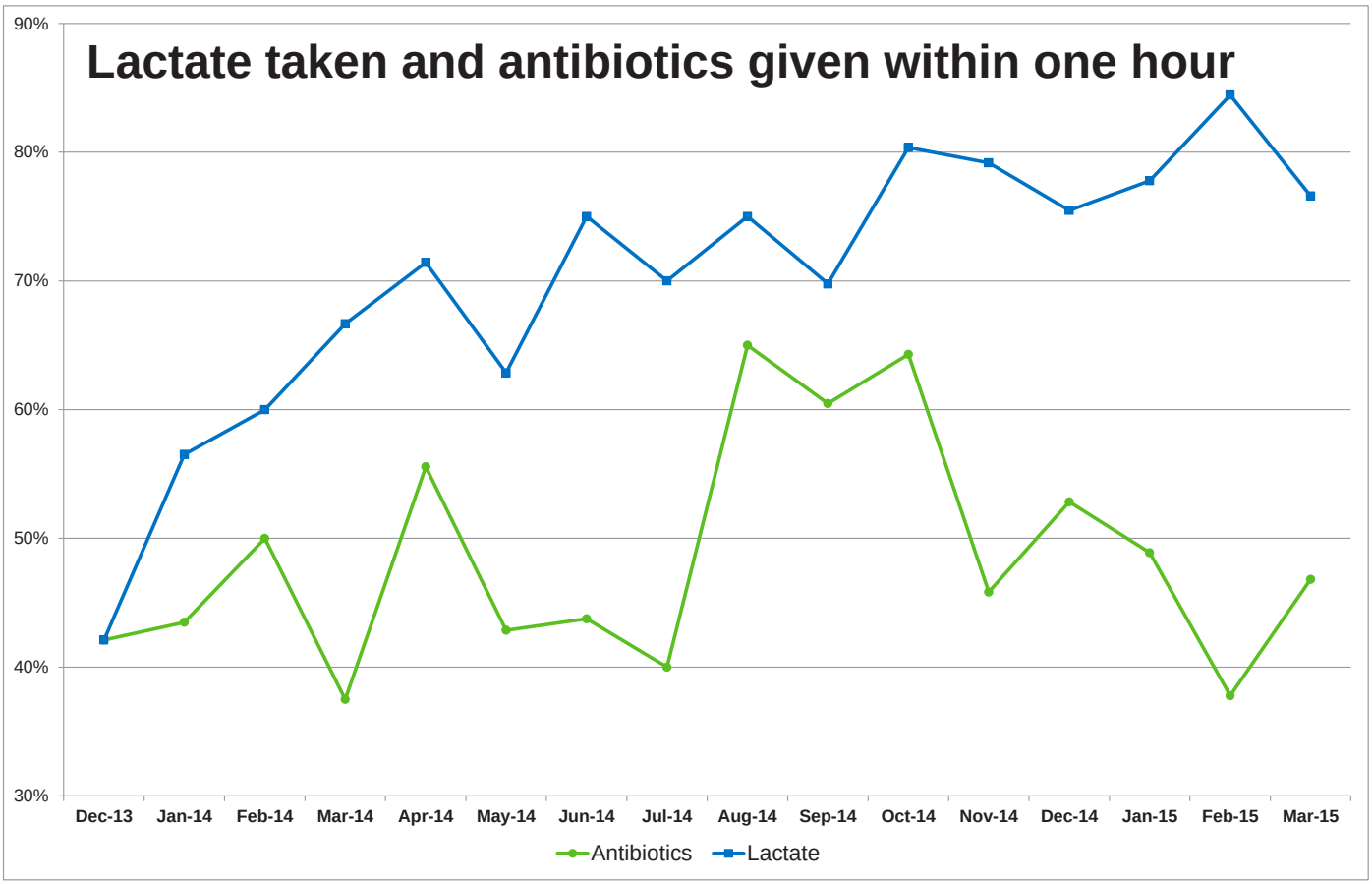
On 1st February 2015, we were successful in our acquisition of the Royal National Hospital for Rheumatic Diseases (RNHRD) securing the future of the renowned specialist services of the RNHRD and allowing patients in our local area and beyond to continue to access world class care and expertise in a wide range of areas from rheumatology to chronic pain and chronic fatigue syndrome.

3 Review of priorities for 2014/15

RUH Priorities

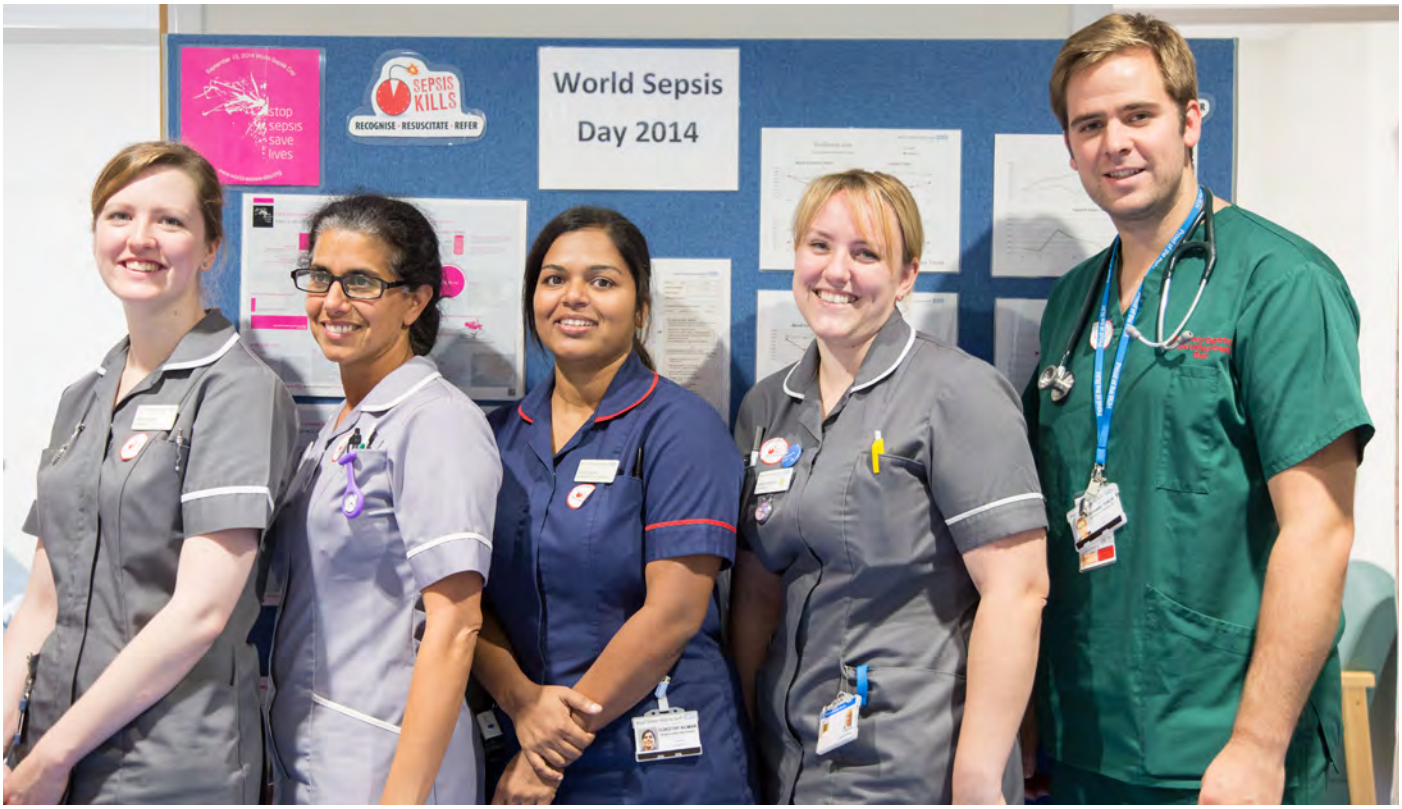
Priority 1: Sepsis

Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. It is an increasingly common and serious condition, which can progress rapidly and cause many patients to become critically ill and even die. In the UK 37,000 people die from sepsis every year, more than from breast or bowel cancer. It can affect anyone, young or old, and is also now the leading cause of maternal death in the UK. If we can identify and start treatment of sepsis as early as possible, we can prevent many of these patients from becoming unwell.



During 2014 we increased awareness of sepsis by training over 700 staff during our 60 days sepsis campaign in March and April 2014 and then continued this training with the appointment of two sepsis nurses in May 2014. Sepsis training has been embedded as part of the routine training programmes for all staff in identifying a deteriorating patient. Training is ongoing and is delivered by the sepsis nurses to all ward areas, and includes patient stories. A patient story was also presented to the Trust Board.

For our newly acquired maternity services training was delivered to the multi-disciplinary team with a 'tea- trolley' concept, meaning that the training was taken to the front line and delivered during breaks with tea and brownies. This proved to be very effective and popular. Sepsis training is also included in the mandatory annual maternity skills drills and performance of staff at these sessions is excellent.



Over the year improvement in the identification of severe sepsis in the emergency department has been demonstrated with twice the number of patients identified since December 2013. Earlier treatment of patients with severe sepsis has been seen, with an improvement in the percentage of patients in whom lactate (specific blood test for identifying severe sepsis) was taken within an hour of arrival in the emergency department. However, whilst the administration of antibiotics within an hour in patients with severe sepsis improved between July and October 2014, sustaining this with increasing numbers of patients attending the emergency department over the winter months has been challenging. We will continue to ensure that patients receive antibiotics as soon as possible. In February and March 2015 over 70% of patients received antibiotics within two hours of admission.

The improvement has also been part of a local Commissioning for Quality and Innovation (CQUIN) payment framework target, which has been achieved for the year. Following the 60 day campaign, from May 2014 we have identified double the number of patients with severe sepsis and have maintained our level of improvement. Further improvements occurred in September-November 2014. This has been achieved as a result of exceptional work by the staff in the emergency department and facilitated by the sepsis nurses, who assist staff to implement treatment quickly as well as spreading awareness and training.

The sepsis nurses have also organised specific sepsis training sessions for sepsis champions identified to assist with spreading the improvement across all the wards.

The RUH celebrated World Sepsis Day in September 2014 with a variety of events across the hospital. A large number of staff came along to have their Sepsis 6 training, and joining in with the sepsis simulations, where they were able to put that teaching into practice. There were also many updates about the progress being made throughout the hospital with regards to the Sepsis 6 implementation.

Public awareness of sepsis was also raised at a Caring for You event in November 2014, as part of our patient safety programme.

We have also shared learning and have formed a regional sepsis group with colleagues from other trusts, including a sepsis master class in February to share learning supported by the West of England Academic Health Science Network (WEAHSN).

Priority 2 – to prevent hospital acquired pressure ulcers

We recognise that having a pressure ulcer during a hospital stay has a distressing effect on patients and their families and carers.

We know that most pressure ulcers are avoidable and their treatment and prevention is a critical part of providing holistic nursing care. Pressure ulcers are given categories according to the damage caused to the skin from the least serious (Category 1) to the most serious (Category 4).

In 2013/14 we had just under 200 pressure ulcers acquired in hospital. Whilst the most serious pressure ulcers are low in number, our ambition was to eliminate these Category 3 and 4 pressure ulcers altogether. We also aimed to halve the number of the less serious Category 2 pressure ulcers.

The existence of a pressure ulcer shows that harm has been caused to a patient, so we believe that every pressure ulcer is one too many. When they do occur, we carry out a thorough investigation to find out how they happened, and what could have been done to prevent them.

In 2014/15 we particularly focused on the assessment of patients, taking action to prevent pressure ulcers, and treatment. We launched a major internal campaign, which raised awareness of the right pathway to follow to prevent pressure ulcers, and ensure there were no barriers to stopping this process being followed.

It also raised awareness of the impact of pressure ulcers on patients, using real patient stories to bring their experience to life.

We continued to support staff in the implementation of the five 'SSKIN' steps to prevent pressure ulcers. Each ward has at least one tissue viability link nurse and we used a visual aid training pack, to enable them to spread training among nurses and healthcare assistants.

What are the SSKIN steps?

SSKIN is a procedure of five simple steps to prevent and treat pressure ulcers:

1. **Surface:** Make sure your patients have the right support
2. **Skin inspection:** Early skin inspection means early detection
3. **Keep moving:** Keep your patients moving
4. **Incontinence:** Your patients need to be clean and dry
5. **Nutrition/hydration:** Help patients have the right diet and plenty of fluids.

What we have done

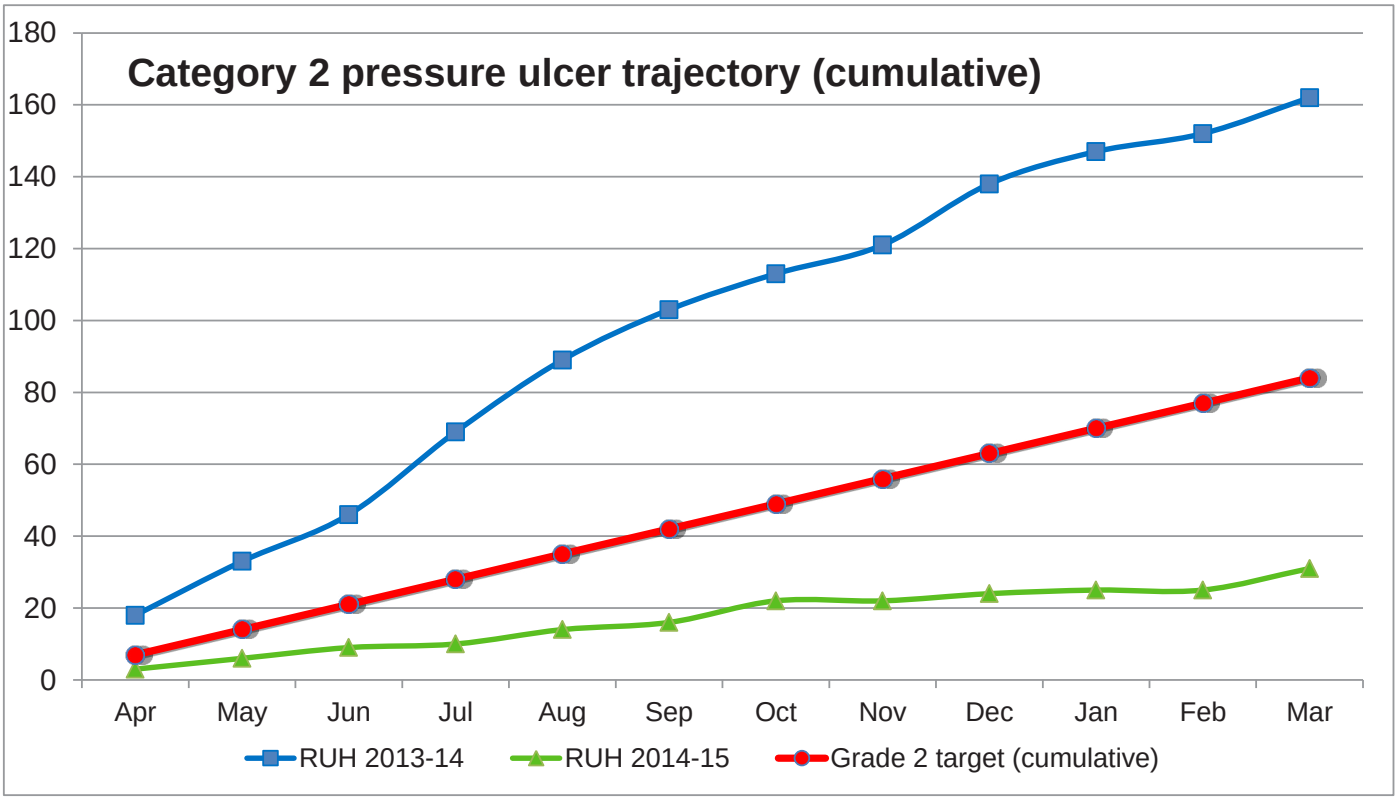
In 2014/15 we set out five aims:

1. To eliminate all avoidable hospital acquired category 3 and 4 pressure ulcers

The ambition to eliminate all avoidable category 3 and 4 pressure ulcers remains a main focus. Although four category 3 pressure ulcers have been reported this year, we have not had any category 4s. This is a 50% reduction in category 3s.

2. To reduce all avoidable category 2 hospital acquired pressure ulcers by 50%

The reduction of category 2 pressure ulcers has been exceeded as illustrated in the graph below. The reasons for the reduction are multi-factorial with patients being skin checked and screened for risk early in their hospital journey, early provision of pressure reducing equipment, a clear prevention pathway and care bundle, awareness and training for all healthcare professionals and improvements in nutritional standards.

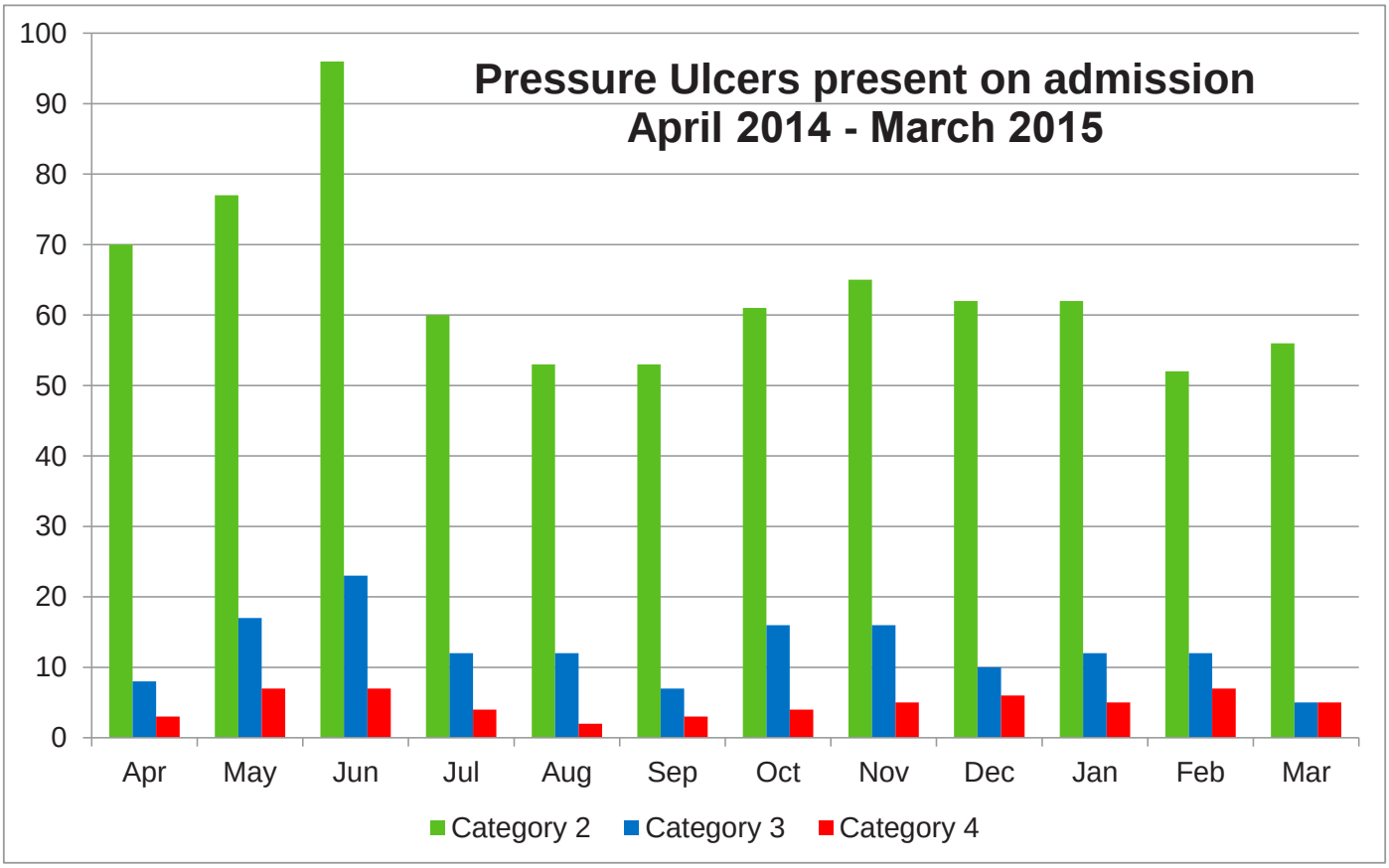


3. To ensure 95% of all nurses and healthcare assistants are trained and competent in the SSKIN steps for pressure ulcer prevention

From a base line of 89% at the beginning of the rapid spread programme, in November, the Trust has exceeded its rapid spread target of 95%, and is at 96%. This includes wards where new starters are added to the database, then trained as part of their ward induction.

4. To accurately monitor all pressure ulcers (hospital acquired or present on admission)

All pressure ulcers are recorded on admission as illustrated in the table below. All pressure ulcers category 2, 3 and 4 are reported on Datix, our incident reporting system and sent back to the community via this system. Dr Foster, the national hospital guide, reports that the RUH remains an outlier for pressure ulcers. This is because they count all pressure ulcers and not just those that are hospital acquired. Work is being done to improve this recording with the help of Dr Foster, coding and the Business Intelligence Unit (BIU). Our tissue viability nurses are ensuring that those patients who are admitted with existing pressure ulcers are identified to their community colleagues. Advice and guidance is also provided by our team on the care of these patients.



5. To audit documentation

The Trust continues to audit key documents regarding pressure ulcer prevention. The documents audited include the Anderson screening tool (used in the emergency department to rapidly identify those patients at risk of developing a pressure ulcer), the pressure ulcer prevention care plan and the comfort record, risk assessment and reassessment, air mattress provision, paediatric nurse awareness, midwifery awareness, safeguarding referrals for category 3 and 4 and any RCAs (Root, Cause, Analysis) required underway. The care plan and comfort record have been added to the CQUIN and both have to achieve 95% in the last quarter of 2014/15.

Priority 3: Diabetes

The Quality Account priorities we set in 2014/15 showed we recognised we could improve the quality and safety of our diabetes care, and in particular be more proactive when patients with diabetes are first admitted to hospital.

During 2014 we established our Acute Diabetes Team; a team of specialist nurses who proactively treat patients with diabetes on admission the hospital.

The team carries out assessments, including examination of the feet, and prepares a care plan with patients to manage the patient's diabetes while they are in hospital. They make initial essential changes to the patient's medication within the first 24 hours where possible and start planning for discharge from the moment they arrive by assessing their last three months of diabetes control, and planning for what they will need beyond hospital admission. All this information is sent to GPs and community nurses to form part of any ongoing care for the patient.

A key element to this project was that the team provides bespoke education and support to the ward staff, allowing them to deliver the best care even when the diabetes team were not present. Feedback from our incident reporting system and staff is used to determine the content of the education we deliver.

The Acute Diabetes Team working in the Medical Assessment Unit (MAU):

- Reduced hypoglycaemic episodes by over 50%
- Reduced diabetes medication errors by over 50%
- Increased numbers of diabetes patients seen by the specialist team by 20%
- Improved staff confidence and knowledge of common diabetes problems in hospital
- Helped our patients get home faster and more safely.

Following the success of the MAU model, the Trust agreed to pilot the service in other wards to see whether similar quality benefits could be achieved.

The Innovation Panel provided funding for the pilot and during 14/15 additional staff were recruited, trained and integrated into the team and the model was implemented on four wards. The aims were to deliver similar reductions in hypoglycaemic episodes, medication errors and to increase the numbers of diabetes patients seen by the specialist team.

A formal evaluation is expected in 2015, but early indications show that within two months the service delivered:

- a 30% reduction in hypoglycaemic episodes
- a 50% reduction in medication errors
- An increase in the number of patients with diabetes who are seen by the specialist team.

This review suggests that the service is exceeding expectations with more patients seen than expected and a significant increase in patient coverage. However, the pilot is still ongoing and results are expected to improve.

Given the increase in patients seen and demand for the specialist team, there is more work to do on education for ward staff and this will be one of the priorities for the service in 2015/16.

Priority 4: Learning from feedback

During 2014/15 we committed to improving the way in which we manage our complaints process to ensure that we made changes to the way in which we provided services following patient feedback.

The Care Quality Commission (CQC) report 'Complaints Matter' published in December 2014 details the state of complaints handling in the NHS and our own survey of previous complaints showed that we were not meeting their needs.

In April 2014, we held a workshop with patients and carers who had written a complaint to the Trust and members of staff. This was a fantastic opportunity for us to design our new complaints process around the needs of our patients and carers. Previous patient surveys had shown that we took longer than we should do to respond to complaints, didn't always keep those who raised a complaint informed and that we could appear defensive in our responses.

Those who had reason to complain in the past told us they wanted a single point of contact, for us to keep them informed as the investigation progressed and to make the system less formal with more opportunities to resolve concerns earlier in the process.

We have worked hard to improve our responses and, where possible, invite those who haveraised a complaint to the hospital to discuss their concerns or meet them in their own homes. This has led to earlier resolution and a more satisfactory outcome. For example here is a quote from a member of the public which was posted on the NHS Choices review section on 28 July 2014, following a complaint on 26 July:

"Thank you for your quick response to my worries and the reassurance you have given my daughter-in-law and son, after many weeks of excellent care and support in NICU you have followed this into the children's ward. Thank you again."

The Trust continues to focus on responding to complainants in a timely manner that it mutually agreed. We do appreciate that some people may have experienced a delay in receiving their response letters and we actively working to address delays in the process in the coming months.

We commissioned 'Plain Words' to run training courses for staff involved in the complaints process. The training focussed on effective listening, writing in a clear and concise style and choosing the best response. Feedback from the staff showed that it has given them the confidence to handle complaints more effectively.

Following the workshop in April, we held further workshops with staff, patients who had made a complaint and one with carers. We worked with 'Unique Voice', a local creative arts education company, to create a play, using actors, to demonstrate a complaint scenario from the perspectives of all those involved.

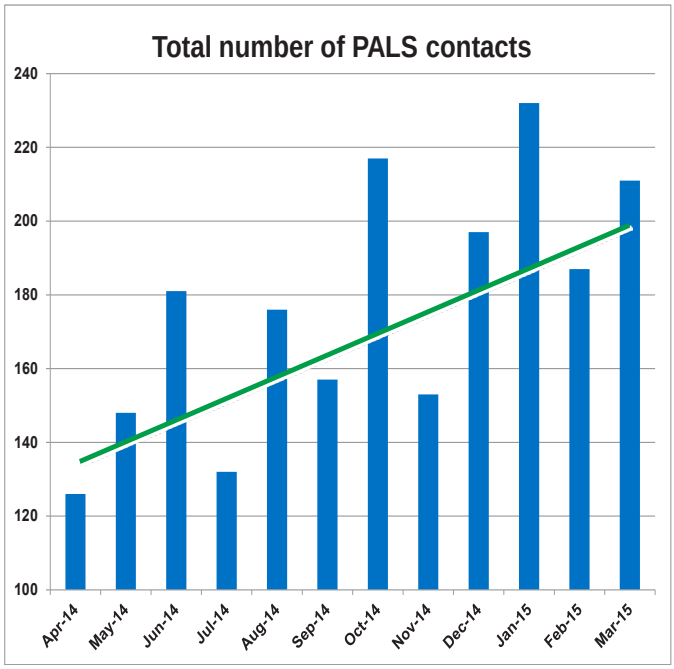
Over 200 staff attended the performances held in February 2015. Following the play over 75% of staff said that it had increased their knowledge and understanding and over 85% of staff said that the session had changed the way that they would work with people who complain. Some examples of what staff said they will do differently include:

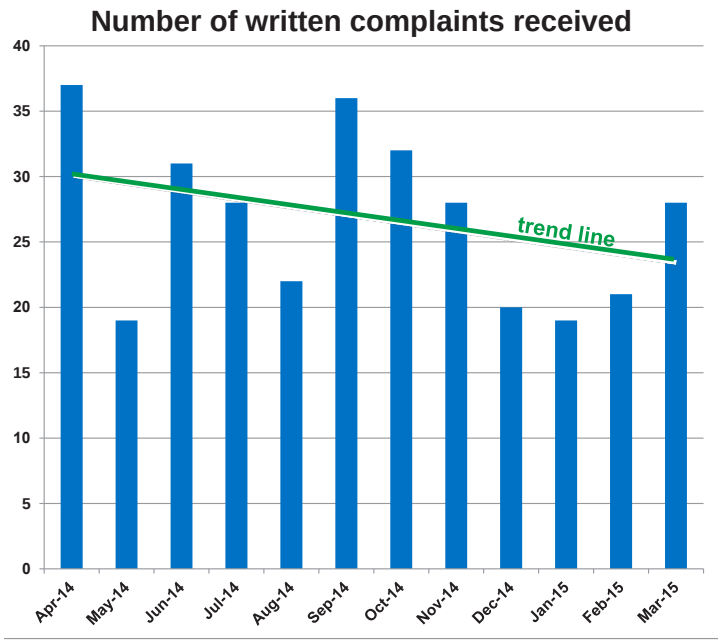
- 'Try to put myself in the patient's position even more to enable a better understanding.'
- 'To remember that people are often frightened.'
- 'Remember the emotional feelings behind waiting for response.'

The comments from staff were put together to form a 'word cloud'. The bigger the word reflects that words appeared more often.

The performance was filmed and staff will be encouraged to view the video on the Trust website. The video will also be used for training purposes.

Caring for patients can put great stress on our staff who often have to deal with highly emotional and distressing situations whilst managing multiple tasks. Too much stress can lead to burnout and get in the way of being compassionate. In March this year, we held the first of our Schwartz Centre Rounds. This is a forum for staff, from all disciplines, to get together and share their experiences of caring for patients





in particular, reflecting on the emotional aspects of their work. Schwartz Rounds have been introduced in other hospitals and have been shown to improve staff confidence in handling sensitive issues and help develop empathy in seeing patients as individuals.

The new approach to complaints is to provide a more responsive service. This is in line with best practice developed by the Patients' Association. Wherever possible we aim to deal with issues and concerns promptly through the Patient Advice and Liaison Service (PALS). As a result the number of PALS contacts has increased in the last year while the number of written complaints has reduced.

We will continue to embed a culture of learning from patient and carer feedback and ensure our staff are equipped with the necessary skills and training to provide compassionate care with every patient contact.

RNHRD Priorities

Priority 1: Falls – pain management patients

All falls that result in moderate harm or above relating to patients at the RNHRD is recorded on Datix, the Trust's incident reporting system. In addition, a monthly audit of falls with analysis of trends together with the pain management for these patients is also undertaken. All clinical staff at the Bath Centre for Pain Services (BCPS) team use a standardised multifactorial falls assessment on admission. This work has allowed further individualisation of care for patients and potential reduction of risk of unnecessary harm to patients through falling.

Priority 2: Urinary tract infections (UTI's)

The focus for this improvement has been to increase the diagnosis of UTI's and ensure the appropriate use of antibiotics. This has improved the early identification of infections with appropriate testing and treatment. The Catheter Taskforce group undertook an audit of health records to assess the accuracy and detection of UTI's. An assessment sheet was developed and used in the outpatient department for all patients who had an abnormal urine specimen result. This has led to a reduction in the number of patients who have had to experience the pain of a UTI and the associated problems this causes in their everyday life.

Priority 3: Emergency transfer process

In depth reviews of patient transfers have been undertaken in the last two years. As a result recommendations for improvement have been identified and implemented and will ensure we have an efficient pathway for patients who transfer in an emergency.

Priority 4: Care of patients with Osteoporosis

Full implementation of treatment plans has been undertaken and clinic letters have been reviewed by Registrars. Letters to GPs now include further information about the patient, when the patient needs to be seen again, a telephone line for advice and a 'GP action' section to ensure that patient care is fully integrated between the GP and the Specialist Consultant. The focus of this work is to ensure that patient care is seamless and appropriate individualised support for the patient's ongoing care is in place.

Priority 5: Clinicial supervision of nurses

A supervision structure has been designed, the policy updated and nurse training identified. Nurses have been trained at the RUH site. Protected time has been agreed by senior staff and integrated into the off-duty. All senior nurses trained and implementing the policy. By valuing staff and supporting professional development this work maximises the quality of care we give to patients every day.

Priority 6: Use of day care beds

An audit of patients who use the service has been undertaken and the results shared with all staff. The admissions referral form has been updated and implemented. This ensured that access to treatment for patients was improved.

Priority 7: Self management of patients with Rheumatoid Arthritis

In October 2014, clinical staff delivered the first stage of training to patients on the management of their Rheumatoid Arthritis (RA). Further training sessions took place in January and February 2015. This has supported patients in learning how to self-manage their care.

Priority 8: Follow-up appointments in Rheumatology

There has been a lack of capacity within the Rheumatology department and delays to patients being followed up in outpatient clinics. A review of the medical resource has been undertaken as capacity issues remain. Each Consultant reviews and triages ten sets of patient records each week to ensure clinical prioritisation of clinic slots. Emergency clinics are in place for urgent referrals. This work has ensured that patients who need to be prioritised can be seen appropriately.

Priority 9: Privacy and Dignity

A refurbishment of the female bathroom facilities has been completed. This has allowed for improvements in the way that staff manage the privacy and dignity of patients.

4 Our priorities for 2015/16

The priorities for 2015/16 have been selected as we recognise that these are areas where we still have more work to do to ensure that our patients receive high quality, safe, effective care and the best patient experience. The work that we undertook last year to reduce the numbers of hospital acquired pressure ulcers is being taken forward with our 'Aiming for Zero campaign, moving to another level in pressure ulcer prevention'.

In addition, we are continuing to focus on providing a more responsive complaints process and ensure that we use all patient feedback to improve the care that we provide.

Priority 1: Sepsis

Having improved the identification and early recognition of patients with sepsis, our ambition is to fully embed and spread changes across all wards, using the sepsis champions.

A national CQUIN (Commissioning for Quality and Innovation – see page 114 for further details) for sepsis has recently been announced which aims to ensure that all patients at risk of severe sepsis are screened on admission and antibiotics are delivered within an hour to these patients. This will drive further improvements.

Our aims for 2015/6 are:

- To deliver the national CQUIN on screening of all patients at risk of severe sepsis and collate monthly measures
- Further improve the delivery of antibiotics within an hour in patients with severe sepsis and monitor performance monthly
- Integrate with other patient safety work streams to improve early decision making and escalation for patients deteriorating from severe sepsis and other critical conditions
- Develop tools with the community for early identification of sepsis and start the development of an integrated pathway of care
- Continue to increase awareness and share experience regionally with second sepsis masterclass planned for June, focusing on surgical sepsis and sepsis identification in the community.

Priority 2: Improve our care of patients with diabetes

Improving the care of inpatients with diabetes will remain a priority this year. Around 5% of the population has diabetes, but the number of patients in the RUH with the condition at any one time is disproportionately high – around 20%. These patients frequently stay longer in hospital, around two to three days on average, and have more complications.

Our previous approach relied on wards contacting diabetes specialists when they thought they needed to, which often led to care being delayed. It also relied on staff recognising when there was a problem. However, in 2013/14 we piloted a more proactive approach with our new acute diabetes service, which involved a team of Diabetes Specialist Nurses making daily rounds of the Emergency Department and the Medical Assessment Unit to meet patients with diabetes, enabling specialist care to be brought to them as quickly as possible. Instead of waiting for the patient to reach the team, we brought the team to the patient.

Our aims for 2015/16

Building on our success on the Medical Assessment Unit we knew we could help patients in other parts of the hospital.

Due to the nature of the complications of diabetes, patients with diabetes admitted to the RUH tend to be admitted to particular wards. In January 2015 the team are now using their expertise on a further five wards in the hospital and we are hoping to improve diabetes care in the same way we did on MAU. In this way we hope to get specialist involvement for more than 70% of our patients with diabetes when they are admitted.

In 2015-16 we aim:

- to roll-out the more proactive approach to diabetes management, initially to wards with high numbers of patients with diabetes
- to provide proactive specialist management to at least 80% of patients with diabetes whilst in hospital
- to improve discharge communication for all patients admitted with diabetes seen by the acute diabetes team
- to see more patients with diabetes within their first 24 hours in hospital and implement a care plan for them
- to provide increased support for ward staff, and provide training and raise awareness of good diabetes management in wards with high diabetes prevalence
- to reduce insulin errors, medication errors and hypoglycaemia prescription errors by 50% in all areas served by the Acute Diabetes Team
- to ensure all patients seen by the Acute Diabetes Team for hypoglycaemia and diabetic ketoacidosis are treated to nationally recognised best practice standards
- to increase staff reporting of any errors in diabetes care and ensure that staff learn from all incidents.

Priority 3: to reduce the occurrence of acute kidney injury

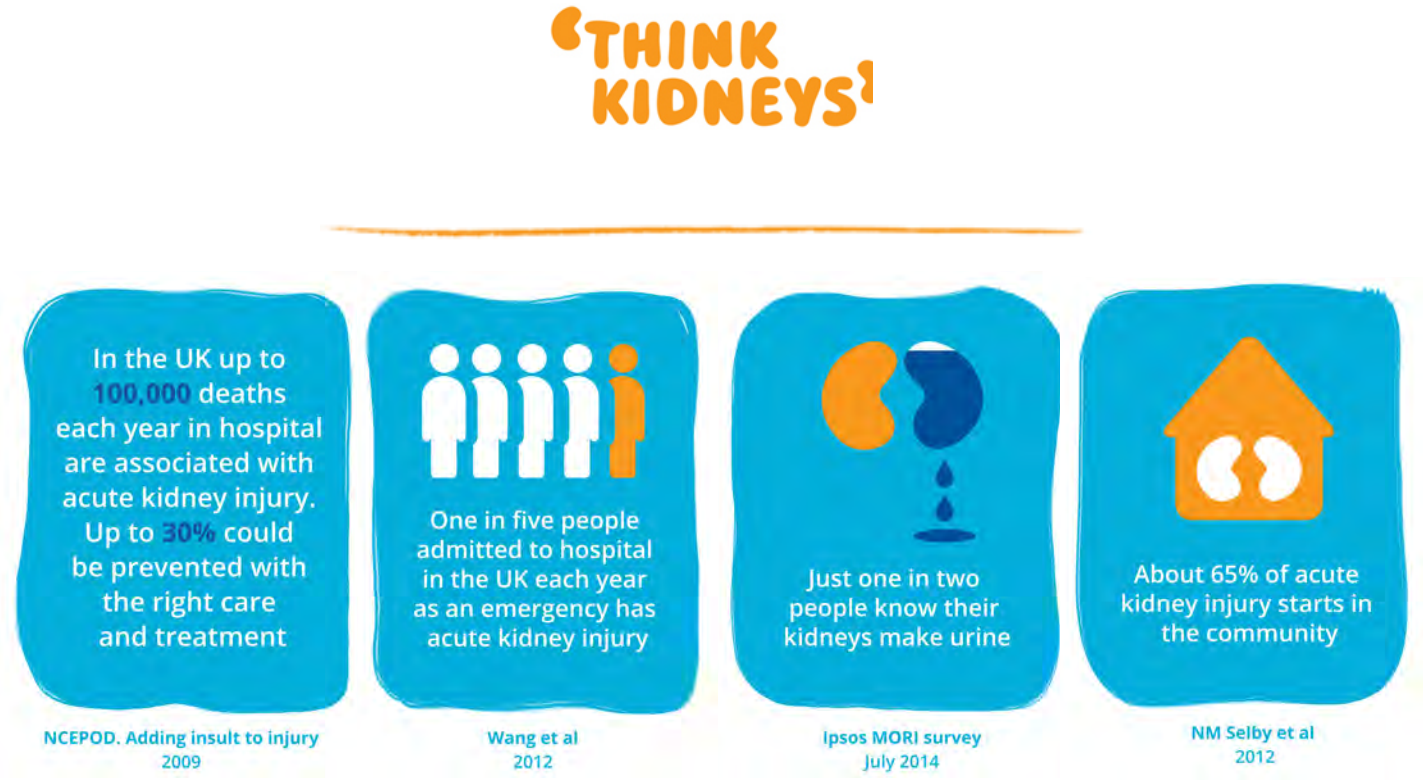
Why have we chosen this as a priority?

Acute kidney injury (AKI), previously known as acute renal failure, is a sudden reduction in kidney function. It encompasses a wide spectrum of injury to the kidneys, not just kidney failure.

Acute kidney injury occurs in 13 -18% of all people admitted to hospital, with older adults being particularly affected. One in five emergency admissions into hospital are associated with AKI. Mortality associated with AKI is up to 30%. These patients are usually under the care of healthcare professionals practising in specialties other than nephrology, who may not always be familiar with the optimum care of patients with acute kidney injury.

The costs to the NHS of acute kidney injury (excluding costs in the community) are estimated to be £500m per year, which is more than the costs associated with breast cancer, or lung and skin cancer combined.

Up to 100,000 deaths in secondary care are associated with AKI and a quarter to a third of those have the potential to be prevented (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Adding Insult to Injury 2009).



Infographic supplied by Acute Kidney Injury National Programme

NHS England in partnership with the UK Renal Registry has launched a National AKI Prevention Programme called 'Think Kidneys', which will include the development of tools and interventions. A priority for the Programme is the development and adoption of e-alert systems, based on the test result, which will proactively notify clinicians when a patient has AKI, supporting implementation of AKI NICE guidance (CG169). Visit www.thinkkidneys.nhs.uk for more information.

Our aims for 2015/16

- Establish an AKI e-alert system in the RUH (whereby if laboratory results indicate a potential case of AKI, this will be flagged to the patient's clinician)
- Establish RUH AKI Multidisciplinary Steering Group
- Create an e-learning package for AKI
- Implement a care bundle approach for the management of AKI
- Raise awareness of AKI within the Trust
- Raise awareness about AKI among our healthcare partners, including GPs
- Reduce incidence of AKI in RUH inpatients
- Review RUH AKI Clinical Guideline (due for review Feb 2016).

AKI measures

A proposal for how we measure improvements against AKI has been sent to our Commissioners and will be included in next year's Quality Report.

Priority 4: Discharge from hospital

We know from patient feedback and from our members that we need to improve the planning for patients being discharged from hospital. We have therefore agreed with our commissioners that this year we will focus on discharge, in particular the experience of patients as they leave hospital. Reliable and safe discharge of patients requires a coordinated approach involving patient and their family, the hospital and healthcare providers in the community, with planning for discharge beginning much earlier in the patient pathway.

A report commissioned by Healthwatch (Bristol, Bath and North East Somerset (BANES) and South Gloucestershire) in August 2014 highlighted that there were mixed experiences of patients on leaving hospital and that there were areas that could be improved, specifically:

- More effective referral into the Voluntary and Community Sector
- Better discharge planning
- Delays in waiting for medicines and transport
- Lack of patient and family involvement in decision-making
- Discharge notes not being sent to the patient's own doctor.

Themes from complaints and contacts with the hospital frequently refer to concerns relating to discharge from the hospital. This is frequently in relation to elderly patients who require support at home and, if not managed effectively, can lead to the patient being readmitted which, in turn, affects patient quality and safety through increasing the likelihood of readmission, prolonged length of stay and poorer health outcomes. It is also especially important to ensure that timely and accurate information accompanies the patient and is available to the patient, carers and partners.

A Discharge Programme Steering Group, chaired by the Director of Nursing and Midwifery has been established to oversee the delivery of the objectives below during the year. We plan to:

- Develop and implement multidisciplinary ward standards for discharge planning, and discharge

- Develop a passport for discharge with patients and carers
- Develop competencies in discharge and discharge planning for clinical staff
- Involve patients and carers in the discharge process focusing on their ongoing needs;
- Timely discharge for patients at the end of life who wish to die at home
- Assess the discharge process developed in collaboration with our community partners, patients and carers.

Progress against this priority will be reported to our Commissioners and Governors throughout the year and in next year's Quality Accounts.

5 Statements of assurance from the Board

Review of services

RUH

During 2014/15 the Royal United Hospitals Bath NHS Foundation Trust provided and sub-contracted nine types of NHS services via three clinical divisions, Medicine, Surgery and Women and Children's.

The income generated by the Trust, in relation to these services, represents 100% of the total income generated from the provision of NHS services by the Trust for 2014/15.

The Health and Social Care Act 2008 lays down a number of 'activities' (types of services provided) which are regulated by the Care Quality Commission (CQC). The CQC will register providers, such as the RUH, to carry out the regulated activities if providers show that they are meeting essential standards of quality and safety. The nine types of activity that, as a Trust we have been registered by the CQC to carry out are:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Management of supply of blood and blood derived products
- Nursing care
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury
- Family Planning
- Maternity and Midwifery Services (from June 2014).

The RNHRD was added as a new location on the Trust's certificate of registration on 1 February 2015.

RNHRD

During 2014/15 the RNHRD NHS FT sub-contracted one relevant health service, the Breast Radiation Injury Rehabilitation service. The RNHRD leads the service, which was also delivered by Barts Health NHS Trust and the Christie NHS Foundation Trust under sub-contract for part of the nine-month reporting period. The Trust's Complex Regional Pain Service transferred to specialist commissioning during 2013/14.

The RNHRD NHS FT reviewed all the data available to it on the quality of care in all of these relevant health services. The volume of activity delivered by these partner organisations during 2014/15 was low, given the very small number of patients covered by the service.

The income generated by the relevant health services represented less than 1% of the total income generated from the provision of relevant health services by the RNHRD NHS FT for the period of this report.

Participation in clinical audits and national confidential enquiries

RUH

During 2014/15, 41 national clinical audits and 4 national confidential enquiries covered NHS services that the Royal United Hospital Bath NHS Trust provides.

During that period the Royal United Hospitals Bath NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2014/15 are listed overleaf, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
NCEPOD		
Gastrointestinal Haemorrhage	Yes	100%
Lower Limb Amputation	Yes	100%
Sepsis	Yes	100%
Tracheostomy Care	Yes	100%
Acute		
Adult community acquired pneumonia	Yes	100% (still ongoing)
Case Mix Programme	Yes	100%
Emergency use of oxygen	N/A	N/A
Fitting child (care in emergency departments)	Yes	100%
Mental health (care in emergency departments)	Yes	100%
National emergency laparotomy audit (NELA)	Yes	83%
National Joint Registry (NJR)	Yes	100%
Non-invasive ventilation (adults)	Yes	Commenced Feb 15
Older people (care in emergency departments)	Yes	100%
Pleural Procedures	Yes	Unknown
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	79.9%
Blood and Transplant		
National Comparative Audit of Blood Transfusion programme: 2014 Audit of transfusion in children and adults with Sickle Cell Disease	Yes	100% (2 cases submitted)
Cancer		
Bowel cancer (NBOCAP)	Yes	100%
Head and neck oncology (DAHNO)	Yes	100%
Lung Cancer (NLCA)	Yes	100%
National Prostate Cancer Audit	Yes	100%
Oesophago-gastric cancer	Yes	100%
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	100%
Congenital heart disease (Paediatric cardiac surgery) (CHD)	N/A	N/A
Coronary angioplasty	Yes	100%
National Adult Cardiac Surgery Audit	N/A	N/A
National Cardiac Arrest Audit (NCAA)	Yes	100%

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
National Heart Failure Audit	Yes	100%
National Vascular Registry	N/A	N/A
Pulmonary hypertension (Pulmonary Hypertension Audit)	Yes	The RUH has a shared care link with the Royal Free who are one of the designated centres that participate. The RUH and RNHRD provide data.
Long term conditions		
Diabetes (Adult) includes National Diabetes Inpatient Audit	Yes	Commenced Jan 15
Diabetes (Paediatric)	Yes	100%
Inflammatory bowel disease	Yes *(The RUH did not participate in the biological therapy audit)*	100%
National Chronic Obstructive Pulmonary Disease Audit Programme	Yes	100%
Renal replacement therapy (Renal Registry)	N/A	N/A
Older People		
Falls and Fragility Fractures Audit Programme	Yes	100%
National Dementia Audit	Yes	Commenced Jan 15
Sentinel Stroke National Audit Programme	Yes	90%+

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
Other		
Elective surgery (National PROMs Programme)	Yes	April – Sept 2014: • Pre-operative questionnaires – 443 eligible episodes, 540 questionnaires returned = **121.9**% • Post-operative questionnaires – 214 sent, 38 returned = **17.8**%
National Audit of Intermediate Care	N/A	N/A
Women's & Children's Health		
Child Health Clinical Outcome Review Programme	N/A	N/A
Epilepsy 12 audit (Childhood Epilepsy)	Yes	N/A
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric intensive care	N/A	N/A

The reports of 38 **national** clinical audits were reviewed by the provider in 2014/15 and the following are examples of the actions the Royal United Hospitals Bath NHS Foundation Trust intends to take to improve the quality of healthcare provided:

- **Sentinel Stroke National Audit** –Two additional Medical Nurse Practitioners were in place from March 2015 to provide a seven-day stroke in-reach service to the Emergency Department. This model was piloted earlier in the year and the model was found to support earlier identification of stroke patients and improved performance against the standard to directly admit stroke patients to a stroke unit within four hours. The RUH is also working closely with our community partners in B&NES, Somerset and Wiltshire to improve the flow of patients out of the care of the stroke unit into appropriate community care settings.
- **National Cardiac Arrest Audit (NCAA)** – In a collaborative project between switchboard, IT, audit and led by the resuscitation training lead, a database has been created, hosted on the intranet and accessed by switch, audit and resuscitation training team – called CARLA (Cardiac Arrest Reporting Logging and Auditing) – with the data collected being driven by ALL calls to switchboard and enabling clinical follow up every weekday by the resuscitation training team and data analysis by audit.
- **Adult Critical Care (Case Mix Programme – ICNARC CMP) 2012/13** – The Trust appointed Alturos (a specialist organisational improvement services provider) to review the issue of the RUH being identified as an outlier for out-of-hours discharges to the ward and delayed transfer to the ward. This information is reviewed monthly and are part of the Critical Care Patient Safety Workstream.
- **National COPD Audit** – the Respiratory ward has developed a COPD bundle, supported by appropriate trained staff, to ensure COPD patients are given optimal treatment. This includes ensuring patients are prescribed oxygen appropriately and are given access to pulmonary rehabilitation and smoking cessation on discharge.

The reports of 94 **local** clinical audits were reviewed by the Trust in 2014/15 and the following are examples of the actions the Royal United Hospitals Bath NHS Foundation Trust intends to take to improve the quality of healthcare provided:

- **Pleural Procedures Audit** – the Pleural Clinic (lung disease) is now led by the specialist team, resulting in improved education. Ultrasound is now encouraged before chest drain insertion (pleural procedures) unless for an emergency case. An increased number of doctors are now complying with this

Photo by Artur Lesniak

recommendation.

- **Resuscitation Equipment Trolley Audit** – The audit showed that the correct equipment was present on resuscitation trolleys, however there were some gaps in recording of daily and weekly equipment checks. The audit findings were fed back to ward staff at the time of the audit and to the resuscitation link nurses on study days. Spot check audits will be carried out during 2015, focusing on departments that were not fully compliant with equipment checks. An equipment checklist has been developed which details equipment that should be checked daily. It is proposed that these checks will be included as part of the daily ward patient safety briefings.
- **An Audit on outpatient letters sent within 14 days to the patient's GP (RNHRD site)** – The audit found that 72% of letters were sent within 14 days of the patient's appointment. Since the audit new staff have been appointed including two bank staff, and a full-time member of staff to assist with the timely distribution of patient letters. Reminders are sent weekly to medical staff about timely verification of letters and discussed at induction by the Outpatient Manager.
- **Medicines Reconciliation (RNHRD site)** – The classic patient safety thermometer identified a few occasions where medicines were not always reconciled. As a result work with the pharmacist to embed a robust process has been put in place by the Drugs and Therapeutics Committee. This is being monitored through monthly audit compliance. An exception report was produced in December 2014. This has been escalated from the Head of Clinical Practice and Nursing at the RNHRD to the Chief Pharmacist at the RUH. Data for February 2015 has shown 100% compliance.
- **Health Record Content Audit** — The Health Record Content Audit is carried out on an annual basis and monitors adherence to the RUH record keeping standards. The audit findings have been presented to the Medical Records User Group and disseminated to the divisions highlighting the top areas of improvement and standards requiring improvement. The RUH record keeping training slides have been updated to incorporate learning from this audit.

RNHRD

During 2014/15, two national clinical audits but no national confidential enquiries covered NHS services that the RNHRD provides.

During that period the RNHRD participated in both the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the RNHRD participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
Acute Care – National Cardiac Arrest Audit	Yes	No cardiac arrests occurred during data collection period therefore no cases were submitted.
Long Term Conditions – Rheumatoid and early inflammatory arthritis	Yes	97.5%

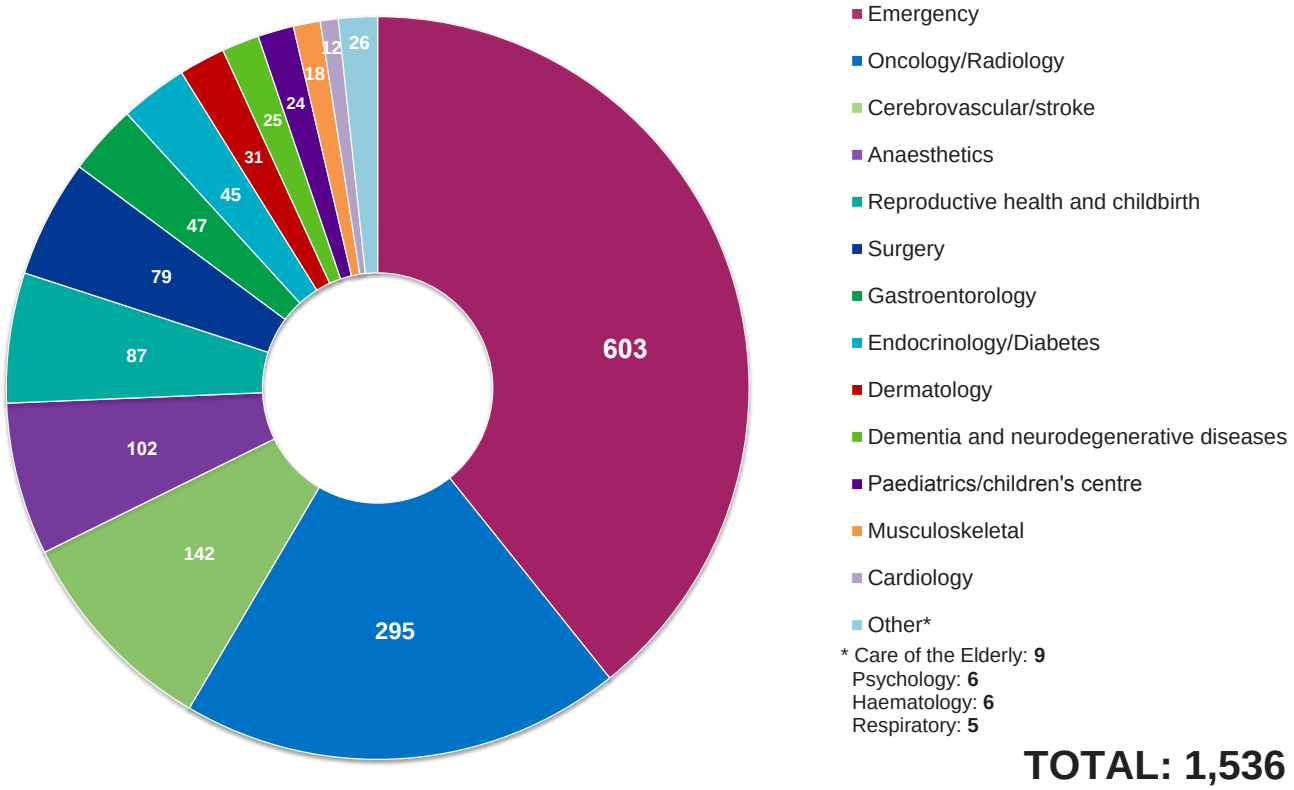
Research

RUH

We are committed to participation in research and it is our ambition for research to take place across all clinical specialities, giving as many patients as possible the opportunity to be involved and to have access to treatments that are at the forefront of medical science. Research, and research evidence, is essential in ensuring that the treatment and care we provide is effective and safe.

The past year has seen an increase in the number of specialities involved in research and adding to the evidence base, with almost 20 different specialties and teams actively conducting research.

Recruitment by specialty 2014/15



* Care of the Elderly: **9**
Psychology: **6**
Haematology: **6**
Respiratory: **5**

TOTAL: 1,536

As in previous years, research into effective treatments for cancer remains a large part of our portfolio, with over 40 studies open and more being set up. A number of studies have resulted in significant savings to the costs of drugs and radiotherapy, thus improving access to these for all patients. The oncology and haematology teams also have strong links with University of Bath, and conduct a number of joint and collaborative research studies.

The creation of the Women and Children's Division has been an exciting development for researchers across the RUH. Both maternity and paediatrics have a great track record in taking part in new and innovative research projects. The coming together of these teams into a single division provides an opportunity for collaborations that will give RUH patients the ability to be involved in research from womb right through to adulthood.

One maternity research study, known as BUMPES, was completed in 2014 and the team were consistently among the top three recruiting centres in the UK. 202 first time mums, who had chosen to have an epidural for labour pain, took part. This study was looking at whether it is better for women to sit upright or lie on their side, to help the baby to be born. The results should be published soon and we hope that this will improve our care of women who are labouring with an epidural.

Within Paediatrics the SNIFFLE study, which aims to test whether a new flu vaccine is safe for use by children with an egg allergy, took place during the winter flu season. A large number of vaccines are produced using eggs, and this can mean that children who are allergic to eggs are unable to be protected from certain infectious diseases. It is hoped that the study will lead to evidence that will ensure that children with an egg allergy can be included in national immunisation programmes.

This has also been an excellent year for research in our Emergency Department, with over 500 patients involved in a number of interesting studies. One such study, PROTECT (Parental Responses to Child

Experiences of Trauma), is a research project led by the Psychology Department of the University of Bath, working in collaboration with both our Emergency and Paediatric Departments. The study involves meeting with parents of children who may have experienced a frightening event to establish how parents can support their child, with the aim that the possibility of lasting psychological distress is reduced. Using the results of this study we can ensure that the practices we employ are evidence-based and not just amended versions of what we know might work well with adults. It also means that staff will know exactly the right approach to adopt when caring for children, to provide the best experience possible when they come to our emergency department.

In one week in May 2014, the RUH research team managed to recruit a staggering 95% of patients admitted for surgery into a study analysing complications following elective surgery. The ISOS (International Surgical Outcomes Study) aimed to follow up all patients who came into hospitals in different countries for elective surgery and look at their clinical outcomes (e.g. what complications they might have had, how long they stayed in hospital etc.). This was an outstanding achievement and will help inform future care of patients who come to RUH for surgery.

Finally, towards the end of this year we joined with colleagues from the Royal National Hospital for Rheumatic Diseases (RNHRD). The RNHRD has a longstanding, international reputation for research and innovation. Continuing to build upon this is a central tenet of the acquisition and the Research and Development Team are excited to be welcoming researchers from the RNHRD and adding to the impressive portfolio of research work that already happens here at RUH. There are many complementary research strengths in both organisations and coming together provides an excellent platform for combining these to make us one of the best research hospitals in our class.

A recent study (http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0118253) demonstrated that hospitals who actively take part in research have better outcomes for all patients, not just those directly involved in research, when compared to hospitals with minimal research activity. Consequently, we will continue to strive to increase the scale and scope of the research we undertake, to improve care and outcomes for our local community.

The number of patients receiving relevant health services provided or sub-contracted by the Royal United Hospitals Bath NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 1,536.

RNHRD

The combined organisation will have one of the largest Research and Development NIHR portfolios amongst medium-sized acute Trusts. The RUH and RNHRD have very different research areas and the acquisition of the RNHRD provides an opportunity for further growth in research as external funding applications, research culture and fund management are further strengthened alongside access to a wider selection of commercially funded clinical trials. It is expected that this will enhance the research and development profile through improved grant funding and clinical fellowships.

It has been a core principle throughout the RNHRD's evolution to combine clinical research and development with the focus on high-quality patient care to meet patient needs. Its clinical reputation is augmented by research. These factors have maintained, on a national and international basis, the RNHRD's reputation amongst patients and referrers for clinical excellence.

The RNHRD has an excellent reputation for research both nationally and internationally. Research informs the treatment programmes and contributes to a better understanding of many of the conditions that the hospital specialises in.

2014/15 has been a year of growth in many aspects for R&D at the RNHRD with a growing team, significant new grant awards and commercially funded trials. The number of projects on the National

Institute for Health Research (NIHR) portfolio also continued to grow however there has been a reduction in the number of patients recruited to studies in-year when compared with previous years. During 2014/15 610 new participants were recruited into portfolio studies.

This reduction can be attributed, in part, to a change in the balance of observational studies to interventional studies requiring more complex visits and often more visits per patient. In contrast to previous years there was no set NIHR network recruitment target for individual trusts, but the R&D committee set an aspirational target of 775 new patients recruited to NIHR Portfolio studies for 2014/15 in the annual plan.

In 2014/15 there were 35 projects on the NIHR portfolio, an increase of 2 from 2013/14 and exceeding the local target set at 30. This included five interventional studies (non-industry sponsored). New areas of NIHR Portfolio research which commenced in 2013/14 have continued to expand with further research in paediatric and adult chronic fatigue and hypermobility.

The trust saw continued success in RNHRD-led and collaborative grant applications with:

- A five-year NIHR Programme grant of £1,969,581 to work in collaboration with eight academic and NHS partners studying early detection and improved outcomes in patients with undiagnosed psoriatic arthritis (PsA)
- An assessment of the resource utilisation and costs associated with patients with Psoriatic Arthritis (PsA) and the association with disease severity £85,300 (Celgene)
- Dr Phil Hamman was awarded a British Society of Rheumatology (BSR) fellowship to complete a PhD with the University of Bath and in conjunction with the BSR Biologics Registry (based at University of Manchester) £190,876. This research will explore the factors determining remission in patients with Rheumatoid Arthritis.
- Dr Victoria Flower and Dr John Pauling were awarded a grant from the Raynaud's and Scleroderma

Association for Dr Flower to complete a PhD with the University of Bath £187,245. This research will be investigating the relationship between vasculopathy, inflammation and fibrosis in Systemic sclerosis.

- Dr Sarah Tansley and Prof Neil McHugh were awarded a Fellowship from the Bath Institute for Rheumatic Diseases for a study into Autoantigen Specificity in Juvenile Idiopathic Arthritis as part of her PhD with the University of Bath.
- Prof Candy McCabe £32,000 – Balgrist Foundation (Switzerland) to carry out an international project, COMPACT, Complex Regional Pain Syndrome (CRPS) Outcome Measures for Pain in Clinical Trials
- Sarah Wilson, Physiotherapist – NIHR Clinical Academic PhD preparatory grant £10,000 for research into the use of psychological methods of physiotherapists in chronic pain.
- Dr John Pauling received a £2000 travel bursary to visit the University of Utah Scleroderma Centre

Researchers were supported by the trust to engage in higher degrees and research training and several have been working towards PhD and Masters Degrees. This includes Dr Philip Hamman, Dr Vicky Flower, Dr Sarah Tansley and Sarah Wilson (Physiotherapist).

During 2014 the long-standing collaborative work with the Bath Institute for Rheumatic Diseases (BIRD) went through several changes as the charity moved their lab-based services to the RUH and the RNHRD set up blood sample processing for research trials and DNA preparation on site. Investment also took place to ensure the bio-banks, previously housed in the BIRD building, were appropriately accommodated within the RNHRD. The Trust continues to work with BIRD to promote research and education.

The number of patients receiving relevant health services provided or subcontracted by the RNHRD NHS FT in the reporting period that were recruited during that period to participate in research approved by a research ethics committee was approximately 1,100 (includes both portfolio and non-portfolio recruitment).

Goals agreed with Commissioners

RUH

A proportion of Royal United Hospitals Bath NHS Foundation Trust's income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between Royal United Hospitals Bath NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. In value terms, this represents 2.5% of the RUH contract with our Commissioners.

It is anticipated that the Trust will receive £4.602m in CQUIN payments out of a possible £4.750m, which represents 97% achievement.

RNHRD

A proportion of RNHRD NHS FT income in the ten-month period was conditional upon achieving quality improvement and innovation goals agreed between the RNHRD NHS FT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2014/15 and for the following 12-month period are available online.

The monetary total for the amount of income at 31 January 2014/15 conditional upon achieving quality improvement and innovation goals was £403,000 which was received in full or part thereof.

The monetary total for the amount of income for 2013/14 conditional upon achieving quality improvement and innovation goals was £230k which was received in full.

What others say about us

CQC Registration

RUH

The Royal United Hospitals Bath NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registration without conditions'. The CQC has not taken enforcement action against the Royal United Hospitals Bath NHS Foundation Trust during 2014/15. The RUH has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC Pilot Inspection/review

In December 2013 the CQC inspected the trust under their new inspection model for NHS hospitals. As this was a pilot, the Trust did not receive a rating as a result of this inspection. The inspection report published in February 2014 found that overall the Trust was found to be providing good care and treatment in all five CQC domains. It reported that the Trust had significantly improved how it managed the demand for its services and staff fed back that there had been a tangible shift in culture towards a greater focus on patients. The CQC made a number of recommendations where the Trust could improve, however none were found to be of significan concern.

The Trust developed an improvement plan in consultation with its key stakeholders detailing the actions that would be taken to address the recommendations from the CQC's report. During 2014/15, the Board of Directors and the Quality Board monitored the delivery of the Improvement Plan until its completion in February 2015.

In June 2014, the CQC undertook a review of services for children looked after and safeguarding in Bath and North East Somerset (B&NES). The review focused on the experiences and outcomes for children within the boundaries of the local authority area and reported on the performance of health providers serving the area, including Clinical Commissioning groups and Local Area Teams. The review explored the effectiveness of health services for children looked after and the effectiveness of safeguarding arrangements with health services for all children. The focus was on the experiences of looked after children and children and their families who receive safeguarding services.

The CQC made a number of recommendations for further improvement relating to the Royal United Hospitals Bath NHS Foundation Trust and Bath and North East Somerset Clinical Commissioning Group. An action plan has been developed in response and delivery of the actions is being monitored by the Safeguarding Children's Committee.

Responsibility for the provision of maternity services both on the RUH site (Princess Anne Wing) and in the community (based in Trowbridge, Paulton, Shepton Mallet, Chippenham and Frome) transferred from Great Western Hospitals NHS Foundation Trust to the Trust on 1 June 2014. The CQC last inspected the Princess Anne Wing in August 2013. The CQC confirmed that maternity services met the standards under inspection.

RNHRD

The Trust acquired the RNHRD on 1 February 2015. The CQC last inspected the RNHRD in December 2013. The CQC confirmed that the RNHRD met the standards under inspection. The RNHRD did not participate in any special reviews or investigations during the period.

Data quality

RUH

The Royal United Hospitals Bath NHS Foundation Trust submitted records during 2014/15 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data*: — which included the patient's valid NHS number was:	
% for admitted patient care	99.7
% for outpatient care	99.8
% for accident and emergency care	98.6

The percentage of records in the published data*: — which included the patient's valid General Medical Practice Code was:	
% for admitted patient care	100
% for out patient care	99.8
% for accident and emergency care	99.9

** Latest published date is April 2014 - December 2014 inclusive*

Royal United Hospitals Bath NHS Foundation Trust Information Governance Assessment Report overall score for 2014/15 was 89% and was graded as satisfactory.

In total there are 45 standards and for each one we are required to evidence our compliance. Dependent on the evidence each standard is judged from level 0 (no evidence) to level 3 (evidence of full compliance). This year the Trust has achieved at least level 2 for all 45 standards and for many standards it reached the highest level 3.

Clinical coding translates the medical terminology written in a patient's health record to describe a patient's diagnosis and treatment into a standard, recognised code. The accuracy of this coding is a fundamental indicator of the accuracy of the patient's records and underpins payments and financial flows with the NHS.

The Royal United Hospitals Bath NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. There were two HRG groups audited: HRG subchapter AA (stroke and nervous system) and HRG subchapter LB (urinary and male reproductive organs) and the error rates are recorded in the following tables. This audit is based on 100 Consultant episodes in each of the specialties.

APC Technical Appendix - AA - (Full)		
Summary of errors	**Actual no. of errors**	**Overall % error rate**
Primary diagnoses incorrect - including all errors	2	2.0
Secondary diagnoses incorrect (including all errors)	23	5.2
Primary procedures incorrect (including all errors)	3	6.0
Secondary procedures incorrect (including all errors)	7	7.6

APC Technical Appendix - LB - (Full)		
Summary of errors	**Actual no. of errors**	**Overall % error rate**
Primary diagnoses incorrect - including all errors	10	10.0
Secondary diagnoses incorrect (including all errors)	14	5.4
Primary procedures incorrect (including all errors)	11	13.3
Secondary procedures incorrect (including all errors)	16	31.4

The RUH level of performance relating to clinical coding by our external Payment by Results (PbR) audit in December 2014 (commissioned by Monitor) was deemed to be adequate.

RNHRD

The RNHRD submitted records during 2014/15 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data (to November 2014). The percentage of records in the published data which included the patient's valid NHS number was:

- 99.9% for admitted patient care
- 100% for outpatient care
- There is no accident and emergency service provided by the Trust.

The percentage of records in the published data which included the patient's valid General Practitioner Registration Code was:

- 99.8% for admitted patient care
- 99.8% for outpatient care
- There is no accident and emergency service provided by the Trust

The RNHRD was not subject to any Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Data quality improvement

In order to improve data quality the Royal United Hospitals Bath NHS Foundation Trust will continue to embed a culture of excellent data quality within the Trust through the development of the oversight mechanisms such as the Data Quality Assurance Framework, a tool for assessing the quality of information in key performance standards.

RNHRD

The RNHRD took the following action to improve data quality:

- improvement in the legibility and format of the off-duty rota.

6 Review of quality performance

This section of our Quality Accounts provides an overview of the quality of care we provided in 2014/15. The information shows our performance against mandated indicators as set out in the guidance from Monitor (the independent health regulator) and also against a number of indicators selected by the Board of Directors in consultation with our Commissioners.

Three indicators have been selected from each of the domains of patient safety, clinical effectiveness and patient experience. Where possible, we have included our previous year's performance and how we benchmark against the national average. The measures in this section cover both the Royal United Hospitals Bath NHS Foundation Trust (RUH) and the Royal National Hospital for Rheumatic Diseases (RNHRD).

For the RUH these indicators have been selected from the Trust's Integrated Balanced Scorecard and the Monitor Risk Assessment Framework and fit within the domains of caring, effective, safe and responsive. They also link to the areas that we have identified in our Quality Accounts and the CQUIN targets. We believe that our performance against these indicators demonstrates that we are providing high quality patient-centred care and will continue to monitor our performance over the coming year.

The indicators selected for the RNHRD reflect quality measures chosen by the trust as priority areas of focus in 2014/15.

Patient safety

RUH

The three patient safety indicators are:

- falls
- infections
- pressure ulcers.

Falls	RUH local target	2014/15 Perform-ance	Did we achieve in 2014/15 against our target?	2013/14 Perform-ance	Have we improved on 2013/14?	2012/13 Perform-ance	Have we improved on 2012/13?
Falls assessment completed within 24 hours (average per month)	95%	96.8%	✓	95.0%	✓	94.5%	✓
Number of falls result-ing in harm (average per month)	N/A	2	N/A	3	✓	3	✓
Falls resulting in harm per 1,000 bed days	N/A	0.059	N/A	0.094	✓	0.086	✓

We are confident that the data we use to monitor falls is an accurate way of looking at falls within our organisation. Falls assessments are completed on our Patient Administration System, and completion rates are monitored by our Senior nursing team. When a patient falls it is reported via our incident reporting tool, and the number of falls and any harm caused are monitored by our falls group.

Infections		RUH Target (National)	RUH Target (Local Stretch) [1]	2014/15 Total	Did we achieve in 2014/15 against our local target?	Did we achieve in 2014/15 against our national target?
Clostridium difficile (C.diff)	Total infections	37	27	27	✓	✓
	Rate per 100,000 bed days [2]	16.1	11.8	12.5	✗	✓
MRSA	Total infections	0	N/A	2	N/A	✗

Infections contd		2013/14 total[3]		Have we improved on 2013/14?	Were we better than the 13/14 national rate in 14/15?[2]	2012/13 total	Have we improved on 2012/13?
		Reported	Actual				
Clostridium difficile (C.diff)	Total infections	37	28	✓	N/A	41	✓
	Rate per 100,000 bed days [2]	18.3	13.8	✓	✓	19.4	✓
MRSA	Total infections	1		✗	N/A	4	✓

[1] We set ourselves a local 'stretch' target for the year which was significantly lower than the national target.

[2] The rate per 100,000 bed days is a method of looking at infections in relation to the number of people that have been in hospital to give an idea of the frequency of infection. This is also an effective way of comparing ourselves against national infection rates. National data is not yet available for 2014/15, but we can compare ourselves to last year to give an idea of where we are nationally.

[3] In 2013/14 we reported 37 cases of Clostridium difficile, however nine of these were later found not to be attributable to the Trust. As a result of this, both reported and actual figures are shown above. The published rate per 100,000 bed days is based on the number reported instead of the actual, as this has been calculated nationally using reported figures. The rate per 100,000 bed days based on the actual cases is also shown for completeness.

Our local 'stretch' target for C.diff reflected our ambition to reduce the number of cases we had last year. We met this target, however our rate per 100,000 bed days was slightly above our target because the number of cases as a proportion of total bed days for the year was lower than expected.

We are confident that our data on infections is accurate. Mandatory surveillance is undertaken by the Trust for blood stream infections caused by Meticillin-resistant staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA) and Escherichia coli (E coli.). All infections caused by Clostridium difficile are also reportable. The Infection Prevention and Control Team receive notification of all of these infections and they report them to Public Health England via the Health Care Associated Infection Data Capture System including enhanced surveillance where necessary, e.g. in some cases we will be required to have undertaken detailed analysis of the infection and identify causes or the source. This is done in line with national definitions.

We are disappointed to have had two cases of MRSA bacteraemia this year. Having completed thorough investigations of each case, it has highlighted that we need to improve our MRSA screening processes and sampling.

Pressure Ulcers		2014/15 Trust local target	2014/15 Total	2014/15 Average per month	Did we achieve in 2014/15 against our local target?
Grade 2	Grade 2	96	31	3	✓
	Device related		15	1	
	Total		**46**	**4**	
Grade 3		0	4	0	✗
Grade 4		0	0	0	✓

Pressure Ulcers	2013/14 total	2013/14 Average per month	Have we improved on 2013/14?	2012/13 total	2012/13 Average per month	Have we improved on 2012/13?
Grade 2	191	16	✓	259	22	✓
Grade 3	8	<1	✓	17	1	✓
Grade 4	1	<1	✓	0	0	✓

[1] Of the 46 Grade 2 pressure ulcers, 15 were device-related (i.e. caused by medical equipment). In line with trust policy these are reported separately on the Trust scorecard.

Pressure ulcers are given categories according to the damage caused to the skin from the least serious (Category 1) to the most serious (Category 4).

Our local targets were based on a programme of work that was put in place in 14/15 called Rapid Spread. The aim of this programme of work was to reduce grade two pressure ulcers by 50% and eliminate grade three and four pressure ulcers through pathway redesign and the implementation of tried and tested methods of working.

Although the target for the reduction of category 3 pressure ulcers was exceeded in 2014-2015, the Rapid Spread work has led to large reductions in avoidable hospital acquired pressure ulcers. In 2014-2015 an 84% reduction in avoidable category 2 pressure ulcers (excluding device-related) was achieved as well as a 50% reduction in category 3 pressure ulcers and zero category 4 pressure ulcers. The second phase of the Rapid Spread project in 2015-2016 will be focusing on further reducing avoidable pressure ulcers, particularly around heel pressure ulcer prevention, as the majority of the category 3 pressure ulcers that occurred in 2014-2015 were on the heel.

We are confident that our pressure ulcer data is accurate. Pressure ulcers are recorded on our Patient Administration System and our incident reporting system. These are then checked and confirmed by our Tissue Viability team.

RNHRD

The three patient safety indicators are:

- MRSA Bacteraemia
- Clostridium Difficile
- Meet essential/core standards regarding quality and safety.

Measure	2014/15 RNHRD performance	Was the trust compliant in 2014/15?	2013/14 RNHRD performance	Was the trust compliant in 2013/14?
MRSA	0	✓	0	✓
Clostridium Difficile	1	✗	0	✓

Data was reported nationally and is governed by national definition. A root cause analysis was undertaken on the case of C Diff. The patient had a complex medical history and was at a high risk of developing C Diff.

Measure	Was the trust compliant in 2014/15?	Was the trust compliant in 2013/14?
Meet essential/core standards regarding quality and safety	✓	✓

Data was reported to Care Quality Commission (CQC) and reported through the quality report to the Clinical Commissioning Group (CCG).

Clinical effectiveness

RUH

The three clinical effective indicators are:

- Sepsis
- Cancer access targets
- Hospital Standardised Mortality Ratio (HSMR).

Our Commissioners have requested that we report our performance against national stroke targets. This can be seen on page 126.

Sepsis		2014/15					2013/14	
		Q1	Q2	Q3	Q4	Total	Have we improved on December to March 2013/14?	December to March[1]
Percentage of patients with antibiotics given and lactate measured within one hour	Performance	39%	51%	53%	43%	48%	✓	34%
	Did we meet our CQUIN target?	✓	✓	✓	✓	N/A	N/A	N/A
Percentage of patients with the sepsis proforma completed	Performance	66%	71%	75%	77%	73%	✓	67%
	Did we meet our CQUIN target?	✓	✓	✓	✓	N/A	N/A	N/A

[1] Data collection on sepsis commenced in December 2013, so we can only compare ourselves against four months of last year.

We are confident that the information we use for monitoring sepsis is accurate. Information is collected from the Patient Administration System within our Emergency Department and also from hospital notes. This is then validated by clinical staff and fed back to staff in the department for monitoring performance and driving improvement.

Cancer Access		Royal United Hospitals Bath NHS Foundation Trust							National
	Measure	Target	2014/15 RUH Total	Did we achieve in 14/15?	2013/14 RUH Total	Did we achieve in 13/14?	2012/13 RUH Total	Did we achieve in 2012/13?	2014/15 National total [1]
Two week wait	From GP referral to 1st outpatient appointment	93.0%	93.7%	✓	95.5%	✓	94.8%	✓	94.0%
	From GP referral to 1st outpatient appointment – breast symptoms	93.0%	95.1%	✓	97.3%	✓	98.8%	✓	92.9%
31 day wait	From diagnosis to first treatment for all cancers	96.0%	98.4%	✓	99.2%	✓	99.7%	✓	97.8%
	From diagnosis to subsequent treatment – surgery	94.0%	98.0%	✓	97.9%	✓	99.1%	✓	96.0%
	From diagnosis to subsequent treatment – drug treatments	98.0%	100.0%	✓	100.0%	✓	100.0%	✓	99.7%
	From diagnosis to subsequent treatment – radiotherapy treatments	94.0%	99.0%	✓	99.9%	✓	98.3%	✓	97.4%
62 day wait	From urgent referral to treatment of all cancers	85.0%	90.0%	✓	89.9%	✓	92.6%	✓	83.8%
	From referral to treatment from a screening service	90.0%	97.0%	✓	91.7%	✓	99.2%	✓	93.8%

[1] National data is not yet available for the full 14/15 year, so the national totals are for the period April to December 2014.

We are confident that the information we use for our cancer indicators is accurate. It is collected from our Patient Administration System, cancer information systems and the national cancer waiting times system in line with national definitions. Parts of the process were audited in January 2014 as part of our internal audit programme.

We also use a range of reports to monitor and manage patient pathways with our cancer team.

Mortality – Hospital Standardised Mortality Ratio (HSMR)		2014/15				2013/14		
		National Average	April to December			April to March		
			HSMR value	Were we better than expected?	Were we within expected range?	Were we better than in 2013/14?	HSMR value	Were we better than expected?	Were we within expected range?
HSMR	Overall	100	92.3	✓		✓	99.7		✓
	Weekday	100	91.5	✓		✓	98.1		✓
	Weekend	100	94.9		✓	✓	104.7		✓

We use the Dr Foster intelligence tool to monitor our HSMR performance. This looks at observed and expected outcomes to measure mortality. The calculation uses statistical methods to identify whether mortality is significantly better, worse or within expected range of the national average.

Due to the time it takes to publish the data we are only able to include figures from April to December 2014.

We monitor HSMR through our monthly Clinical Outcomes Group meeting. This meeting is chaired by our Medical Director, and is attended by clinical and non-clinical staff within the Trust. As part of this any areas of concern are investigated.

We are pleased to note that our overall and weekday HSMR values for April to December 2014 are significantly better than expected, and our weekend rate is within the expected range. In 2013/14 we were also within the expected range.

SSNAP Stroke Data			2014/15			2013/14		
			Apr - Jun	Jul - Sep	Oct - Dec	Jul - Sep	Oct - Dec	Jan - Mar
SSNAP Performance	Domain 2: Stroke Unit – level (team-centred)	RUH	D	D	D	E	D	C
	Domain 2: Stroke Unit – score (team-centred)	RUH	65.2	63.4	60.7	49	62.5	70.3
	2.1 Proportion of patients directly admitted to a stroke unit within 4 hours of clock start	RUH	49.6%	44.4%	43.2%	27.1%	44.5%	58.1%
		National	58.0%	59.8%	56.9%	58.4%	58.1%	57.8%
	2.2 Median time between clock start and arrival on stroke unit (hours:mins)	RUH	4:00	4:04	4:11	5:05	4:06	3:55
		National	3:36	3:33	3:41	3:35	3:36	3:38
	2.3 Proportion of patients who spent at least 90% of their stay on stroke unit	RUH	86.0%	85.7%	79%	80.0%	83.1%	82.9%
		National	83.5%	84.3%	83.4%	81.5%	84.2%	83.3%

SSNAP is the Sentinel Stroke National Audit Programme, a national audit run by the Royal College of Physicians. The audit monitors performance across ten domains which include efficiencies with treatment, therapy input and discharge processes. Each of the domains receives an overall score, and is categorised into a level (A-E) as a way of grouping and comparing against other teams. This is ranked with A being the highest and E being the lowest.

The performance above relates to Domain 2 which looks at measures relating to a patient's stay on the stroke unit. These measures include the time taken for patients to be admitted to the stroke unit, and the proportion of time that patients spend on the stroke ward. The Trust has been in level D for 2014/15 (year to date) for this domain.

We are confident that the data reported to SSNAP is accurate, and that results are submitted in line with national definitions. Reporting is done by teams on the stroke unit to make sure all aspects of the submission are accurate.

We have had significant challenges admitting stroke patients directly to the Acute Stroke Unit (ASU) in a timely fashion as the data shows. This is largely as a result of the extreme bed pressures in the hospital. We have not been able to maintain an empty bed at all times for admissions to the due to the pressures in the Emergency Department and throughout the rest of the hospital. We recognise that this is an area that requires improvement. In March 2015 we successfully appointed two new full-time stroke Medical Nurse Practitioners who are working specifically to identify stroke patients at the time of their admission in the Emergency Department and expedite their diagnosis and admission to ASU within the 4 hour target. We expect this to improve our performance during 2015/16.

RNHRD

The three clinical effective indicators are:

- The Trust will continue to implement NICE guidelines relevant to the Trust services
- Improve availablitity of follow-up appointments – number of written complaints regarding availablity of follow ups.
- Meet core standards regarding clinical effectiveness

Measure	Was the trust compliant in 2014/15?	Was the trust compliant in 2013/14?
The Trust will continue to implement NICE guidelines relevant to the Trust services	✓	✓
Meet core standards regarding clinical effectiveness	✓	✓

Data was reported through the Quality Report to the CCG and Annual Report.

Measure	2014/15 performance	2013/14 performance
Improve availablitity of follow-up appointments – number of written complaints regarding availablity of follow ups.	0	0

Data was reported through the Quality Report to the CCG and Annual Report.

Patient experience

RUH

The three patient experience indicators are:

- Referral to Treament (RTT)
- Patient Surveys
- Friends and Family Test (FFT).

Referral to treatment	Royal United Hospitals Bath NHS Foundation Trust							National
Measure	Target	2014/15 RUH Total	Did we achieve in 14/15?	2013/14 RUH Total	Did we achieve in 13/14?	2012/13 RUH Total	Did we achieve in 12/13?	2014/15 National total [1]
Admitted patients (inpatients) treated within 18 weeks of referral	90.0%	85.8%	✗	89.4%	✗	92.6%	✓	87.5%
Non-admitted patients (outpatients) treated within 18 weeks of referral	95.0%	94.1%	✗	96.0%	✓	97.2%	✓	95.3%
Open pathways – patients waiting longer than 18 weeks for treatment	92.0%	92.3%	✓	93.2%	✓	92.4%	✓	93.3%

[1] National data is not yet available for the full 14/15 year, so the national totals are for the period April to February 2015.

Admitted Performance: The Trust achieved the admitted target of 90% until the autumn of 2014 when there was significant increases in non- elective pressures moving into the winter months. There was an agreement that the trust would be unable to achieve the admitted performance in the last quarter of the year the outcome being achievement of 85.8% overall for 2014/15.

Non-admitted Performance: The Trust saw an increase in the total number of referrals over the last six months of the year (5.4%) compared to the same period last year (2013/14), this included an increase in the number of cancer referrals leading to a significant impact on non-admitted performance.

We are confident that the information reported here is accurate. Our referral to treatment pathways are recorded on our Trust Patient Administration System and are monitored and reported in line with national definitions. In August 2014 our processes and reporting were audited as part of our internal audit programme. We have a range of reports available to monitor and manage patient pathways on a daily basis. Our referral to treatment data for open pathways (patients not yet treated) was audited as part of the process for creating these accounts. Whilst the audit found a small number of errors, the figure reported in these accounts was found to be correct. We are confident that our processes for checking the accuracy of our data are robust. Our patient pathways are subject to thorough checking by a dedicated validation team, with detailed daily checks being conducted from the twelve week stage of a patient pathway onwards. This ensures that any errors are identified and corrected. The errors found by the audit were on patient pathways that had not yet reached the twelve week stage, and so had not been subject to full validation at that point. In August 2014 the Trust had a detailed audit of referral to treatment pathways conducted as part of our internal audit programme, which found our processes to be robust.

In February 2015 we acquired the RNHRD, and so their performance is included for February and March 2015. RNHRD performance for April 2014 to January 2015 is shown in the table below.

Referral to treatment	RNHRD		
Measure	**Target**	**2014/15 RNHRD Total***	**Did performance meet the target in 14/15?**
Admitted patients (inpatients) treated within 18 weeks of referral	90.0%	100.0%	✓
Non-admitted patients (outpatients) treated within 18 weeks of referral	95.0%	96.7%	✓
Open pathways – patients waiting longer than 18 weeks for treatment	92.0%	98.0%	✓

RUH

Emergency Department	Royal United Hospitals Bath NHS Foundation Trust							National
Measure	**Target**	**2014/15 RUH Total**	**Did we achieve in 14/15?**	**2013/14 RUH Total**	**Did we achieve in 13/14?**	**2012/13 RUH Total**	**Did we achieve in 12/13?**	**2014/15 National total [1]**
Patients attending the Emergency department waiting a maximum of four hours before a decision is made to treat, admit or discharge – Emergency Department only	95.0%	90.5%	✗	93.7%	✗	91.9%	✗	90.4%
Patients attending the Emergency department waiting a maximum of four hours before a decision is made to treat, admit or discharge, including the Urgent Care Centre 1	95.0%	91.4%	✗	N/A	N/A	N/A	N/A	93.6%

[1] In 2014/15 the Urgent Care Centre opened alongside our Emergency Department. Because of this we have reported attendances for both the RUH Emergency Department and the Urgent Care Centre this year.

We have continued to see an increase on non-elective demand in the Emergency department across the year and particularly across the winter months. The opening of the Urgent care centre in 2014 provides patients with an alternative to attending the emergency department.

We are confident that our Emergency Department data is accurate. Attendances are recorded on our Emergency Department Patient Administration System and wait times are checked by clinical teams. Our attendances and waits are monitored and reported in line with national guidance. We have a range of reports available to help us to monitor and manage attendances and wait times on a daily basis.

The RNHRD does not have an emergency department.

RUH

Patient surveys – National Accident and Emergency Survey	National		Royal United Hospitals Bath NHS Foundation Trust		
Measure	2014 lowest score	2014 highest score	2014 RUH Score	Number of questions better than or the same as 2012	RUH Variance to national in 2014
Overall Experience of A&E	7.2	9.0	8.7	2/2	→
Experience of arriving at A&E – Overall	6.8	8.6	8.5	1/2	↑
Experience of waiting times – Overall	4.9	7.0	6.3	1/3	→
Experience of our doctors and nurses – Overall	7.2	8.7	8.5	6/6	↑
Experience of our care and treatment – overall	6.8	8.5	8.2	5/5	↑
Experience of tests conducted (where applicable)	7.4	8.9	8.6	2/3	→
Experience of our hospital environment and facilities	7.3	9.0	8.6	3/3	→
Experience of leaving A&E	4.8	7.1	6.2	4/6	→

We are confident that our patients have been given the opportunity to take part in the Accident and Emergency survey. We provided a list of patients to Picker, an external company who sent out questionnaires on our behalf to make sure that responses could remain anonymised. These responses were then analysed by Picker. Our data set matched the national definitions that we were given to identify the patient group for the survey, and was checked as part of our internal data quality processes.

The RNHRD does not have an emergency department.

Friends and Family Test			Royal United Hospital			National
Measure			2014/15 RUH Total [2]	Have we improved on 2013/14?	2013/14 RUH Total	2014/15 Total [1]
Inpatients	Response rate		44.7%	✓	42.4%	36.5%
	Net Promoter Score		76	✓	70	71
	Percentage of patients that would recommend the RUH to friends and family		96.4%	✓	95.0%	94.1%
A&E	Response rate		20.2%	✓	14.9%	19.6%
	Net Promoter Score		79	✓	75	53
	Percentage of patients that would recommend the RUH to friends and family		97.5%	✓	95.5%	86.8%
Maternity [1]	Antenatal care	Net Promoter Score	75	N/A	N/A	65
		Percentage of patients that would recommend the RUH to friends and family	97.1%	N/A	N/A	94.5%
	Birth	Response rate	21.7%	N/A	N/A	22.4%
		Net Promoter Score	91	N/A	N/A	76
		Percentage of patients that would recommend the RUH to friends and family	99.4%	N/A	N/A	95.7%
	Postnatal ward	Net Promoter Score	78	N/A	N/A	64
		Percentage of patients that would recommend the RUH to friends and family	97.4%	N/A	N/A	92.1%
	Postnatal community provision	Net Promoter Score	83	N/A	N/A	76
		Percentage of patients that would recommend the RUH to friends and family	97.4%	N/A	N/A	96.5%

[1] The Trust took on Maternity services in June 2014 from Great Western Hospitals NHS Foundation Trust. Because of this we have only been collecting Friends and Family Test responses since we started the service. This means that the maternity figures do not include the first two months of 2014/15, and historic data is not available.

[2] The latest published data is only available up to February 2015, so 2014/15 national performance is currently April 2014 to February 2015 only.

The percentage of patients that would recommend our emergency department has been in the top five nationally throughout all months of the 2014/15 to date. In January our emergency department ranked first nationally, with 98% of patients responding that they would recommend the RUH to their friends and family.

We are confident that our patients have been given the opportunity to provide feedback via the Friends and Family test, and that the information displayed represents the responses that we have received. Patients are given the opportunity to complete feedback cards, which are then entered onto our patient experience system. Eligible patient numbers are taken from our Patient Administration System. Responses and eligible populations are reported in line with national definitions. Our processes were audited for our 2013/14 Quality Accounts.

In February 2015 we acquired the Royal National Hospital for Rheumatic Diseases, and so their performance is included for February and March 2015. RNHRD performance for April 2014 to January 2015 is shown in the table below.

Friends and Family Test		RNHRD
Measure		2014/15 RNHRD Total*
Inpatients	Response rate	54.3%
	Net Promoter Score	90
	Percentage of patients that would recommend the RNHRD to friends and family	98.4%

RUH

Access to healthcare for patients with learning disabilities	Were we compliant in 2014/15?	Were we compliant in 2013/14?
	✓	✓

We are measured on our compliance with the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008) and specified in Monitor's Risk Assessment Framework.

RNHRD

The three patient experience indicators are:

- Improve bathroom facilities and signage for wards – national inpatient survey results for mixed sex bathroom facilities
- Improve telephone access for appointments – number of complaints or PALS contacts
- All written complaints to continue to be managed effectively within policy timescales – % written complaints managed as specified

The indicator to improve bathroom facilities and signage for wards is detailed on page 132 . National inpatient survey results for mixed sex bathroom facilities showed performance of 8.1 which was about the same as other trusts, and was an improvement on the 2012/13 score. Data for 2014/15 was not available at the time of reporting.

Measure	2014/15 performance	2013/14 performance
Improve telephone access for appointments – number of complaints or PALS contacts	0	25

Number of complaints or PALS contacts was reported in the Quality Report to the CCG.

Measure	2014/15 performance	2013/14 performance
All written complaints to continue to be managed effectively within policy timescales – % written complaints managed as specified	86.7%	91.7%

Number of written complaints received and number managed locally within national complaints policy timescales.

2014/15 - 15 written complaints received, 13 of which were managed locally within the national complaints policy timescales. For 2 complaints the investigation took longer than anticipated and an interim letter was sent to the patient to explain the reason for the delay.

2013/14 - 12 complaints received 11 of which were managed locally within the national complaints policy timescales.

For one complaint the investigation took longer than anticipated and an interim letter was sent to the patient to explain the reason for the delay.

Core indicators

RUH

Preventing people from dying prematurely		RUH Performance		National Average	"National Best"	"National Worst"
Measure		Jul 2013 - Jun 2014	Apr 2013 - Mar 2014	Jul 2013 - Jun 2014	Jul 2013 - Jun 2014	Jul 2013 - Jun 2014
Summary Hospital Level Mortality Indicator (SHMI)	Value	0.95	0.98	1.00	0.54	1.20
	Banding	2	2	2	3	1
	% of Patient Deaths with Palliative Care Coding	20.7%	19.5%	24.6%	49.0%	0.0%

The Royal United Hospitals Bath NHS FoundationTrust considers that this data is as described for the following reasons:

- The data shown is published by the Health and Social Care Information Centre using data provided by the Trust, and therefore this measure is not calculated by the RUH.
- SHMI is reported as a twelve month rolling position, and the reporting periods shown are the latest available from the Health and Social Care Information Centre.
- The SHMI value is better the lower it is. The banding level shows whether mortality is within 'expected' range based on statistical methodology. A banding of two indicates that mortality is within expected range.
- This measure is not applicable to the RNHRD.

The Royal United Hospitals Bath NHS Foundation Trust has taken the following actions to improve this performance, and so the quality of its services:

- The Trust scoring against this measure is within expected range, and the latest published figures are in line with the previous time period. Because of this no specific improvement actions have been identified, however the Trust is committed to continuing to reduce mortality as measured by both the SHMI and HSMR (Hospital Standardised Mortality Ratio) indicators. The Trust performance against HSMR is detailed on page 136 of the Quality Accounts.
- Our Clinical Outcomes Group, chaired by the Medical Director monitors these indicators on a regular basis, and we use the Dr Foster Intelligence System to monitor mortality and clinical effectiveness.

Helping people to recover from episodes of ill health or following injury		RUH Performance		National Average	National "Best"	National "Worst"
Measure		**Apr14-Sep14**	**Apr13-Mar14**	**Apr14-Sep14**	**Apr14-Sep14**	**Apr14-Sep14**
PROMS: Patient reported outcome measure	Groin Hernia - EQ VAS	-	-0.96	-0.40	3.63	-4.56
	Groin Hernia - EQ-5D Index	-	0.10	0.08	0.13	-0.01
	Hip Replacement Primary EQ VAS	-	11.29	12.16	16.88	5.38
	Hip Replacement Primary EQ-5D Index	-	0.45	0.44	0.51	0.35
	Hip Replacement Primary Oxford Hip Score	-	22.14	21.92	25.42	18.36
	Hip Replacement Revision EQ VAS	-	13.35	4.05	-	-
	Hip Replacement Revision EQ-5D Index	-	0.36	0.28	-	-
	Hip Replacement Revision Oxford Hip Score	-	15.43	13.09	-	-
	Knee Replacement Primary EQ VAS	-	7.04	6.37	12.51	-0.67
	Knee Replacement Primary EQ-5D Index	-	0.34	0.33	0.39	0.24
	Knee Replacement Primary Oxford Knee Score	-	16.89	16.70	20.85	14.29
	Knee Replacement Revision EQ VAS	-	-	1.95	-	-
	Knee Replacement Revision EQ-5D Index	-	-	0.26	-	-
	Knee Replacement Revision Oxford Knee Score	-	-	11.73	-	-
	Varicose Vein – Aberdeen Questionnaire	-	-	-9.48	-1.96	-16.76
	Varicose Vein EQ VAS	-	-	-0.47	3.96	-2.92
	Varicose Vein EQ-5D Index	-	-	0.10	0.15	0.03

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

- The data shown is published by the Health and Social Care Information Centre using data provided by the Trust and patient responses. It is not possible to calculate this measure internally. The Trust give pre-operative questionnaires to all eligible patients and a follow up post-operative questionnaire is sent to patients by an external company in line with national guidance.
- Information is not available for the Trust against the PROMS measures for the most recent reporting period. This is because a low number of the post-operative questionnaires have been returned to date, due to the time it takes to gather and process responses. Small numbers are not used because it is difficult to make accurate assumptions about improvements in care, and in some cases information has to be excluded to protect patient confidentiality.
- The reporting periods shown are the latest available from the Health and Social Care Information Centre.
- This measure is not applicable to the RNHRD.

The Royal United Hospitals Bath NHS Foundation Trust has taken the following actions to improve this performance, and so the quality of its services:

- Historically the Trust scoring against this measure has been within expected range (above national average) for the majority of areas. In particular we have been above average on the Oxford Hip and Knee scores, which are a key area of focus as they relate specifically to the patient's condition. Because of this, no specific improvement actions have been identified. However, the Trust intends to continue to improve against this measure in 2015/16.
- Of the other two measures, EQ-5D Index is a combination of five key criteria concerning general health and EQ VAS is the current state of the patients general health marked on a visual analogue scale.
- The Trust will continue to review performance against PROMS measures when more recent data becomes available.

		RUH Performance		National Average*	National "Best"*	National "Worst"*
Measure		**Apr14-Dec14**	**Apr13-Mar14**	**2011/2012**	**2011/2012**	**2011/2012**
Patient readmitted to a hospital within 28 days of being discharged	0-15 years old	8.40%	10.73%	8.15%	0.00%	13.58%
	16 years or over	8.96%	8.79%	10.02%	0.00%	13.50%

* Medium acute trusts.

The RUH considers that this data is as described for the following reasons:

- Published data from the Health and Social Care Information Centre for the most recent time periods was not available at the time of reporting, and so in order to provide more up to date information the performance above has been taken from a different source. This data has been taken from Dr Foster Intelligence, a tool used by the Trust to monitor patient outcomes using data submitted by the Trust.
- A recent national comparator is not currently available, as the most recent data published by the Health and Social Care Information Centre is for the year 2011/12. Because of this figures for the time period have been used to identify the national average, best and worst figures for these measures and so are not directly comparable to the time periods used for RUH performance. National figures are based on all medium acute trusts as a comparison.
- Due to the time it takes to publish the data we are only able to include figures from April to December of this year for the latest time period.

The Royal United Hospitals Bath NHS Foundation Trust has taken the following actions to improve this performance, and so the quality of its services:

- We are pleased to note that the re-admission rate for children and young people (0-15) has improved this year so far, and the rate for adults is in line with 2013. Re-admission rates published by Dr Foster are reviewed at our monthly clinical outcomes group meeting that is chaired by our Medical Director. The paediatric service provides open access as a safety net and therefore would expect to have a percentage of children returning to hospital.

RNHRD

		RNHRD Performance		National Average*	National "Best"*	National "Worst"*
Measure		**Apr14-Dec14**	**Apr13-Mar14**	**2011/2012**	**2011/2012**	**2011/2012**
Patient readmitted to a hospital within 28 days of being discharged	0-15 years old	0.00%	0.00%	7.55%	3.75%	8.36%
	16 years or over	1.90%	0.70%	9.73%	0.00%	14.09%

* Acute specialist trusts

RUH

Ensuring people have a positive experience of care	RUH Performance		National Average	National " Best"	National " Worst"
Measure	2013/14	2012/13	2013/14	2013/14	2013/14
Responsiveness to the Personal needs of Patients – Inpatient Overall score	67.4%	67.5%	68.7%	84.2%	54.4%

The Royal United Hospitals Bath NHS FoundationTrust considers that this data is as described for the following reasons:

- The data shown is published by the Health and Social Care Information Centre using patient responses to the National Inpatient Survey. The list of patients were provided by the Trust using the methodology and criteria specified for the survey. In order to protect the confidentiality of responses the survey is analysed by an external company, and so this cannot be calculated internally. Responses for the 2014 National Inpatient Survey have not yet been released, therefore the latest available surveys have been included. These relate to the 2012 and 2013 inpatient surveys.

The Royal United Hospitals Bath NHS Foundation Trust has taken the following actions to improve this performance, and so the quality of its services:

- In 2013/14 our overall score was slightly below the national average and there were three areas where we focused our improvements. These were the cleanliness of wards, availability of hand gel and patients sharing their sleeping area with members of the opposite sex. The Trust awaits the publication of the 2014 National Inpatient Survey to see if there have been improvements in these areas.

RNHRD

Ensuring people have a positive experience of care	RNHRD Performance		National Average	National " Best"	National " Worst"
Measure	2013/14	2012/13	2013/14	2013/14	2013/14
Responsiveness to the Personal needs of Patients – Inpatient Overall score	74.7%	76.6%	68.7%	84.2%	54.4%

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust considers that this data is as described for the following reasons:

- The data shown is published by the Health and Social Care Information Centre using patient responses to the National Inpatient Survey. Responses for the 2014 National Inpatient Survey have not yet been released, therefore the latest available surveys have been included. These relate to the 2012 and 2013 inpatient surveys.

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust intends to take the following actions to improve this performance, and so the quality of its services, by:

- The results of the 2014 Inpatient survey will be used to identify if there are any necessary improvement actions for the RNHRD site.

RUH

		RUH Performance		National Average*	National " Best"*	National " Worst"*
Measure		**2014**	**2013**	**2014**	**2014**	**2014**
Staff who would recommend the trust to their family or friends		75%	70%	65%	89%	38%

* Acute Trusts

The Royal United Hospitals Bath NHS FoundationTrust considers that this data is as described for the following reasons:

- The data shown is taken from the NHS Staff Survey. The survey is run and analysed by an external company and so this cannot be calculated internally. This is done in line with national guidance. This year all staff members were given the opportunity to complete a staff survey to make sure opinions were captured from as many people as possible.

The Royal United Hospitals Bath NHS Foundation Trust has taken the following actions to improve this performance, and so the quality of its services:

- We are pleased to note that we are above the national average for this measure, and that the proportion of staff who would recommend friends and family has improved on last year. Our Human Resource team have held listening events and are working with specific staff groups to ensure we continue to improve.

RNHRD

		RNHRD Performance		National Average*	National " Best"*	National " Worst"*
Measure		**2014**	**2013**	**2014**	**2014**	**2014**
Staff who would recommend the trust to their family or friends		91%	89%	87%	93%	73%

* Acute specialist trusts

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust considers that this data is as described for the following reasons:

- The date is from the 2014 National Staff Survey, the score is higher than the national average for specialist acute trusts.

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust intends to take the following actions to improve this performance, and so the quality of its services, by:

- Any actions identified will be incorporated into the RUH Bath NHS FT plan going forwards.

RUH

Treating and caring for people in a safe environment and protecting them from avoidable harm		RUH Performance		National Average	National "Best"	National "Worst"
Measure		**2014/15**	**2013/14**	**2014/15**	**2014/15**	**2014/15**
Patients admitted to hospital who were risk assessed for venous thromboembolism	Q1	97.50%	95.44%	96.00%	100.00%	87.20%
	Q2	95.90%	95.37%	96.00%	100.00%	86.40%
	Q3	97.00%	95.98%	96.00%	100.00%	81.00%
	Q4	97.18%	97.02%	N/A	N/A	N/A

The Trust considers that this data is as described for the following reasons:

- The data shown is published by NHS England using data provided by the Trust. The figures published are consistent with local calculations of the information that has been submitted.
- Performance is published as monthly and quarterly totals. At the time of reporting only data to the end of quarter three has been published, and so quarter four performance shown has been calculated internally by the Trust.
- In February 2015 we acquired the Royal National Hospital for Rheumatic Diseases, and so their performance is included for February and March 2015.

The Royal United Hospitals Bath NHS Foundation Trust has taken the following actions to improve this performance, and so the quality of its services:

- The Trust scoring against this measure is in line with national average, and performance has improved on 2013/14. No specific improvement actions have been identified, however the Trust intends to continue to improve against this measure in 2015/16.

RNHRD

Treating and caring for people in a safe environment and protecting them from avoidable harm		RNHRD Performance		National Average	National "Best"	National "Worst"
Measure		**2014/15**	**2013/14**	**2014/15**	**2014/15**	**2014/15**
Patients admitted to hospital who were risk assessed for venous thromboembolism	Q1	99.90%	100.00%	96.00%	100.00%	87.20%
	Q2	100.00%	100.00%	96.00%	100.00%	86.40%
	Q3	100.00%	100.00%	96.00%	100.00%	81.00%
	Q4	99.95%	100.00%	N/A	N/A	N/A

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust considers that this data is as described for the following reasons:

- The national average is the percentage of adult patients admitted to NHS funded care as published by NHS England. The RNHRD NHS FT has policies and procedures in place for the risk assessment of venous thromboembolism and conducts clinical audits against these policies and procedures.
- The Royal United Hospital acquired the Royal National Hospital for Rheumatic Diseases in February 2015, therefore quarter four figures for 2014/15 are January 2015 only, as February and March performance is included in the RUH total.

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust intends to take the following actions to improve this performance, and so the quality of its services, by:

- The RNHRD as part of the RUH Bath NHS FT will continue to review any new national guidance and existing policies and procedures to maintain this score.

RUH

		RUH Performance		National Average	National "Best"	National "Worst"
Measure		Apr14-Mar15	Apr13-Mar14	Apr13-Mar14	Apr13-Mar14	Apr13-Mar14
Rate of C.difficile infection	Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over	12.5	18.3	14.7	0.0	37.1

The Trust considers that this data is as described for the following reasons:

- The Trust report the incidence of infections to Public Health England on a monthly basis as recorded by the Infection Prevention and Control Team. This is done based on national guidance. The infection rate shown for 13/14 was calculated and published by Public Health England based on the number of cases of C difficile that the Trust reported. This number was higher than the amount of infections that were found to be attributable to the Trust in the year, and therefore the rate per 100,000 bed days is higher than the rate for the actual infections in 2013/14. When calculated internally using the final validated figure, our rate per 100,000 bed days for the year 2013/14 was 13.8. This has been calculated in line with national definitions.

- The performance shown for the current reporting period (April 2014 to March 2015) has been calculated internally by the Trust using the data submitted nationally, as published data was not available at the time of reporting.

The Royal United Hospitals Bath NHS Foundation Trust has taken the following actions to improve this performance, and so the quality of its services:

- The Trust is pleased to note a significant reduction in the number of C.difficile infections during 2014/15, which continues positive year on year improvements in infection rates. More detail on infections within the Trust can be found on page 132.

RNHRD

		RNHRD Performance		National Average	National "Best"	National "Worst"
Measure		Apr14-Mar15	Apr13-Mar14	Apr13-Mar14	Apr13-Mar14	Apr13-Mar14
Rate of C.difficile infection	Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over	28.0*	0.0	14.7	0.0	37.1

* Because the RNHRD only has a small number of beds, the proportion per 100,000 bed days appears high. This refers to only one case of C diff.

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust considers that this data is as described for the following reasons:

- The RNHRD NHS FT had in place policies and procedures to reduce the risk of infection.

- The performance shown for the current reporting period (April 14 to March 15) has been calculated internally by the Trust using the data submitted nationally, as published data was not available at the time of reporting.

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust intends to take the following actions to improve this performance, and so the quality of its services, by:

- As part of the RUH Bath NHS FT RNHRD will continue to review any new national guidance and existing policies and procedures to prevent and control infection.

RUH

		RUH Performance		National Average*	National Highest*	National Lowest*
Measure		**Apr14-Feb15**	**Apr13-Mar14**	**Apr13-Mar14**	**Apr13-Mar14**	**Apr13-Mar14**
Patient Safety incidents and the percentage that resulted in severe harm or death	Number of Patient Safety Incidents	8093	4817	5979	10317	2587
	Rate of Patient Safety Incidents (per 100 admissions)	10.3	7.13	7.75	13.94	2.98
	Number Resulting in severe harm or death	60	58	39.5	2	153
	% resulting in severe harm or death	1.34%	1.13%	1.40%	0.10%	4.10%

* Medium acute trusts

The Trust considers that this data is as described for the following reasons:

- The data shown for 2013/14 is published by the National Reporting and Learning System (NRLS). This uses incident data provided by the Trust based on national definitions, and figures published are consistent with local calculations. National averages, best and worst figures are based on all medium acute trusts, with the national averages being calculated internally using the published data.
- The figures for April 14 to March 15 have been calculated internally by the Trust using the data submitted to the NRLS, as published data was not available at the time of reporting.
- In February 2015 we acquired the Royal National Hospital for Rheumatic Diseases, and so their performance is included for February and March 2015.

There has been an increase in the number of patient safety incidents reported in 2014/15 compared to the previous year. This is a result of acquiring maternity services on 1st June 2014 and our campaign to ensure that staff report and act upon patient safety incidents.

There was one Never Event in 2014/15 which related to maternity services and a retained vaginal swab. A full root, cause analysis was undertaken in which the patient's views were included. Our clinical teams have been open and transparent and their priority was to support the patient. As a result of this event, new

paperwork has been introduced which records the numbers of swabs in place. The patient did not suffer any ongoing harm from this event.

The Royal United Hospitals Bath NHS Foundation Trust has taken the following actions to improve this performance, and so the quality of its services:

- Reporting patient safety incidents provides a greater level of transparency, and therefore an opportunity for learning to take place. This can help avoid similar incidents occurring again, and also can help improve processes. Because of this there is no 'correct' or 'safe' number of patient safety incidents. Organisations that report low numbers should not necessarily be considered safe as they could be under-reporting and therefore not having the facility to learn from incidents. Similarly a high reporting rate may represent an open and more effective safety culture.

- The RUH are keen to learn from incidents, and we have an Incident Reporting Project to support a reporting culture and to ensure that learning takes place quickly and effectively across the organisation.

RNHRD

		RNHRD Performance		National Average*	National Highest*	National Lowest*
Measure		**Apr14-Jan15**	**Apr13-Mar14**	**Apr13-Mar14**	**Apr13-Mar14**	**Apr13-Mar14**
Patient Safety incidents and the percentage that resulted in severe harm or death	Number of Patient Safety Incidents	112	210	1727	3426	210
	Rate of Patient Safety Incidents (per 100 admissions)	4.52	6.76	8.09	30.38	4.73
	Number Resulting in severe harm or death	0	0	8	0	40
	% resulting in severe harm or death	0.0%	0.0%	0.5%	0.0%	3.2%

*Acute specialist trusts

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust considers that this data is as described for the following reasons:

- Data for April 2014 to January 2015 have been calculated internally as nationally published figures were not available at the time of reporting. The RNHRD was acquired by the RUH in February 2015, therefore incident figures for February and March 2015 are included in the Royal United Hospital data above.
- Historic data is based on information published for acute specialist organisations 1.04.13 – 31.3.14 by NRLS. There were 0 incidents that were reported as resulting in severe harm or death for the RNHRD NHS FT.
- National averages, best and worst figures are based on all Acute Specialist Trusts, with the national averages being calculated internally using the published data.

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust has taken the following actions to improve this performance, and so the quality of its services, by:

- Any incidents which result in severe harm or death would be investigated by root cause analysis and resulting actions for improvement would be monitored by the Clinical Risk committee.

Commissioning for Quality and Innovation

The Commissioning for Quality and Innovation (CQUIN) is a payment framework which enables Commissioners to reward excellence by linking a proportion of acute healthcare provider's income conditional on demonstrating improvements in quality in specified areas of care. Some improvement goals are nationally defined, with additional goals agreed locally between the Trust and its commissioners.

Each CQUIN quality improvement programme is led by a clinician, who supports the achievement of quality indicator milestones and targets as well as the financial performance for their scheme. The following outlines the progress with the 2014/2015 CQUIN quality improvement schemes.

RUH

Family & Friends Test (FFT)

The FFT or patients and staff has continued from 2013/2014. It is anticipated that all elements of the scheme will be achieved. From 1st October 2014 FFT was extended to outpatient areas and a refreshed approach has been embedded in our maternity services.

Staff are asked whether they would 'recommend the RUH as a place to be treated and as a place to work' on a quarterly basis.

Reduction in new pressure ulcers

The Trust's implemented the 'Rapid Spread pressure ulcer improvement programme' in 2014/15 and has achieved a significant reduction in hospital acquired pressure ulcers. Overall hospital acquired pressure ulcers have been reduced by more than 50% and work is on-going to ensure continued improvement.

Dementia

The national scheme relating to dementia continued in 2014/2015. The Trust has achieved the challenging improvement targets identified overleaf:

- **The Find, Assess, Investigate and Refer (FAIR) initiative** – aims to ensure that patients aged 75 and over (who are admitted as emergencies) are identified as having dementia or delirium, or asked the dementia case finding question. The proportion of those identified as potentially having dementia are properly assessed/diagnosed and the number referred on to specialist services is then measured. The requirement for delivery of FAIR for 2014/15 was that 90% or more for each element was achieved by 31st March 2015.

- Another element of the CQUIN refers to clinical leadership and Dementia training for staff.

- **Supporting carers of people with dementia –** the third element of the scheme aims at ensuring carers feel supported. A monthly audit of carers of people with dementia has been undertaken to determine whether carers feel supported and inform areas for improvement.

Sepsis 6

Sepsis 6 was agreed as a local CQUIN and aims to improve the care of patients with Sepsis admitted to the Trust through the emergency department. The Sepsis 6 scheme has been successfully delivered, making a real difference to patient's well-being.

We are now identifying more patients with sepsis (twice the number over the year) and also picking up these patients earlier and implementing treatment early, therefore reducing the progression to more severe disease which can lead to organ failure and poor outcome. Length of stay overall for patients with sepsis has also decreased. This is discussed in more detail in Chapter Two.

Frailty

Maximising functional (mobilisation) recovery in hospital for elderly care patients was a local CQUIN scheme aimed at reducing the physical effects of emergency hospital admissions for the frail elderly population. The outcome has been a systematic approach to improved mobilisation in the pilot wards which means that patients are helped to walk and move around as soon as possible, reducing possible complications and a loss of independence.

End of Life Care

The end of life care scheme has built on the end of life conversation project improvement programme delivered in 2013/14 and continues to be embedded, sustained and rolled out to other wards. The Conversation Project supports and trains all staff in having what can be difficult conversations with patients and their relatives in relation to their care and treatment when it is believed that they are nearing the end of their life.

A questionnaire to ensure carers and families have the opportunity to feedback on their and the patient's palliative care experience has been introduced. The information provided will be used by the clinical staff to ensure improvements are made in how we care for patients and families at the end of their loved one's life.

Antibiotic Prescribing

The antibiotic prescribing scheme aimed to improve antibiotic prescribing practice and review whether the practice is compliant with Trust protocols and guidelines. The milestones for this improvement scheme have all been met with the exception of patients being prescribed antibiotics in line with Trust guidelines for the period January - March 2015. This was as a result of high numbers of patients being admitted from the community who were already taking antibiotics for pneumonia. Their medication had not been reviewed in line with Trust guidelines. The focus of the work has been to improve prescribing practice ensuring that patients get the most appropriate treatment for the infection they have and do not have longer courses of antibiotics than is necessary.

Heart failure

The locally agreed heart failure scheme has achieved all three elements. That is, a specialist review for heart failure patients, appropriate medication and the introduction of a heart failure passport to help coordinate a holistic approach to the management throughout their care.

Specialised commissioning

Specialist commissioning CQUINs have been in place relating to Quality Dashboards (these are collections of information asked for by specialist commissioners in relation to specific services). These are to increase

the use of breast milk for neonates and increase the use of Homecare delivery schemes for patients on some long term medications so that they can receive their medicines at their home.

CQUIN schemes for maternity services

Following the successful transfer of maternity services to the Trust on 1st June 2014, CQUIN schemes for 2014/15 for maternity services were developed. One nationally mandated and three local schemes were agreed. The national scheme related to the implementation of the Family and Friends test (FFT) for staff commencing.

The local schemes relate to the implementation of FFT for maternity patients throughout their care; the improved management of patients with gestational diabetes (a condition in which women without previously diagnosed diabetes exhibit high blood sugar levels during pregnancy). Women with unmanaged gestational diabetes are at increased risk of developing type 2 diabetes mellitus after pregnancy, as well as having a higher incidence of pre-eclampsia (high blood pressure and protein in the urine) and Caesarean section. The other local CQUIN related to increasing the uptake of breast feeding. All the schemes have been successfully implemented and some of these will be continued next year.

RNHRD

Friends and Family Test (FFT)

The Friends and Family Test was implemented for inpatients in 2013/14. From 1st April 2015, in line with national requirements, FFT for outpatient areas was also implemented. All elements of the CQUIN were met which included the implementation of staff FFT and increasing the response rate for inpatient FFT.

NHS Safety Thermometer

This CQUIN was to ensure that the Trust maintained the same level of performance for all indicators within the safety thermometer tool. The NHS Safety Thermometer is designed for use by frontline staff to measure a snapshot of harm once a month from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE. All elements of the CQUIN were met.

Dementia

The Trust has a named lead clinician for Dementia and has put in place appropriate training for all staff. As a result, this CQUIN has been met.

Synovitis clinic

This CQUIN involved the establishment of an early Synovitis (inflammation of a synovial membrane) clinic. Patients are given individualised treatment plans and a patient passport. There is strong evidence that treatment early on in the disease improves the outcomes for patients with Rheumatoid Arthritis. This CQUIN was met.

Fibromyalgia programme

Fibromyalgia is a complex musculoskeletal condition leading to widespread pain, anxiety and fatigue. The focus of the CQUIN was to develop a database of patient feedback in relation to the management of their condition, specifically, their fatigue, number of visits to the GP, ability to work, management of pain and other functions. The database has been established and analysis of the data will inform future improvements.

Care and compassion project

The RNHRD are part of a cross community project to deliver a programme for Health Care Assistants (HCA's) and support staff working in care homes across Bath and North East Somerset. The programme developed in partnership with the RUH and Dorothy House Hospice will enable staff to explore the patient pathway from an acute and community perspective. Evaluation of the programme is ongoing.

Specialised services

The specialised services completed clinical dashboards to ensure that services could be bench marked nationally. The Bath Centre for Pain Services met all targets set by the dashboard and also maintained the CQUIN Targets for data collection, addressing work, school and medication review.

Furthermore, the Complex Regional Pain Syndrome (CRPS) service met all targets set by the dashboard. The service constantly review services and implemented an internal audit of the CRPS pathway. No major issues were identified.

The Breast Radiotherapy Injury Rehabilitation Service (BRIRS) provided full participation of the highly specialised service in a collaborative audit workshop. A report covering the highly specialised services was sent to the Commissioner to ensure the standards of service provision are being met.

An audit using the Medicine Thermometer risk assessment tool (national medication safety thermometer) has been undertaken every month and, where necessary, the data has been used to ensure improvements in patient safety.

Statements from Stakeholders

Response from Wiltshire Council Health Select Committee

Wiltshire Council has been invited to comment on the Royal United Hospital NHS Trust's Quality Account for 2014/15. It is believed that it is a fair reflection of the progress made by the Trust and gives comprehensive coverage of the services provided.

The Committee would like to express its thanks to the RUH for attending the Health Select Committee Meeting on 5 May to present the Quality Account and answer member's questions. The Committee would also like to congratulate the RUH on achieving Foundation Trust Status and in successfully acquiring the Royal National Hospital for Rheumatic Diseases which means that these important services will be able to continue.

The Committee were pleased to see the focus on learning from incidents and complaints, it was felt that this is a worthy priority as is the work on ensuring that the working environment is conducive to staff reporting incidents confidently and proactively, particularly amongst more junior staff.

It is believed that the priorities identified demonstrate a commitment to delivering patient centred care which is to be commended; this includes the continued focus on reducing delayed transfers of care. This is an area the Committee has taken a particular interest in through a Task Group.

Response from the Bath and North East Somerset Council Wellbeing Policy Development and Scrutiny Panel

Submission of a quality account statement is a voluntary process. The Chair of the Wellbeing PDS Panel has advised that B&NES will not be providing a statement for the Royal United Hospitals Bath NHS Foundation Trust this year due to the impending election period.

Joint Response from Healthwatch Wiltshire and Healthwatch B&NES

We are pleased to see that the Trust are prioritising the discharge process and listening to patients and carer feedback around this issue. We particularly welcome the concentration on timely discharge for patients at the end of life who wish to die at home. We know from their own work and conversations with members of the public that there is still work to be done around the discharge process. We will be closely monitoring the outcomes of this work and would welcome the opportunity to continue working with the trust and other local Healthwatch to ensure that patients and relatives continue to be engaged and consulted.

We note the acquisition of the RNHRD by RUH and will be monitoring any possible effects of this on patient experience over the coming year.

We are pleased to see that the CQC have rated RUH as having a risk rating of 6, one of the lowest in the country, and hope that this remains the case over the coming year.

The RUH has consistently not met the 4-hour access targets for emergency patients but we acknowledge that this has been an issue nationally. Despite this we see that the emergency department was highly recommended by patients with 98% stating that they would recommend it to friends and family.

We are happy to see that The RUH have involved both staff and patients in the development of their two-year quality strategy. Service user involvement is key to making sure that services are patient focused and

therefore we welcome the work that has been done to engage with service users over 2014/15.

We note that RUH have won the bid to provide maternity services and will be closely monitoring the outcomes for patients as a result of this.

We applaud all the work that is being done around achieving better outcomes in the management of pressure ulcers, sepsis and diabetes. In particular, we welcome the increased early identification and treatment of sepsis in the emergency department and the reduction in the number of hospital acquired category 3 and 4 pressure ulcers. We hope to see this continue over the coming year.

In 2014 we carried out a piece of work on the NHS complaints process in Wiltshire. This found that patients still find it difficult to navigate the system. Therefore, we are happy to see that the Trust is committed to improving the way that they manage complaints process and acknowledge the work that they have done with staff and previous complainants to make improvements in this area. There is still work to be done in terms of response times and welcome the work which the Trust is doing to deal with this issue.

We welcome the opportunity to work with service users at RUH thus far and we are looking forward to a more regular interface during 2015/16.

Furthermore, we recognise that the wider health care community has a role to play in the RUH's performance and as such will take a particular interest in monitoring the partnership effort to provide patients with a seamless experience of acute and primary health services and social care services.

NHS
Bath and North East Somerset
Clinical Commissioning Group

May 19, 2015

Mr James Scott
Chief Executive
Royal United Hospitals Bath NHS Foundation Trust
Combe Park
Bath
BA1 3NG

By E-Mail

Dear James

Re: The Royal United Hospitals Bath NHS Foundation Trust (RUH) Quality Report 2014-2015 incorporating the Royal National Hospital for Rheumatic Diseases

Thank you for the opportunity to review the Royal United Hospitals Bath NHS Foundation Trust (RUH) Quality Report 2014-2015 incorporating the Royal National Hospital for Rheumatic Diseases. Please find below the statement from Bath and North East Somerset Clinical Commissioning Group (BaNES CCG).

Bath and North East Somerset Clinical Commissioning Group is pleased to have had the opportunity to review the Quality Report prepared by the Royal United Hospitals Bath NHS Foundation Trust (RUH) which incorporates the report of the Royal National Hospital for Rheumatic Diseases.

BaNES CCG congratulates the RUH on its achievement of Foundation Trust status in 2014 and for the safe acquisition and integration of the Royal National Hospital for Rheumatic Diseases (RNHRD) in 2015. The RUH also took over the successful management of maternity services in 2014. In a joint vision to maintain and continually improve the quality of services, the RUH and the RNHRD have worked collaboratively with commissioners to sustain and progress a comprehensive quality framework and the CCG and our partner CCGs meet with the RUH on a monthly basis to seek assurance against these contractually agreed quality indicators and the programme of site visits continues. There are robust joint arrangements in place with the RUH to agree, monitor and review the quality of services covering the key quality domains of safety, effectiveness and patient experience.

As with many other acute trusts across England and Wales, the urgent and emergency care system at the RUH was under significant pressure during the winter and early part of 2015. This has had an impact on a number of important indicators. However, the RUH has taken positive steps to ensure that patient safety and experience of care is maintained and the CCG recognise their commitment to working closely with commissioners and the public to ensure the ongoing delivery of safe, high quality services.

It is pleasing to note that the trusts priorities continue to focus on patient experience, patient safety and clinical effectiveness. Both the RUH and RNHRD have scored consistently high in the national Friends and Family Test and we congratulate the trust that the emergency department ranked first nationally, with 98% of patients responding that they would recommend the RUH to their friends and family. During 2014-2015 the trust has also substantially improved its incident reporting, complaints management processes and feedback mechanisms to support a more effective safety culture for patients and staff and

the account includes progress and evidence of outcome measures in order to provide assurance to the public of continued improvements in these areas. The report also included an impressive list of Research and Development activities and national audits that both the RUH and the RNHRD have been involved with and have included examples of the actions it intends to take to further improve the quality of healthcare provided.

It was disappointing that the trust did not achieve its MRSA trajectory. However, the CCG commends the RUH and RNHRD on the reduction in clostridium difficile numbers and is confident that the focus on reducing healthcare acquired infections and antimicrobial stewardship will continue. Both trusts made good progress achieving the 2014-2015 priorities and the CCG fully endorses the chosen priorities for 2015-2016.

The NHS Contract and the Commissioning for Quality and Innovation (CQUIN) Scheme provides further support for ensuing quality measures are in place and we are pleased with the significant progress made implementing these CQUIN schemes in 2014-2015. The CCG and our partner commissioners have worked collaboratively with the RUH clinicians this year to develop relevant and robust CQUIN schemes for 2015-2016. This year's local schemes include discharge planning and falls management ensuring that consistent high quality, safe and effective patient care is in place.

BaNES Clinical Commissioning Group commissions for outcomes and quality and it is anticipated that the improved level of clinical involvement with the trust and other respective organisations will make a significant difference to the care of our population. The Trust has complied with its contractual obligations and has made progress over the last year with evidence of improvements in key quality and safety measures. In conclusion, BaNES CCG looks forward to working collaboratively with the RUH in the forthcoming year; this approach will reflect the local accountability that the CCG has to the BaNES population to maintain a sustained focus on patient experience, patient safety and clinical effectiveness.

Yours sincerely

Tracey Cox
Chief Officer

Clinical Chair: Dr Ian Orpen | **Chief Officer:** Tracey Cox
St Martin's Hospital, Clara Cross Lane, Bath BA2 5RP | **Tel:** 01225 831800 | **Fax:** 01225 840407 | www.banesccg.nhs.uk

NHS
Wiltshire
Clinical Commissioning Group

Wiltshire Clinical Commissioning Group (CCG) has reviewed the Royal United Hospital (RUH) Quality Accounts for 2014/2015. In so doing, the CCG reviewed the Account in light of key intelligence indicators and the assurances sought and given in the monthly Clinical Outcomes and Quality Assurance meetings attended by the RUH and Commissioners. This evidence is triangulated with information from Quality Assurance Visits to RUH which encompass clinician to clinician feedback and reviews. Wiltshire CCG therefore confirms that the Quality Account appears to be accurate and fairly interpreted.

It is the view of Wiltshire CCG that the Quality Account reflects the ongoing commitment from RUH to quality improvement and addressing key issues in a focused and innovative way. The Account summarises the achievements against quality priorities throughout the year and the CCG acknowledges and commends this, in particular the significant improvement in Hospital Acquired Pressure Ulcers and the outstanding performance in the Emergency Department Friends and Family test, both of which were maintained during an intense period of challenging demand.

The CCG is supportive of the priorities that RUH have identified for 2015/2016 which are reflective of the NHS Outcomes Framework. Sepsis and Acute Kidney Injury were rightly identified as priorities in advance of the National CQUIN frameworks being issued and Hospital Discharges and Diabetes align with key CCG priorities. An area which the CCG supports and is not specifically identified within the report is the RUH 15/16 plan to deliver hospital services out in the community - a 'Hospital Without Walls'. This innovative work includes a range of community clinics; including new community x-ray arrangements which move hospital services closer to people in their own homes.

2014/2015 has seen RUH acquire the RNHRD and the award of the Maternity services contract. Since June 2014 when the service was transferred, the CCG is pleased to confirm an increase in patient-reported satisfaction with maternity services, evidenced in the Friends and Family Test results. The CCG continues to work closely with the RUH on further improving the quality of maternity services delivery.

The CCG confirms that we believe the accounts are accurate in regard to the service provided to Wiltshire patients and looks forward to working with RUH in 2015/16 to embed learning and on the identified Quality Priorities. The CCG would like to see the RUH further develop its Quality Account into 2015/2016 to include more information on the following:-

- Trust-wide learning from clinical / safety incidents – building on the excellent work to increase reporting rates this year.
- Having the right staff with the right skills in the right place.
- Themes and learning from patient contacts and complaints – building on the very innovative work done in 2014/2015
- Ambulatory care service for better patient care and quality of experience

Deborah Fielding
Chief Officer
NHS Wiltshire Clinical Commissioning Group

9 Statement of directors' responsibilities in respect of the Quality Report

The directors are required, under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor (the independent regulator of NHS Foundation Trusts) has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporates the above legal requirement) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period 1 April 2014 to 31 March 2015
    - Papers relating to Quality reported to the board over the period 1 April 2014 to 31 March 2015
    - Feedback from Bath and North East Somerset Clinical Commissioning Group dated 19/05/2015
    - Feedback from Governors dated 14/05/2015
    - Feedback from local Healthwatch organisations dated 19/05/2015
    - Feedback from Wiltshire Council Health Select Committee dated 13/05/2015
    - Feedback from Bath and North East Somerset Council Wellbeing Policy Development and Scrutiny Panel dated 17/04/2015
    - The latest National Patient (accident and emergency) Survey dated 02/12/2014
    - The latest National Staff Survey 24/02/2015
    - The Head of Internal Audit's Annual Opinion over the Trust's control environment dated 15/05/2015;
    - CQC Intelligent Monitoring Report dated 03/12/2014.

The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered:

- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

James Scott,
Chief Executive

Brian Stables,
Chairman

Independent auditor's limited assurance report to the Board of Governors and Board of Directors of Royal United Hospitals Bath NHS Foundation Trust on the Quality Report

We have been engaged by the Board of Directors and Board of Governors of Royal United Hospitals Bath NHS Foundation Trust to perform an independent limited assurance engagement in respect of Royal United Hospitals Bath NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditor

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual'
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2014/15', and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2014/15'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual', and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2014 to 27 May 2015
- papers relating to quality reported to the board over the period 1 April 2014 to 27 May 2015
- feedback from Commissioners, dated 15/05/2015
- feedback from Governors, dated 15/05/2015
- feedback from local Healthwatch organisations, dated 15/05/2015
- feedback from Overview and Scrutiny Committee, dated 15/05/2015
- the national patient survey, dated 02/12/2014

- the national staff survey, dated 2014
- Care Quality Commission Intelligent Monitoring Report, dated December 2014
- the Head of Internal Audit's annual opinion over the Trust's control environment, dated 31/03/2015
- the Trust's complaints report for 2013/14, published under requlation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009; and
- Quarterly complaints, PALS and inquests report for 2014/15.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Governors of Royal United Hospitals Bath NHS Foundation Trust as a body and the Board of Directors of the Trust as a body, to assist the Board of Directors and Board of Governors in reporting Royal United Hospitals Bath NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Board of Directors and Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body, the Board of Governors as a body and Royal United Hospitals Bath NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- analytical procedures
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' to the categories reported in the quality report and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information,

given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual'.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Royal United Hospitals Bath NHS Foundation Trust.

Basis for qualified conclusion

The indicator reporting the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways did not meet the six dimensions of data quality in the following respects:

- Validity as the data contained one non consultant led referral which had been incorrectly included due to a coding error
- Accuracy as the data included two patients for whom the start date of the pathway did not match the start date recorded in the supporting documentation and contained one patient for whom a new pathway was set up when an existing valid pathway for the same treatment was already in use.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter(s) reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual';
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual'.

Grant Thornton UK LLP
Hartwell House
55-61 Victoria Street
Bristol
BS1 6FT

May 2015

The Trust's response to the Auditor's opinion

The Trust recognises the inherent limitations in non-financial performance information and therefore has a robust validation process to check the data quality of all patients still waiting at 12 weeks. These data quality issues would have been picked up and corrected at that point. The Trust is clear that the RTT indicator as stated within the report is correct.

7 Disclosures in the public interest

Policies and procedures with respect to countering fraud and corruption

The Trust works closely with the NHS counter Fraud Service to tackle fraud and corruption in all areas of income and expenditure. The aim of the service is to reduce fraud to an absolute minimum thereby releasing much needed resources for providing better patient care and services. The Local Counter Fraud Specialist (LFCS) works throughout the year to prevent and investigate fraud issues and the causes of fraud within the Trust. This is done through a combination of planned risk assessments, and investigations in response to Trust matters raised by staff or other sources. The importance of countering fraud and the existence of the service is promoted through staff training, newsletters and on the staff intranet.

Health & wellbeing

During the reporting period between 1 November 2014 and 31 March 2015 the trust had no health and safety enforcement notices during the reporting period.

An Occupational Health service including an Employee Assistance scheme providing confidential counselling services for employees and their families was available via a contract with the Royal United Hospitals NHS Foundation Trust Occupational Health providers.

The action plan generated as a result of the NHS Employers health and wellbeing survey in June 2013 continued to be monitored during 2014-2015. This was included as a standard agenda item of the monthly meeting with staff side. During 2014-2015 the trust continued to invest in the resilience of its managers and employees and health and well-being of staff.

When monitoring and reporting on health and safety the Trust uses the Health and Safety Executive's RIDDOR system to report incidents, dangerous occurrences and diseases as per the regulations. The Health and Safety Committee also receives assurance in line with legislation on water safety (L8), Fire safety (RR(FS)O) as well as the the CQC standards of:

- Outcome 10 – Safety and Suitability of Premises
- Outcome 11 – Safety, availability and suitability of equipment
- Outcome 12– Requirements relating to workers.

Communication and consultation

On acquisition of the RNHRD on the 1 February 2015 RNHRD staff transferred to RUH NHS FT employment under the Transfer of Undertakings (Protection of Employment) Act (TUPE), a TUPE with measures consultation with employees during December 2014 and January 2015. Management and staff side, which includes union representatives, were involved with this consultation.

Consultations with local groups and organisations, including the Overview and scrutiny committee committees covering the membership areas.'

Patient and public involvement activities

Patient and public feedback is important to our organisation. During 2014/15 a number of activities and

initiatives have taken place to actively obtain feedback and include:

- The Friends and Family Test, and inpatient surveys. Any actions resulting from the feedback obtained are fed back to the relevant department to take forward and feedback is reported to the Trust board.
- Patient representation at a number of Trust meetings
- Regular presentations to patient groups around the community
- 'Caring for you' events are held throughout the year and are a platform to hear about health topics and discuss developments in care
- The Trust has established a patient and carer experience group chaired by the Director of Nursing and Midwifery which meets on a monthly basis. Members include patients and carers and patient bodies such as Healthwatch.

The number of, and average pension liabilities for individuals who retired early on ill-health grounds during the year.

Three employees retired early on ill-health grounds. The total pension liabilities is £109,000, therefore the average pension liabilities is £36,000.

Detailed disclosures in relation to 'other income'

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. 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.

Cost allocation and charges

Royal United Hospitals Bath NHS Foundation Trust complied with the cost allocation and charging requirements set out in HM Treasury guidance.

8 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 Monitor.

Under the NHS Act 2006, Monitor has directed the Royal United Hospitals Bath NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and basis set out in the Accounts Direction. 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, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- Observe the Accounts Direction issued by Monitor, 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 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; and
- Prepare the financial statements on a going concern basis.

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 him to ensure that the accounts comply with requirements outline in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed

James Scott
Chief Executive
Date: 27 May 2015

9 Annual Governance Statement

This governance statement covers the period from 1 November 2014 (the month the Trust was authorised as an NHS Foundation Trust) to 31 March 2015. There is a separate Governance Statement for the period 1 April 2014 - 31 October 2014.

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 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 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 Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

I have the 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 within resources.

The Board of Directors has ultimate responsibility and accountability for the quality and safety of services provided by the Trust. The Board of Directors has approved the Strategic Framework for Risk Management which provides a clear, 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 Assurance Committees, together with the individual responsibilities of the Chief Executive, Executive Directors and all staff in managing risks.

The Trust uses an electronic risk management system (DATIX) to record and manage risks on the Trust-wide Risk Register. Significant risks are reviewed monthly by the Management Board. The Management Board then takes on oversight of the significant risks until they have been managed to a reduced level of risk.

The Board of Directors has approved the risk management processes and defined the objectives for managing risk. The Board of Directors reviews the top operational risks scoring 16-25 on a quarterly basis and undertakes an annual review of the complete Risk Register. The Board of Directors last reviewed the full Risk Register in January 2015. In addition, the monthly operational performance and finance reports highlight any key areas of risk and the Board of Directors report template includes a section on risks. The Board of Directors also identifies risks as part of the self-assessment documentation submitted to Monitor.

The Trust has mechanisms to act upon alerts and recommendations made by all relevant central bodies. The Risk Register of the former Royal National Hospital for Rheumatic Diseases (RNHRD) NHS Foundation Trust has been incorporated into the Trust's Risk Register following the acquisition on 1 February 2015.

Assurance Committees

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

Audit Committee

- Provides assurance to the Board of Directors about the soundness of overall systems of governance and internal control
- Risk Management Systems and Processes
- Financial Risk Management
- Reviews allocated risk on the Board Assurance Framework

Clinical Governance Committee

- Provides assurance that the key clinical systems and processes are effective and robust
- Reviews allocated risk on the Board Assurance Framework

Non-Clinical Governance Committee

- Provides assurance that the non-clinical systems and processes are effective and robust.

After every meeting, the Committee Chair presents a report to the Board of Directors highlighting the key issues discussed, key decisions and recommendations and identifies any risks.

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, including the former charitable funds of the Royal National Hospital for Rheumatic Diseases post acquisition on 1 February 2015.

Divisional Boards

The three clinical Divisions (Medicine, Surgery and Women and Children's have each established a Governance Committee which is responsible for reviewing and managing risks within their respective divisions. The Operational Governance Committee which is a sub-committee of the Management Board acts as the operational committee 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:

Director of Nursing and Midwifery

- 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.
- As the Senior Information Risk Officer (SIRO) is the designated director with responsibility ensuring that there is a framework in place for the management of information governance related risks.

Director of Human Resources

- Designated director with responsibility for ensuring that there is a framework in place for the management of non-clinical risk across the organisation.

Director of Estates and Facilities

- Designated director responsible for health and safety.
- Responsible for ensuring effective physical and human precautions are in place to control health and safety risks.

Medical Director

- Director Lead for Medical Risk for the Trust

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 supporting the directors. The Head of Risk and Assurance is responsible 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 through supporting divisional teams.

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 are provided with details of the Trust's risk management systems and processes and understand their responsibilities for reporting incidents. The corporate induction is augmented 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 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.

Communication with Stakeholders

Communication with stakeholders is key to ensuring risks identified by stakeholders that affect the Trust can be identified, 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 which has a formal role as a stakeholder body for the wider community in the governance of the Trust.
- Partner organisations, including clinical commissioning groups, voluntary sector and local universities
- Staff – staff engagement meetings, open staff meetings, staff survey and team briefings
- Public and service users – patient surveys, Patient and Carer Experience Group and Patient Advice and Liaison Service

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 process and structure by which it is undertaken
- Defines the Trust's risk appetite which articulates the content and range of risk(s) that it might take
- 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 risk matrix methodology. This prioritisation tool is based on the National Patient Safety Agency guidance. Each risk is given a score for both the consequence (C) (severity) of the potential risk and its likelihood (L) of occurring. The two score are then multiplied together to give an overall risk impact score. The higher the final score the greater the risk. All risks are entered onto the DATIX risk management system which is used to produce reports for all levels of management.

The Trust seeks to ensure that lessons learned from incident, complaint and other investigations are used to update and improve practice. These issues are regularly communicated to the Operational Governance Committee 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 Operational Governance Committee reports to the Management Board and escalates issues which require higher level scrutiny.

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 monthly Board of Directors' Quality Report which is published on the Trust's website.

The Trust's Internal Auditors reviewed the Trust's risk management process in August 2014 and concluded that: "The RUH have a clear and well documented process in place for recognising, reporting and reviewing risk".

Board Assurance Framework

The Trust has a Board Assurance Framework. The Board Assurance Framework is a process by which the

Trust gains 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 the objectives.

The Assurance Framework was developed using the Trust's Integrated Business Plan and the corporate objectives for 2014/15. The strategic objectives were assessed, and risks in achieving the objectives identified, including any gaps in assurance or control. The Assurance Framework was reviewed quarterly by the Board of Directors. Each risk is assigned to the relevant assurance committee. The assurance committees review their respective risks at each meeting and their comments are reported to the Board of Directors.

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 corporate induction programme for all new employees and all staff are required to undertake information governance training to national standards.

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

A rolling programme of Information Risk Management audits has been continued in the current year with action plans being produced to further ensure risks are reduced and legal compliance with the Data Protection Act maintained.

The Trust has achieved level 2 of the Information Governance Toolkit in 2014/15.

The Trust has rigorous and robust processes and procedures in place to mitigate breaches of the Data Protection Act. When a breach occurs the Trust ensures that remedial action has been undertaken to minimise the risk of a recurrence.

From 1 November 2014 to 31 March 2015, the Trust had 14 serious information governance incidents requiring investigations involving personal data. The incidents were reported to the Information Commissioner's Office. The Trust fully investigated each incident and has put measures in place to mitigate further incidents. The Trust has recently formed a Patient Correspondence Working Group to investigate the root causes, highlight any issues and problems and ensure that processes and policies are updated and followed going forward.

Quality Accounts

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued

guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual. The Annual Quality Report 2014/15 has been developed in line with relevant national guidance.

The Quality Board has responsibility for the development of the Trust's annual quality accounts. Following the acquisition of the Royal National Hospital for Rheumatic Diseases on 1 February 2015, the Quality Accounts 2014/15 include RNHRD quality information for February and March 2015. Details of the RNHRD's quality accounts for April 2014-31st January 2015 are reported separately in the RNHRD report.

The Quality Board receives regular updates about clinical quality and was been responsible for the development of the Quality Strategy 2014-16 which was approved by the Board of Directors in April 2014. In addition, the Director of Nursing and Midwifery has led negotiations with the clinical commissioning groups on the agreement of the CQUIN (commissioning for quality and innovation targets).

The Board of Directors and the Management Board have reviewed the annual quality accounts and have considered on-going compliance with the priorities via the monthly Quality Reports. A range of both internal and external groups have helped to develop the Quality Accounts report 2014/15 and to identify the Quality Priorities for 2015/16, including staff, governors, members, Healthwatch and Clinical Commissioning Groups. The Trust's external auditors are responsible for reviewing the Quality Accounts against national requirements and for testing a sample of the quality indicators disclosed in the Quality Accounts to ensure that the performance information contained in the Quality Accounts is accurate and robust.

The quality accounts contain information that is subject to internal and external validation. The information has been made available to the public through the quality and operational performance reports that are provided to the public meeting of the Council of Governors.

The Trust's report on quality accounts is subject to review by its external auditors who will report on their review of the arrangements that the Trust has put in place to secure the data quality of information included in the quality accounts.

How we monitor data and report on quality

The Trust's review 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.

The Trust's Internal Auditors reviewed data quality in October 2014 and concluded that: "There are clear governance structures and monitoring mechanisms in place to maintain data quality". In response to the Auditor's recommendations, the Trust has developed a Data Quality Assurance Framework to provide assurance on the quality of data used in performance reporting to the Board of Directors.

Clinical audit

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 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 receive a quarterly progress report on the outcome of clinical audit programme.

Compliance with NHS pension scheme regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments 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 climate change adaptation reporting to meet the requirements under the Climate Change Act 2008.

The Trust has undertaken risks assessments and carbon reduction delivery plans are in place in accordance with the emergency preparedness and civil contingency requirements as based on UKCIP 2009 weather projects, to ensure that the Trust's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

Compliance with the Care Quality Commission

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

The Trust was a pilot for the Care Quality Commission's new inspection regime. The Care Quality Commission conducted their inspection in December 2013 and published their Quality Report on the outcome of the inspection in February 2014. As a pilot site, the Trust did not receive a rating but the Care Quality Commission concluded that:

"From this inspection, the Trust has demonstrated that it could lead significant change effectively. It has been open and transparent with partners about challenges and funding had been used to support innovative changes. It had engaged the national Emergency Care Intensive Support Team to change services in both the Trust and across the local health and social care community to improve the management of patient admissions and discharge. The changes had significantly improved how the Trust managed the demand for its services and ensured that patients received good quality and safe care".

The full Care Quality Commission report is available at: http://www.cqc.org.uk/sites/default/files/new_reports/AAAA0780.pdf

Review of services for children looked after and safeguarding

In June 2014, the CQC undertook a review of services for children looked after and safeguarding in Bath and North East Somerset (B&NES). The review focused on the experiences and outcomes for children within the boundaries of the local authority area and reported on the performance of health providers serving the area, including Clinical Commissioning groups and Local Area Teams. The review explored the effectiveness of health services for children looked after and the effectiveness of safeguarding arrangements with health services for all children. The focus was on the experiences of looked after children and children

and their families who receive safeguarding services.

The CQC made a number of recommendations for further improvement relating to Trust and Bath and North East Somerset Clinical Commissioning Group. An action plan has been developed in response and delivery of the actions is being monitored by the Safeguarding Children's Committee.

Maternity services

Responsibility for the provision of maternity services both on the RUH site (Princess Anne Wing) and in the community (based in Trowbridge, Paulton, Shepton Mallet, Chippenham and Frome) transferred from Great Western Hospitals NHS foundation trust to the Trust on 1 June 2014. The CQC last inspected the Princess Anne Wing in August 2013 when it confirmed that maternity services met the standards under inspection.

RNHRD

The Trust acquired the RNHRD on 1 February 2015. The CQC last inspected the RNHRD in December 2013. The CQC confirmed that the RNHRD met the standards under inspection.

Quality Governance arrangements

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 as the key operational delivery group in the Trust 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 Management Board, 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.

The Operational Governance Committee is the group which delivers quality improvement at an operational level. The Operational Governance Committee works closely with the Quality Board and the Quality Board's sub groups – the Patient Safety Steering Group, the Patient Experience Group and the Clinical Outcomes Group – as well as the Divisional Clinical Governance Groups.

In March 2014, the Trust commissioned KPMG to undertake an independent assessment of the Trust's performance against the four domains and ten questions in the Monitor's Quality Governance Framework. KPMG found that overall the Trust has a strong quality governance focus with an awareness from staff of the value that effective systems and processes can have on the services provided to patients. KPMG identified the following key strengths:

- High level of clinical engagement and strong quality focussed culture – and a genuine enthusiasm from clinicians to engage in clinical governance issues and to apply effective clinical governance to improving the quality of patient care. An openness to identify mistakes and a focus on finding solutions was also evident from the observations of meetings.
- Strong executive leadership – the Trust participation in national and regional quality initiatives sets the tone for the rest of the organisation and demonstrates that quality improvement is a top priority. Staff, patients and external stakeholders praised the skills and leadership of the Executive team.
- KPMG identified the following areas for the further development:
- Effectiveness of the Qulturum – the Qulturum was seen as a good idea and used well corporately how-

ever it was identified as having further potential to support divisions in delivering their quality improvement objectives.

- Clear lines of accountability at Divisional level – there was inconsistency in the Divisions as to who is accountable for Divisional performance.
- Risk Management – there are some 'quick fixes' that can be implemented to improve the risk management process, such as the inclusion of Executive Leads on all risks presented to the Board.

The Trust accepted KPMG's recommendations in full and developed an action plan to implement the recommendations.

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

Effective Board of Directors' decision making is reliant upon the quality of the data received to inform those decisions. It is therefore imperative that the Board of Directors receives regular assurances over 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 structure Senior Business Analysts who provide support to the clinical teams / service lines in reviewing quality, activity and finance information. Analysts support investigation and correction of data errors. The development of user-friendly reporting formats (such as Business Objects, Scorecards and Dashboards) 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 the Data Quality Steering 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 is being progressed and the requisite governance improvements are being undertaken in line with Information Governance Toolkit standards.

The Trust's Internal Auditors reviewed data quality in October 2014. As part of the review, the auditors performed detail testing on the 18 week referral to treatment performance indicator. The Auditors noted that validation checks were performed on a daily, weekly and monthly basis to gain assurance of the appropriateness of the data. In the sample testing, the Auditors identified three instances where errors existed due to input error from a clinical perspective. The Auditors concluded: "Based on the findings of our work, significant assurance with minor improvement opportunities has been provided in relation to the data quality process. The Internal Auditors recommendations for further improvement have been accepted in full and an action plan has been developed to implement recommendations.

Acquisition of the RNHRD NHS Foundation Trust

Prior to making the decision to proceed with the acquisition of the RNHRD, the Trust conducted a comprehensive clinical, financial, commercial and legal due diligence process in order to ensure that the Board of Directors' made an informed decision about the costs, benefits and risks.

The Trust completed the acquisition of the RNRHD on 1 February 2015. As requested by Monitor, the RNHRD provided an assurance statement on quality at the point of acquisition. The RNHRD Board of Directors on 28th January 2015 confirmed:

In line with the Monitor Q3 2014/15 return the RNHRD NHS Foundation Trust Board note that:-

"Up to the 28th January 2015, and, as far as the Board can reasonably be aware, the RNHRD Trust Board is satisfied that there is clear accountability for quality of care throughout the RNHRD NHS foundation trust

including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate."

The Trust is planning to undertake its annual review of the Quality Governance Assurance Framework in April 2015 and will incorporate the RNHRD services as part of the review. The outcome of the self-assessment process will be reported to the June Board of Directors meeting and to Monitor as part of the post-acquisition reporting requirement.

Strategy

The Board of Directors approved the Quality Strategy 2014-16 in April 2014. The Quality Board oversees the implementation of the strategy.

Capabilities and culture

The Trust has established the Qulturum under the leadership of the Director of Nursing and Midwifery 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.

The Trust has changed the way it handles complaints and has adopted a more personal approach which involves meeting with complainants to discuss their concerns rather than responding in writing.

The Trust has developed a cultural integration programme to support RNHRD staff to integrate into the Trust.

Systems and Processes

Patient feedback is reviewed by the Board of Directors in a number of different ways:

- Monthly Board of Directors' Quality Report includes the friends and family test results which is triangulated with other performance data for each ward; feedback through complaints, patient surveys and PALs contacts;
- Monthly Board of Directors' patient story at every meeting and matron presentations;
- Executive and Non-Executive Directors patient safety visits;
- Board of Directors annual mortality review

Measurement

The Trust has developed an integrated balanced operational performance scorecard based around the Care Quality Commission's five domains: Caring, Well-led, Safe, Responsive and Effective which is integral to the monthly Board of Directors Operational Performance report.

Compliance with the NHS Constitution

The Trust operates with regard to the NHS Constitution in all its decisions and actions concerning staff and service users.

Description of the principal risks facing the Trust

The Management Board identified the Trust's current top risks at its February 2015 meeting as:

- Bed capacity and patient flow to ensure right patient, in the right bed, first time

- Capacity, Capability and Staffing Numbers
- Medical Records – the riskis associated with a hybrid process of collecting patient information on the PAS system and in paper notes which can result in different information being captured and stored in two places.
- “Exit Block” – delayed transfers of care/”Green to Go” patients and its effect on flow and performance.

Other key risks from 1 November 2014 to 31 March 2015 include:

- The risk of failing to deliver the planned financial surplus which could impact on the Trust’s ability to deliver its Estates Strategy;
- Operational Pressures and not meeting the four hour and referral to treatment performance targets;
- Failing to deliver the agreed standards of care leading to a failure to achieve the CQUIN gateway and best practice tariffs and additional income.

These risks will be continued to be managed throughout 2015/16.

In making its corporate governance statement for the period 1 November 2014 to 31 March 2015, 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.

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 performance of the Trust and highlight any areas through benchmarking or traffic light system where there are concerns.

The Trust’s reference cost index score for 2013/14 was 83.3 which indicated that the cost of the Trust providing healthcare was 13.7% below the national average.

Internal audit has reviewed the systems and processes in place during the year and have published reports setting out any 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 assurance committees.

Monitor requires the Board of Directors to self-assess on a quarterly basis and Monitor assigns ratings based on its assessment of the Trust under its risk assessment framework. Additionally, the Board of Directors commissioned from KPMG a review of its quality governance arrangements against Monitor’s quality governance assurance framework and is now implanting an action plan to address the findings and recommendations. 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.

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 directors 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 the content of the Quality Report attached to this Annual Report and 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 Committee, Clinical 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' Assurance Framework itself provides me with evidence on 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, Non-Clinical and Clinical Governance 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.

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 through:

- Board of Directors review of the Board Assurance Framework, including the risk register and internal audit reports on its effectiveness;
- Audit Committee and 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
- External review of the Quality Governance Assurance Framework

Conclusion

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

Signed

James Scott
Chief Executive
Date: 27 May 2015

10 Independent Auditors' Report to the Board of Governors of Royal United Hospitals Bath NHS Foundation Trust

Our opinion on the financial statements is unmodified.

In our opinion the financial statements:

- give a true and fair view of the state of the financial position of the Group and Royal United Hospitals Bath NHS Foundation Trust as at 31 March 2015 and of the Group and Trust's income and expenditure for the period then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual and the directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006.

Who we are reporting to

This report is made solely to the Board of Governors of Royal United Hospitals Bath NHS Foundation Trust, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Board of Governors 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 Trust and the Trust's Board of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

What we have audited

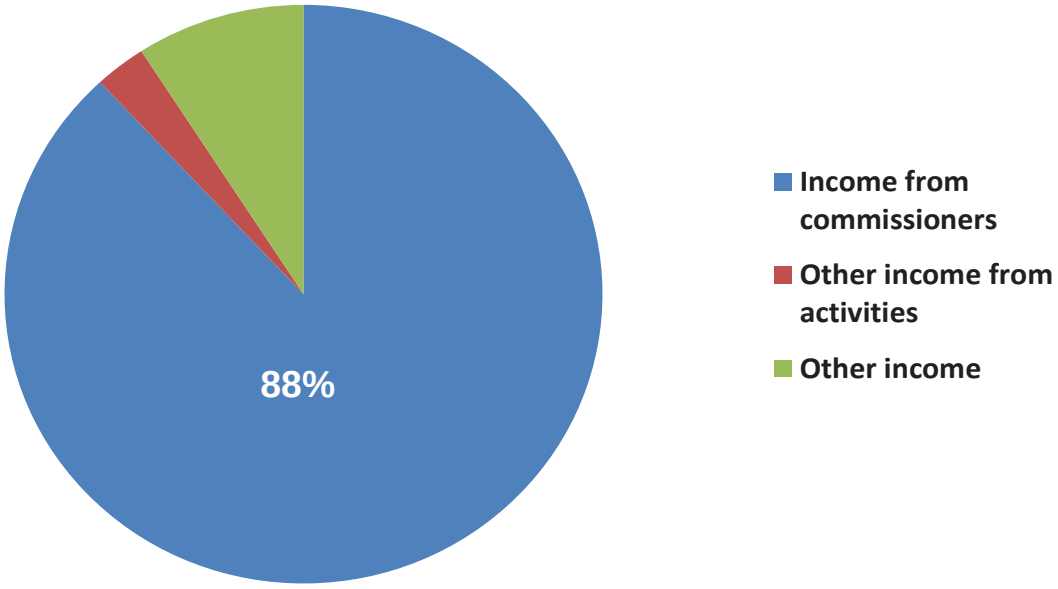
We have audited the financial statements of Royal United Hospitals Bath NHS Foundation Trust ('the Trust') for the period ended 31 March 2015 which comprise the Group and Trust statement of comprehensive income, the Group and Trust statement of financial position, the Group and Trust statement of cash flows, the Group and Trust statements of changes in taxpayers' equity and the related notes.
The Group financial statements include the financial transactions of Royal United Hospitals Bath NHS Foundation Trust and Royal United Hospital Charitable Fund for the period ended 31 March 2015.
The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that are, in our judgement, likely to be most important to users' understanding of our audit.

Valuation of contract income from commissioning bodies and associated receivables
The risk: The Group receives a large proportion of its income from commissioners of healthcare services. It invoices its commissioners throughout the year for services provided, and at the period end estimates and accrues for activity not yet invoiced. Invoices for the final quarter of the year are not finalised and agreed until after the period end and after the deadline for the production of the financial statements. There is therefore a risk that the income from commissioners (and associated receivables) recognised in the financial statements may be misstated. We identified the accounting for the contract arrangements with commissioning bodies (in particular the consistency of the income with contract terms) as one of the risks that had the greatest impact on our audit strategy.

Group operating income 2014/15



Our response: Our audit work included, but was not restricted to, assessing the Group's accounting policy for revenue recognition, understanding management's processes to recognise this income in accordance with the stated accounting policy, performing walk-throughs of management's key controls over income recognition (for example controls over contract billing, pricing and agreement of contract variations) to assess whether they were designed effectively and substantively testing the income and associated receivables.

Our substantive testing included:

- testing the income figures in the financial statements for material contracts with commissioning bodies to signed contracts;
- review of month 12 agreement of balances exercise;
- testing a sample of the contract variations to ensure they were accounted for appropriately and not in dispute; and
- testing any significant non-contractual adjustments to commissioning income such as income for partially completed spells to confirm they have been accounted for appropriately.

The Group's accounting policy on revenue recognition is shown in note 1.2 to the financial statements and its analysis of its total operating income is included in note 3.1 and 3.2.

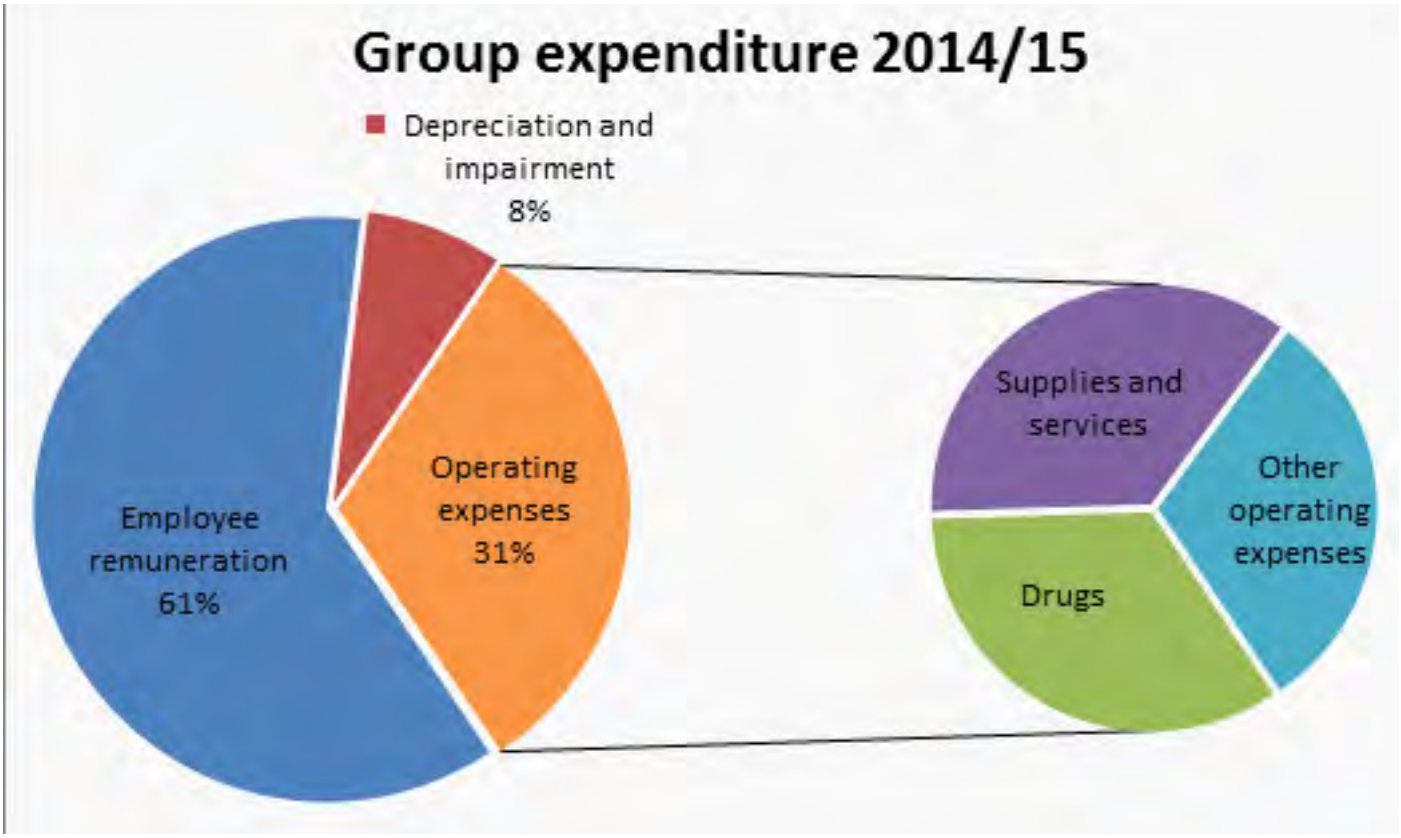
Our findings:

We did not note any exceptions from our work on this income.

Completeness of employee remuneration and operating expenses and associated payables

The risk: The majority of the Group's expenditure relates to employee remuneration and operating expenses. Together they account for 92% of the Group's gross expenditure. The Group pays the majority of this expenditure through its payroll and accounts payable systems and at the year-end estimates and accrues for un-invoiced expenses. Invoices for the final weeks of the year are not received and

processed until after the period-end and in many cases after the deadline for the production of the financial statements. There is therefore a risk that the expenses (and associated payables) recognised in the financial statements may be misstated. We identified the completeness of employee remuneration and operating expenses (in particular the understatement of accruals) as risks that had the greatest impact on our audit strategy.



Our response:

Our audit work included, but was not restricted to, understanding management's processes to recognise payroll and accounts payable expenditure and year-end accruals for unprocessed invoices and expenditure incurred and not yet invoiced (GRNI), walking through management's key controls over recognition of expenditure (for example authorisation of expenditure subsystem interfaces, processing of adjustments and authorisation of payments) to assess whether they were designed effectively and substantively testing expenditure and associated payables.

Our substantive testing included:

- testing the reconciliation of employee remuneration expenditure in the financial statements to the general ledger and payroll subsystems;
- performing a trend analysis of payroll costs to identify any unusual cost variations for completeness;
- sample testing payroll expenditure to source documents;
- sample testing of operating expenses in year and;
- testing a sample of post period end payments to confirm the completeness of accruals.

The Group's accounting policy for recognition of expenditure is shown in note 1.4, its analysis of employee remuneration costs is included in note 7 and its analysis of operating costs is included in note 5 to the financial statements.

Our findings:

We did not note any exceptions from our work on this expenditure.
Our application of materiality and an overview of the scope of our audit

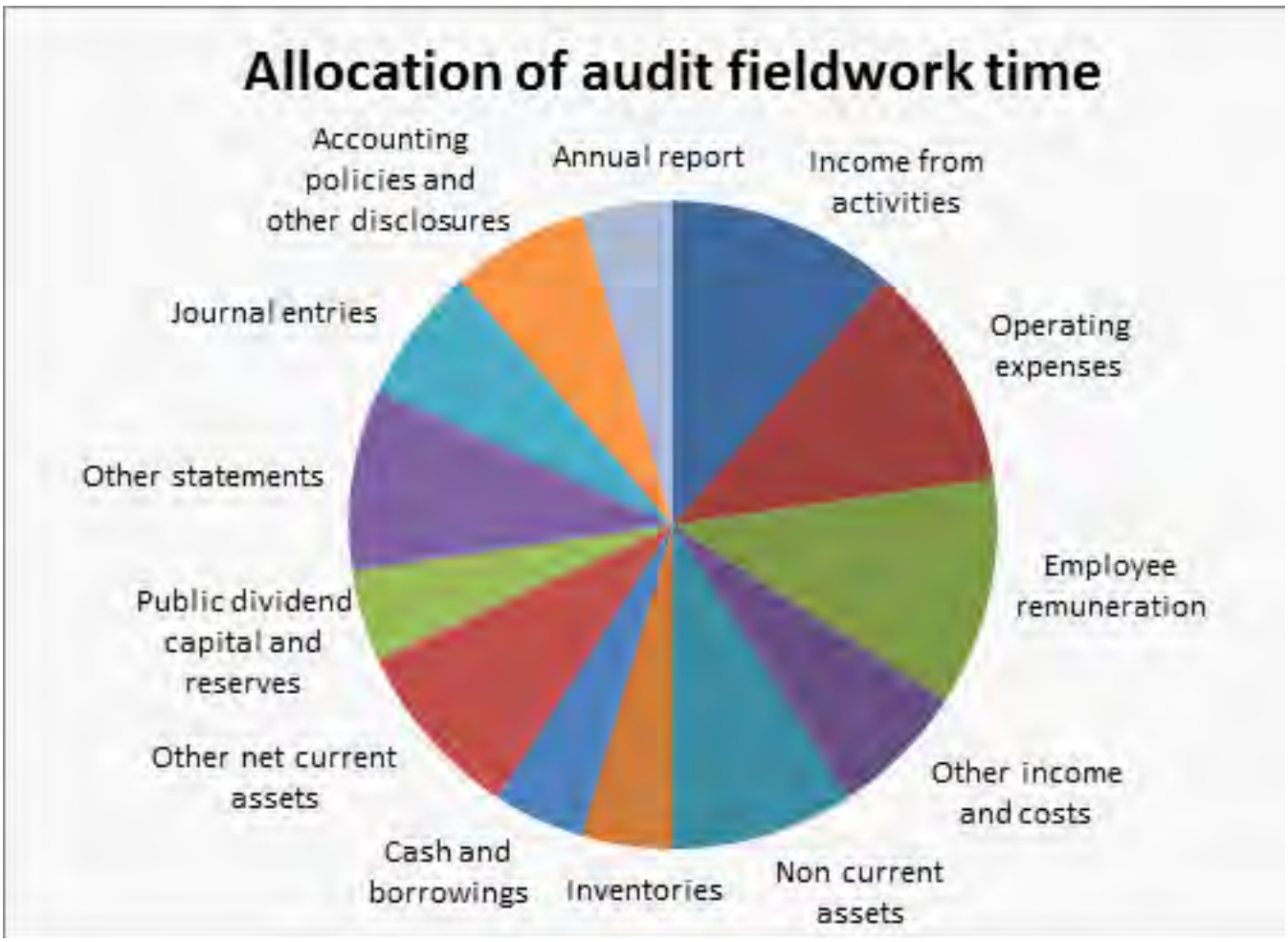
Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the judgement of a reasonably knowledgeable person would be changed or influenced.

We determined materiality for the audit of the Group financial statements as a whole to be £2,921,000 which is 2% of the Group's gross operating costs. This benchmark is considered the most appropriate because users of the financial statements are particularly interested in how healthcare funding has been spent. We use a different level of materiality, performance materiality, to drive the extent of our testing and this was set at 75% of financial statement materiality for the audit of the Group financial statements. We also determine a lower level of specific materiality for certain areas such as senior officer remuneration and related party transactions.

We determined the threshold at which we will communicate misstatements to the Trust's Audit Committee to be £146,000. In addition we communicate misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

Overview of the scope of our audit



We conducted our audit in accordance with International Standards on Auditing (ISAs) (UK and Ireland) having regard to the Financial Reporting Council's Practice Note 10 'Audit of Financial Statements of Public Bodies in the UK (Revised)'. Our responsibilities under the Code and the ISAs (UK and Ireland) are further described in the 'Responsibilities for the financial statements and the audit' section of our report. We believe that the audit evidence we have obtained from our audit is sufficient and appropriate to provide a basis for our opinion.

We are independent of the Group in accordance with the Auditing Practices Board's Ethical Standards for Auditors, and we have fulfilled our other ethical responsibilities in accordance with those Ethical Standards. Our audit approach was based on a thorough understanding of the Group's business and is risk based. Accordingly, our audit work was focused on obtaining an understanding of, and evaluating, relevant internal controls at the Group.

In order to gain appropriate audit coverage of the risks described above and of the Trust's charity, we performed testing of the significant balances and transactions of the charity as part of our audit work on the Group financial statements.

We undertook substantive testing on significant transactions, balances and disclosures in the Group financial statements, the extent of which was based on various factors such as our overall assessment of the Group's control environment, the design effectiveness of controls over significant financial systems and the management of risks.

Other reporting required by regulations

Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is unmodified

In our opinion:

- the part of the Directors' Remuneration Report subject to audit has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014-15 issued by Monitor; and
- the information given in the strategic report and directors' report for the financial year for which the financial statements are prepared is consistent with the Group financial statements.

Matters on which we are required to report by exception

We are required by Monitor's Audit Code for NHS Foundation Trusts to satisfy ourselves that the Trust's Quality Report has been prepared in line with the requirements set out in Monitor's published guidance and is consistent with other sources of evidence.

Our testing of the mandated indicator 'Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways' identified errors in the recording of referral dates, incorrect inclusion of non-consultant led referrals and new pathways which had been incorrectly created when valid open pathways were already in existence. Our limited assurance report to the Board of Directors and Board of Governors of Royal United Hospitals Bath NHS Foundation Trust on the Quality Report, is therefore qualified as we were unable to provide assurance that this indicator in the Quality Report, subject to limited assurance, had been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual. Other than for the issue reported above we have nothing to report in relation to the Trust's Quality Report.

As a result of the above matter, we have been unable to satisfy ourselves that Royal United Hospitals Bath NHS Foundation Trust's Quality Report has been prepared in line with all the requirements set out in Monitor's published guidance and is consistent with other sources of evidence.
We have nothing to report in respect of the following:

Under the Code 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 or is misleading or inconsistent with the information of which we are aware from our audit; or
- we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under the ISAs (UK and Ireland), we are also required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to report to you if:

- we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable; or
- the annual report does not appropriately disclose those matters that were communicated to the Audit Committee which we consider should have been disclosed.

Responsibilities for the financial statements and the audit

What an audit of financial statements involves:

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Group's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially inconsistent with the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

What the Chief Executive is responsible for as accounting officer:

As explained more fully in the Chief Executive's Responsibilities Statement, the Chief Executive as Accounting Officer is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Direction issued by Monitor and for being satisfied that they give a true and fair view.

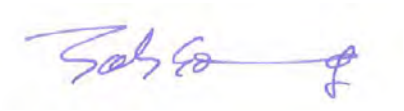
What are we responsible for:

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts issued by Monitor, and ISAs (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Certificate

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

As set out above, and as a result of our work on the mandated indicator referred to above, we have been unable to satisfy ourselves that the Trust's Quality Report has been prepared in line with all the requirements set out in the NHS Foundation Trust Annual Reporting Manual and is consistent with other sources of evidence.



John Golding
Partner
for and on behalf of
Grant Thornton UK LLP
Hartwell House
55-61 Victoria Street
Bristol
BS1 6FT

11 Summary Accounts for the five months ended 31 March 2015

The summary financial statements which follow do not contain sufficient information to allow as full an understanding of the results and state of affairs of the Trust and its policies and arrangements as provided by the full set of annual accounts.

The auditor's report on the full annual report and accounts was unqualified and the auditor's statement confirmed the strategic report and directors' reports were consistent with the accounts and were unqualified.

A full set of the accounts is available on request from the Director of Finance.

The following statements are attached:

- Summary Financial Statements
- Independent Auditor's report

The summary financial statements do not include the results for Royal United Hospital Bath Charitable Fund. The Charitable Fund is registered with the Charity Commission for England and Wales under registration number, 1058323. Its principle office is at the Royal United Hospitals Bath NHS Foundation Trust, Combe Park, Bath BA1 3NG. Details of the charitable fund can be found on the website: www.ruh.nhs.uk. The main fundraising appeal of the fund, the Forever Friends Appeal, can be found at www.foreverfriendsappeal.co.uk.

Administrative details

Trust contact:	**Director of Finance** Royal United Hospitals Bath NHS Foundation Trust Malvern House Combe Park Bath BA1 3NG Telephone: 01225 428331 E-mail: ruh-tr.FOIRequests@nhs.net
Solicitors:	**Bevan Brittan Solicitors** 35 Colston Avenue Bristol BS1 4TT
Bankers:	**Government Banking Service** Sutherland House Russell Way Crawley West Sussex RH10 1UH
Auditors:	**Grant Thornton LLP** Hartwell House 55-61 Victoria Street Bristol BS1 6FT

Consolidated Statement of Comprehensive Income 1 November 2014 to 31 March 2105	Group 5 Months to 31 March 2015 £000
Operating income from patient care activities	106,783
Other operating income	9,493
Total operating income from continuing operations	**116,276**
Operating expenses	(119,624)
Operating surplus from continuing operations	**(3,348)**
Finance income	20
Finance expenses	(55)
PDC dividends payable	(2,376)
Net finance costs	**(2,411)**
Gains arising from transfers by absorption	7,034
Surplus for the year	**1,275**
Other comprehensive income	
Will not be reclassified to income and expenditure:	
Impairments	(2,947)
Revaluations	3,676
May be reclassified to income and expenditure when certain conditions are met:	
Fair value gains on available-for-sale financial investments	251
Total comprehensive income for the period	**1,925**
Surplus for the period attributable to:	
the Foundation Trust	1,275
Total comprehensive income for the period attributable to:	
the Foundation Trust	1,925

Statement of financial position

	Group		Trust	
	31 March 2015 £000	1 November 2014 £000	31 March 2015 £000	1 November 2014 £000
Non-current assets				
Intangible assets	1,194	795	1,194	795
Property, plant and equipment	182,791	178,223	182,791	178,223
Other investments	6,516	6,038	-	-
Trade and other receivables	1,346	1,272	1,346	1,272
Total non-current assets	**191,847**	**186,328**	**185,331**	**180,290**
Current assets				
Inventories	4,874	4,400	4,874	4,400
Trade and other receivables	17,953	15,358	17,953	15,540
Cash and cash equivalents	10,679	9,564	9,610	8,527
Total current assets	**33,506**	**29,322**	**32,437**	**28,467**
Current liabilities				
Trade and other payables	(20,973)	(19,456)	(20,709)	(19,462)
Other liabilities	(1,527)	-	(1,527)	-
Borrowings	(1,079)	(1,109)	(1,079)	(1,109)
Provisions	(979)	(943)	(979)	(943)
Total current liabilities	**(24,558)**	**(21,508)**	**(24,294)**	**(21,514)**
Total assets less current liabilities	**200,795**	**194,142**	**193,474**	**187,243**
Non-current liabilities				
Borrowings	(9,315)	(6,510)	(9,315)	(6,510)
Provisions	(1,393)	(1,470)	(1,393)	(1,470)
Total non-current liabilities	**(10,708)**	**(7,980)**	**(10,708)**	**(7,980)**
Total assets employed	**190,087**	**186,162**	**182,766**	**179,263**
Financed by				
Public dividend capital	148,855	139,806	148,855	139,806
Revaluation reserve	46,979	45,825	46,979	45,825
Income and expenditure reserve	(13,068)	(6,368)	(13,068)	(6,368)
Charitable fund reserves	7,321	6,899	-	-
Total taxpayers' and others' equity	**190,087**	**186,162**	**182,766**	**179,263**

James Scott
Chief Executive
Date: 27 May 2015

Statement of Cash Flows

	Group 5 Months to 31 March 2015 £000	Trust 5 Months to 31 March 2015 £000
Cash flows from operating activities		
Operating deficit	(3,348)	(3,744)
Non-cash income and expense:		
Depreciation and amortisation	3,500	3,500
Impairments and reversals of impairments	5,484	5,484
Loss on disposal of non-current assets	37	37
Non-cash donations/grants credited to income	(50)	(50)
Increase in receivables and other assets	(857)	(709)
Increase in inventories	(421)	(421)
Increase in payables and other liabilities	1,312	1,312
Decrease in provisions	(112)	(112)
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows	(396)	-
Net cash generated from operating activities	**5,149**	**5,297**
Cash flows from investing activities		
Interest received	17	17
Purchase of intangible assets	(516)	(516)
Purchase of property, plant, equipment and investment property	(6,584)	(6,584)
Net cash generated used in investing activities	**(7,083)**	**(7,083)**
Cash flows from financing activities		
Public dividend capital received	2,000	2,000
Movement on loans from the Independent Trust Financing Facility	3,290	3,290
Movement on loans from the Department of Health	(495)	(495)
Capital element of finance lease rental payments	(62)	(62)
Interest paid on finance lease liabilities	(2)	(2)
Other capital receipts	3	3
Other interest paid	(50)	(50)
PDC dividend paid	(2,667)	(2,667)
Net cash generated from financing activities	**2,017**	**2,017**
Increase in cash and cash equivalents	**83**	**231**
Cash and cash equivalents at 1 November 2014	**9,564**	**8,527**
Cash and cash equivalents transferred under absorption accounting	1,032	852
Cash and cash equivalents at 31 March 2015	**10,679**	**9,610**

Statement of Changes in Equity for the period ended 31 March 2015

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	NHS charitable funds reserves £000	Total £000
Taxpayers' and others' equity at 1 November 2014 – brought forward	**139,806**	**45,825**	**(6,368)**	**6,899**	**186,162**
Surplus/(deficit) for the year	-	-	876	399	1,275
Transfers by absorption: transfers between reserves	7,049	1,146	(8,525)	330	-
Other transfers between reserves	-	(721)	721	-	-
Impairments	-	(2,947)	-	-	(2,947)
Revaluations	-	3,676	-	-	3,676
Fair value gains on available-for-sale financial investments	-	-	-	251	251
Public dividend capital received	2,000	-	-	-	2,000
Other reserve movements	-	-	228	(558)	(330)
Taxpayers' and others' equity at 31 March 2015	**148,855**	**46,979**	**(13,068)**	**7,321**	**190,087**

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000		Total £000
Taxpayers' and others' equity at 1 November 2014 - brought forward	**139,806**	**45,825**	**(6,368)**		**179,263**
Surplus/(deficit) for the year	-	-	876		876
Transfers by absorption: transfers between reserves	7,049	1,146	(8,525)		(330)
Other transfers between reserves	-	(721)	721		-
Impairments	-	(2,947)	-		(2,947)
Revaluations	-	3,676	-		3,676
Public dividend capital received	2,000	-	-		2,000
Other reserve movements	-	-	228		228
Taxpayers' and others' equity at 31 March 2015	**148,855**	**46,979**	**(13,068)**		**182,766**

Glossary

Term	Definition
Agenda for Change	Current NHS pay system (excluding doctors, dentists and some senior managers) implemented to standardise pay across various staff groups and across NHS organisations.
Amortisation	An amount which is charged to expenditure on a periodic basis to reflect the use of an intangible asset over more than one reporting period.
Asset	A balance which represents the value of finance benefit the Trust will gain in future periods as a result of a past transaction or event.
BIU	The Business Intelligence Unit BIU aims to provide Information and analytical support to inform decision making across all levels of the RUH and the Local Health Community. Performance and clinical outcomes are monitored to help the trust and its employees be more efficient and productive in order to deliver a high quality of care and an excellent patient experience.
Borrowings	Amounts which the Trust has borrowed, either as a loan or as a finance lease.
Breakeven Duty	A statutory requirement for the Trust to ensure that it balances income and expenditure over a period of three years (or in certain exceptions, five years).
Cash Equivalents	Assets that can be easily and quickly converted into cash.
CQUIN	Commissioning for Quality and Innovation, a payment framework which enables Commissioners to reward excellence by making a proportion of an acute healthcare provider's income conditional on demonstrating improvements in quality in specified acreas of care.
Current Asset	An asset used or sold in the Trust's normal activities, such as stocks.
Depreciation	An amount which is charged to expenditure and which recognises the reduction in value of a non-current asset over its life due to wear and tear, technological changes or the general passing of time.
Exit packages	A financial arrangement with an employee which will result in a termination of their contract of employment with the Trust. This can be the result of a MARS scheme, redundancy, severance agreement, or pay in lieu of notice.
Finance Costs	A balance which represents interest costs, arising from borrowings and unwinding the discounts applied to future liabilities reflecting the time-value of money.
Finance Lease	A contractual agreement arising where an underlying asset is transferred to the lessee, but where legal ownership remains with the lessor.
IFRS	International Financial Reporting Standards, a set of rules that were set up to standardise accounting procedures and reporting processes across international boundaries. These have been applied for the first time in 2009/10.
Impairment	The reduction in value of an asset due to damage or obsolescence.
Independent Sector Treatment Centres	Privately owned treatment centres which perform procedures on behalf of the NHS.
Intangible Asset	An asset which cannot be seen or touched but which has value, such as software licences.
Inventories	Stock.
Liabilities	A balance which represents an expected future financial outflow to the Trust arising as a result of a past transaction or event.

Term	Definition
MARS	Mutually Agreed Resignation Scheme. The Scheme enables individual employees – in agreement with their employer – to choose to leave their employment voluntarily, in return for a severance payment. It is not a redundancy.
Non-Current Asset	An asset which is held for more than one year and not sold during the normal course of Trust activities, such as medical equipment.
Operating Expenses	Costs incurred through carrying out the day to day activities of the Trust i.e. patient care activities.
Operating Revenue	Income received from the day to day activities of the Trust i.e. patient care activities.
Payables	Balances owed to others.
PDC Dividend	An amount which represents a return on the net assets of the Trust which is paid annually to HM Treasury. The net assets used for this calculation excludes the value of donated assets and cash held in Government Banking Services bank accounts.
Provision	A liability arising as a result of a past event which will be payable in future periods.
Public Dividend Capital (PDC)	Represents Central Government's investment in the Trust. This is similar to the 'Share Capital' in a company.
QIPP	Quality, Innovation, Productivity and Prevention Programme
Receivables	Balances owed by others.
Redundancy	Termination of employment of an employee or a group of employees for business reasons.
Revaluation Reserve	A reserve which is credited with historic increases in the value of assets as a result of changes in prices. Any subsequent reductions in values are also recorded here.
RNHRD	Royal National Hospital for Rheumatic Diseases
Taxpayers' Equity	A balance representing the net assets of the Trust.
UK GAAP	UK Generally Accepted Accounting Practice represents the collective term for the standards, rules and practices which developed in the UK. From 2009/10 onward, these have been replaced by International Financial Reporting Standards in the NHS.

Are we talking your language?
If you need this document in another format,
including large print,
please contact the
Patient Adivce and Liaison Service
Tel: 01225 825656
E-mail: ruh-tr.Pals@nhs.net

Se você gostaria desta informação em seu idioma, por favor nos contate em 01225 825656.

如果你希望这一信息在你的语言,请联系我们关于 01225 825656.

Jeśli chcesz tę informację w twoim języku, prosimy o kontakt z 01225 825656.

We value your opinion
We want to make sure future reports give you all the information you need on our services, so please tell us if you think we could improve.

If you would like to know more, or to comment on our plans, please write to the
Chairman Brian Stables or
Chief Executive James Scott at:

Royal United Hospitals Bath NHS Foundation Trust
Combe Park
BATH
BA1 3NG
Telephone: 01225 824032
E-mail: ruh-tr.trustboard@nhs.net
Website: www.ruh.nhs.uk

Date of publication: May 2015
Ref: RUHAR 0004/7

Royal United Hospitals Bath NHS
NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation Trust

Accounts for the five month period ended 31 March 2015

Foreword to the accounts

Royal United Hospitals Bath NHS Foundation Trust

These accounts, for the 5 month period ended 31 March 2015, 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 James Scott
Job title Chief Executive
Date 27 May 2015

Consolidated Statement of Comprehensive Income

	Note	Group 5 Months to 31st March 2015 £000
Operating income from patient care activities	3	106,783
Other operating income	4	9,493
Total operating income from continuing operations		**116,276**
Operating expenses	5, 7	(119,624)
Operating surplus/(deficit) from continuing operations		**(3,348)**
Finance income	9	20
Finance expenses	10	(55)
PDC dividends payable		(2,376)
Net finance costs		**(2,411)**
Gains/ (losses) arising from transfers by absorption	32	7,034
Surplus/(deficit) for the year		**1,275**
Other comprehensive income		
Will not be reclassified to income and expenditure:		
Impairments	6	(2,947)
Revaluations	17	3,676
May be reclassified to income and expenditure when certain conditions are met:		
Fair value gains/(losses) on available-for-sale financial investments	18	251
Total comprehensive income/(expense) for the period		**1,925**
Surplus / (deficit) for the period attributable to:		
the Foundation Trust		1,275
Total comprehensive income / (expense) for the period attributable to:		
the Foundation Trust		1,925

Royal United Hospitals Bath NHS Foundation Trust

Accounts for the five month period ended 31 March 2015

Statement of Financial Position		Group		Trust	
		31 March 2015	1 November 2014	31 March 2015	1 November 2014
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	12, 13	1,194	795	1,194	795
Property, plant and equipment	14, 15	182,791	178,223	182,791	178,223
Other investments	18	6,516	6,038	-	-
Trade and other receivables	22	1,346	1,272	1,346	1,272
Total non-current assets		**191,847**	**186,328**	**185,331**	**180,290**
Current assets					
Inventories	21	4,874	4,400	4,874	4,400
Trade and other receivables	22	17,953	15,358	17,953	15,540
Cash and cash equivalents	23	10,679	9,564	9,610	8,527
Total current assets		**33,506**	**29,322**	**32,437**	**28,467**
Current liabilities					
Trade and other payables	24	(20,973)	(19,456)	(20,709)	(19,462)
Other liabilities	25	(1,527)	-	(1,527)	-
Borrowings	26	(1,079)	(1,109)	(1,079)	(1,109)
Provisions	28	(979)	(943)	(979)	(943)
Total current liabilities		**(24,558)**	**(21,508)**	**(24,294)**	**(21,514)**
Total assets less current liabilities		**200,795**	**194,142**	**193,474**	**187,243**
Non-current liabilities					
Borrowings	26	(9,315)	(6,510)	(9,315)	(6,510)
Provisions	28	(1,393)	(1,470)	(1,393)	(1,470)
Total non-current liabilities		**(10,708)**	**(7,980)**	**(10,708)**	**(7,980)**
Total assets employed		**190,087**	**186,162**	**182,766**	**179,263**
Financed by					
Public dividend capital		148,855	139,806	148,855	139,806
Revaluation reserve		46,979	45,825	46,979	45,825
Income and expenditure reserve		(13,068)	(6,368)	(13,068)	(6,368)
Charitable fund reserves	19	7,321	6,899		-
Total taxpayers' and others' equity		**190,087**	**186,162**	**182,766**	**179,263**

The financial statements on pages 3 to 51 were approved by the Board on 27th May 2015 and signed on its behalf by

Signature

Position CHIEF EXECUTIVE

Date **27 May 2015**

Statement of Changes in Equity for the period ended 31 March 2015

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	NHS charitable funds reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 November 2014 - brought forward	**139,806**	**45,825**	**(6,368)**	**6,899**	**186,162**
Surplus/(deficit) for the year	-	-	876	399	**1,275**
Transfers by absorption: transfers between reserves	7,049	1,146	(8,525)	330	-
Other transfers between reserves	-	(721)	721	-	-
Impairments	-	(2,947)	-	-	**(2,947)**
Revaluations	-	3,676	-	-	**3,676**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	251	**251**
Public dividend capital received	2,000	-	-	-	**2,000**
Other reserve movements	-	-	228	(558)	**(330)**
Taxpayers' and others' equity at 31 March 2015	**148,855**	**46,979**	**(13,068)**	**7,321**	**190,087**

Statement of Changes in Equity for the period ended 31 March 2015

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 November 2014 - brought forward	**139,806**	**45,825**	**(6,368)**	**179,263**
Surplus/(deficit) for the year	-	-	876	**876**
Transfers by absorption: transfers between reserves	7,049	1,146	(8,525)	**(330)**
Other transfers between reserves	-	(721)	721	**-**
Impairments	-	(2,947)	-	**(2,947)**
Revaluations	-	3,676	-	**3,676**
Public dividend capital received	2,000	-	-	**2,000**
Other reserve movements	-	-	228	**228**
Taxpayers' and others' equity at 31 March 2015	**148,855**	**46,979**	**(13,068)**	**182,766**

Information on reserves

NHS charitable funds reserves
This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these accounts. These reserves are classified as restricted or unrestricted.

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 trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation 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 NHS foundation trust.

Statement of Cash Flows

	Note	Group 5 Months to 31st March 2015 £000	Trust 5 Months to 31st March 2015 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(3,348)	(3,744)
Non-cash income and expense:			
Depreciation and amortisation	5.1	3,500	3,500
Impairments and reversals of impairments	6	5,484	5,484
(Gain)/loss on disposal of non-current assets	5.1	37	37
Non-cash donations/grants credited to income	4	(50)	(50)
(Increase)/decrease in receivables and other assets		(857)	(709)
(Increase)/decrease in inventories		(421)	(421)
Increase/(decrease) in payables and other liabilities		1,312	1,312
Increase/(decrease) in provisions		(112)	(112)
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		(396)	-
Net cash generated from/(used in) operating activities		**5,149**	**5,297**
Cash flows from investing activities			
Interest received		17	17
Purchase of intangible assets		(516)	(516)
Purchase of property, plant, equipment and investment property		(6,584)	(6,584)
Net cash generated from/(used in) investing activities		**(7,083)**	**(7,083)**
Cash flows from financing activities			
Public dividend capital received		2,000	2,000
Movement on loans from the Independent Trust Financing Facility		3,290	3,290
Movement on loans from the Department of Health		(495)	(495)
Capital element of finance lease rental payments		(62)	(62)
Interest paid on finance lease liabilities		(2)	(2)
Other capital receipts		3	3
Other interest paid		(50)	(50)
PDC dividend paid		(2,667)	(2,667)
Net cash generated from/(used in) financing activities		**2,017**	**2,017**
Increase/(decrease) in cash and cash equivalents		**83**	**231**
Cash and cash equivalents at start of period for new FTs		**9,564**	**8,527**
Cash and cash equivalents transferred under absorption accounting	32	1,032	852
Cash and cash equivalents at 31 March	23	**10,679**	**9,610**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *FT ARM* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the *FT ARM 2014/15* issued by Monitor. The accounting policies contained in that manual follow IFRS and HM Treasury's *FReM* to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Comparatives

This is the first accounting period as an authorised NHS Foundation Trust, as such there are no stated comparatives for the period apart from in the Statement of Financial Position and the corresponding notes.

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, inventories and certain financial assets and financial liabilities.

Going concern

These accounts have been prepared on a going concern basis.

Note 1.1 Consolidation

RUH Charitable Fund

The NHS foundation trust is the corporate trustee to the RUH Charitable Fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation 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 2005) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

1. Recognise and measure them in accordance with the foundation trust's accounting policies; and
2. Eliminate intra-group transactions, balances, gains and losses.

Note 1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.3 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments 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 NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost 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 1.4 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 1.5 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; and
- the cost of the item can be measured reliably.

Assets that collectively, have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control are also capitalised.

Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost are capitalised

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

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.

All assets are measured subsequently at fair value. Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

Plant and equipment of significant purchase value or useful life are to be assessed for fair value annually. Any of these assets that are thought to be held on the register deemed to be an amount that significantly differ from fair value will undergo a revaluation exercise. All other fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic 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' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

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

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 *FT ARM*, 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 income 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 all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale'; and
- the actions needed to complete the plan indicate it is unlikely that it will be dropped or significant changes made to it.

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. 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 economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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

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

Useful Economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	6	78
Dwellings	20	50
Plant & machinery	5	25
Transport equipment	5	7
Information technology	4	7
Furniture & fittings	4	16

Finance-leased assets are depreciated over the shorter of the useful economic life or the lease term, unless the FT 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 1.6 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.

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 fair value. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

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 economic lives in a manner consistent with the consumption of economic or service delivery benefits.

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

	Min life Years	Max life Years
Intangible assets - purchased		
Software	2	5
Licences & trademarks	5	10

Note 1.7 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.8 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

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

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

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. [Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The trust's loans and receivables comprise:
- cash and cash equivalents,
- NHS receivables,
- accrued income and
- "other receivables"

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Note 1.9 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation 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 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 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. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

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.

Note 1.10 Provisions

The NHS foundation 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 the discount rates published and mandated by HM Treasury.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 28.2 but is not recognised in the NHS foundation trust's accounts.

Note 1.11 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 trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation 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 NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (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 thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.12 Value added tax

Most of the activities of the NHS foundation 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 1.13 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, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However 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 1.14 Transfers of functions from other NHS bodies

For functions that have been transferred to the trust from another NHS Foundation Trust, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain corresponding to the net assets transferred is recognised within income, but not within operating activities. In 2014/15 the net gain corresponding to the net assets transferred from The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust is recognised within the income and expenditure reserve under the principles of modified absorption accounting which applied to transfers where the transferring body ceased to exist on 31 January 2015.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

Note 1.15 Critical accounting estimates and judgements

In accordance with IAS 1, foundation trusts should disclose details of critical accounting judgements and key sources of estimation and uncertainty in these account.

Critical judgements in applying Royal United Hospitals NHS Foundation Trust's accounting policies

Management has exercised the following critical judgements in applying the Royal United Hospital NHS Foundation Trust's accounting policies for the year ended 31 March 2015:

VAT on Professional costs

That VAT on professional costs included in the professional valuations on property assets based on Market Equivalent Valuations are recoverable on a modern equivalent build.

Classification of Leases

Under IAS 17 a finance lease is one that transfers to the lessee 'substantially all the risks and rewards incidental to ownership of an asset'. This requires the consideration of a number of factors for each lease. The Trust considers that where the net present value of lease payments amounts is up to 90% of the fair value of the asset there is a strong presumption that a lease is a finance lease unless there is other evidence to the contrary. The impact of the classification of leases as finance leases is disclosed in Note 30.1 (Finance lease obligations).

Asset Lives and residual values

Property, plant and equipment is depreciated over its useful life taking into account residual values, where appropriate. The actual lives of the assets and residual values are assessed annually and may vary depending on a number of factors. In reassessing asset lives, factors such as technological innovation and maintenance programmes are taken into account. Residual value assessments consider issues such as the remaining life of the asset and projected disposal values.

Provisions

The Trust regularly monitors the position regarding provisions, including legal claims and restructuring, to ensure that it accurately reflects at each balance sheet date the current position in providing for potential future costs from past events, including board resolutions. Provisions are disclosed in Note 28.2.

Impairment of Assets

At each balance sheet date, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually. The impact of impairments is discussed in Note 17 (Revaluations of property, plant and equipment)

Note 2 Operating Segments

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

Summary Table - aggregate of all schemes	5 months to 31 March 2015 £000s
Income	1,331
Full cost	1,405
Surplus/(deficit)	(74)

Catering	5 months to 31 March 2015 £000s
Income	693
Full cost	637
Surplus/(deficit)	56

Car Parking	5 months to 31 March 2015 £000s
Income	638
Full cost	768
Surplus/(deficit)	(130)

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	Group
	5 Months to 31st March 2015 £000
Acute services	
Elective income	14,694
Non elective income	38,164
Outpatient income	26,293
A & E income	3,215
Other NHS clinical income	21,437
All other services	
Private patient income	259
Other clinical income	2,721
Total income from activities	106,783

Note 3.2 Income from patient care activities (by source)

	Group
Income from patient care activities received from:	5 Months to 31st March 2015 £000
CCGs and NHS England	103,533
Local authorities	461
Department of Health	9
Other NHS foundation trusts	904
NHS trusts	300
Non-NHS: private patients	259
NHS injury scheme (was RTA)	341
Non NHS: other	976
Total income from activities	106,783
Of which:	
Related to continuing operations	106,783
Related to discontinued operations	-

Note 4 Other operating income

	Group
	5 Months to 31st March 2015 £000
Research and development	251
Education and training	5,185
Receipt of capital grants and donations	111
Charitable and other contributions to expenditure	31
Non-patient care services to other bodies	510
Reversal of impairments	22
Rental revenue from operating leases	180
Income in respect of staff costs where accounted on gross basis	408
Incoming resources received by NHS charitable fund	851
Other income	1,944
Total other operating income	**9,493**
Of which:	
Related to continuing operations	9,493
Related to discontinued operations	-

Note 5.1 Operating expenses

	Group
	5 Months to 31st March 2015
	£000
Services from NHS foundation trusts	75
Services from NHS trusts	24
Services from other NHS bodies	2
Purchase of healthcare from non NHS bodies	729
Employee expenses - executive directors	474
Employee expenses - non-executive directors	64
Employee expenses - staff	72,676
Supplies and services - clinical	11,198
Supplies and services - general	2,049
Establishment	1,098
Research and development	149
Transport	437
Premises	3,354
Increase/(decrease) in provision for impairment of receivables	518
Increase/(decrease) in other provisions	(143)
Inventories written down	40
Drug costs	13,846
Inventories consumed (excluding Drugs)	31
Depreciation on property, plant and equipment	3,361
Amortisation on intangible assets	139
Impairments	5,506
Audit fees payable to the external auditor	
audit services- statutory audit	43
Clinical negligence	1,408
Loss on disposal of non-current assets	37
Legal fees	137
Consultancy costs	270
Training, courses and conferences	903
Hospitality	52
Insurance	95
Other	1,052
Total	**119,624**
Of which:	
Related to continuing operations	119,624
Related to discontinued operations	-

Note 5.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the period 5 Months to 31st March 2015.

Note 6 Impairment of assets

	Group 5 Months to 31st March 2015 £000
Net impairments charged to operating surplus / deficit resulting from:	
Changes in market price	5,484
Total net impairments charged to operating surplus / deficit	**5,484**
Impairments charged to the revaluation reserve	2,947
Total net impairments	**8,431**

Note 7 Employee benefits

	Group		
	Permanent	Other	5 Months to 31st March 2015 Total
	£000	£000	£000
Salaries and wages	57,406	2,713	60,119
Social security costs	4,096	184	4,280
Employer's contributions to NHS pensions	6,651	198	6,849
Agency/contract staff	-	1,932	1,932
NHS charitable funds staff	194	-	194
Total gross staff costs	68,347	5,027	73,374
Recoveries in respect of seconded staff	-	-	-
Total staff costs	68,347	5,027	73,374
Included within:			
Costs capitalised as part of assets	123	-	123

Note 7.1 Average number of employees (WTE basis)

	Group		
	Permanent	Other	5 Months to 31st March 2015 Total
	Number	Number	Number
Medical and dental	503	21	524
Administration and estates	1,167	45	1,212
Healthcare assistants and other support staff	731	-	731
Nursing, midwifery and health visiting staff	1,215	134	1,349
Scientific, therapeutic and technical staff	436	14	450
Bank staff	-	5	5
Total average numbers	4,052	219	4,271
Of which:			
Number of employees (WTE) engaged on capital projects	6	-	6

Note 7.2 Retirements due to ill-health

During 5 Months to 31st March 2015 there were 3 early retirements from the trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements is £109k

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.3 Reporting of compensation schemes - exit packages 5 Months to 31st March 2015

Exit costs in this note are accounted for in full in the period of departure. No exit packages involved making any special payments as defined by the NHS Manual for Accounts. Exit costs relate to dismissals of staff within the period

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	6	6
Total number of exit packages by type	-	6	6
Total resource cost (£)	£0	£16,000	£16,000

Note 7.4 Exit packages: other (non-compulsory) departure payments

	5 Months to 31st March 2015	
	Payments agreed Number	Total value of agreements £000
Exit payments following Employment Tribunals or court orders	6	16
Total	6	16
Of which:		
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-

This disclosure reports the number and value of exit packages agreed in the period. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

The minimum payment made was £58.72, the mean was £2,667 and the maximum was £5,578

Note 7.5 Directors' remuneration

The aggregate amounts payable to directors were:

	Group
	5 Months to 31st March 2015 £000
Salary	358
Taxable benefits	0
Performance related bonuses	0
Employer's pension contributions	41
Total	399

Further details of directors' remuneration can be found in the remuneration report.

Note 8 Operating leases

Note 8.1 Royal United Hospitals Bath NHS Foundation Trust as a lessor

The rent received relates to payment made by residents of the Trust's dwellings on the hospital site. Rent is charged on a rolling monthly basis. The payments are due monthly and are paid in the current month.

	Group 5 Months to 31st March 2015 £000
Operating lease revenue	
Minimum lease receipts	-
Contingent rent	180
Other	-
Total	**180**

Note 9 Finance income

	Group 5 Months to 31st March 2015 £000
Interest on bank accounts	17
Investment income on NHS charitable funds financial assets	3
Total	**20**

Note 10 Finance expenditure

	Group 5 Months to 31st March 2015 £000
Interest expense:	
Loans from the Department of Health	42
Finance leases	2
Total interest expense	**44**
Unwinding of discount on provisions	11
Total	**55**

Note 11 Foundation 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 surplus for the period was £0.549 million. The trust's total comprehensive income for the period was £1.278 million

Note 12.1 Intangible assets - 5 Months to 31st March 2015

Group	Software licences	Licences & trademarks	Other	NHS charitable fund assets	Total
	£000	£000	£000	£000	£000
Valuation/gross cost at start of period for new FTs	1,457	566	-	-	2,023
Transfers by absorption	-	172	-	-	172
Additions	140	376	-	-	516
Disposals / derecognition	(7)	(25)	-	-	(32)
Gross cost at 31 March 2015	1,590	1,089	-	-	2,679
Amortisation at start of period for new FTs	972	256	-	-	1,228
Transfers by absorption	-	147	-	-	147
Provided during the year	95	44	-	-	139
Disposals / derecognition	(7)	(22)	-	-	(29)
Amortisation at 31 March 2015	1,060	425	-	-	1,485
Net book value at 31 March 2015	530	664	-	-	1,194

Note 12.2 Intangible assets financing 5 Months to 31st March 2015

Group	Software licences	Licences & trademarks	Total
	£000	£000	£000
Net book value at 31 March 2015			
Purchased	520	657	**1,177**
Donated and government grant funded	10	7	**17**
NBV total at 31 March 2015	**530**	**664**	**1,194**

Note 13.1 Intangible assets - 5 Months to 31st March 2015

Trust	Software licences	Licences & trademarks	Total
	£000	£000	£000
Valuation/gross cost at start of period for new FTs	**1,457**	**566**	**2,023**
Transfers by absorption	-	172	172
Additions	140	376	516
Disposals / derecognition	(7)	(25)	(32)
Gross cost at 31 March 2015	**1,590**	**1,089**	**2,679**
Amortisation at start of period for new FTs	**972**	**256**	**1,228**
Transfers by absorption	-	147	147
Provided during the year	95	44	139
Disposals / derecognition	(7)	(22)	(29)
Amortisation at 31 March 2015	**1,060**	**425**	**1,485**
Net book value at 31 March 2015	**530**	**664**	**1,194**

Note 13.2 Intangible assets financing 5 Months to 31st March 2015

Trust	Software licences	Licences & trademarks	Total
	£000	£000	£000
Net book value at 31 March 2015			
Purchased	520	657	**1,177**
Donated and government grant funded	10	7	**17**
NBV total at 31 March 2015	**530**	**664**	**1,194**

Note 14.1 Property, plant and equipment - 5 Months to 31st March 2015

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 start of period for new FTs	35,784	118,315	2,783	4,013	44,413	43	8,954	306	214,611
Transfers by absorption	2,082	4,208	-	30	1,039	34	489	58	7,940
Additions	-	1,744	34	1,355	2,082	-	510	211	5,936
Impairments	-	(3,592)	(69)	(438)	-	-	-	-	(4,099)
Reclassifications	-	2,338	65	(2,568)	165	-	-	-	-
Revaluations	-	3,884	93	-	-	-	-	-	3,977
Disposals / derecognition	-	-	-	-	(3,056)	-	(3,629)	-	(6,685)
Valuation/gross cost at 31 March 2015	37,866	126,897	2,906	2,392	44,643	77	6,324	575	221,680
Depreciation at start of period for new FTs	-	3,066	54	-	26,668	31	6,438	131	36,388
Transfers by absorption	-	-	-	-	725	34	361	38	1,158
Provided during the year	-	1,704	34	-	1,233	5	369	16	3,361
Impairments	-	4,258	-	-	96	-	-	-	4,354
Reversals of impairments	-	(22)	-	-	-	-	-	-	(22)
Reclassifications	-	(4)	4	-	-	-	-	-	-
Revaluations	-	298	3	-	-	-	-	-	301
Disposals/ derecognition	-	-	-	-	(3,036)	-	(3,615)	-	(6,651)
Accumulated depreciation at 31 March 2015	-	9,300	95	-	25,686	70	3,553	185	38,889
Net book value at 31 March 2015	37,866	117,597	2,811	2,392	18,957	7	2,771	390	182,791

Note 14.2 Property, plant and equipment financing - 5 Months to 31st March 2015

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
Net book value at 31 March 2015									
Owned	37,866	112,289	2,811	1,811	16,561	7	2,771	297	**174,413**
Finance leased	-	-	-	-	126	-	-	-	**126**
Donated	-	5,308	-	581	2,270	-	-	93	**8,252**
NBV total at 31 March 2015	**37,866**	**117,597**	**2,811**	**2,392**	**18,957**	**7**	**2,771**	**390**	**182,791**

Note 15.1 Property, plant and equipment - 5 Months to 31st March 2015

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 start of period for new FTs	35,784	118,315	2,783	4,013	44,413	43	8,954	306	214,611
Transfers by absorption	2,082	4,208	-	30	1,039	34	489	58	7,940
Additions	-	1,744	34	1,355	2,082	-	510	211	5,936
Impairments	-	(3,592)	(69)	(438)	-	-	-	-	(4,099)
Reclassifications	-	2,338	65	(2,568)	165	-	-	-	-
Revaluations	-	3,884	93	-	-	-	-	-	3,977
Disposals / derecognition	-	-	-	-	(3,056)	-	(3,629)	-	(6,685)
Valuation/gross cost at 31 March 2015	37,866	126,897	2,906	2,392	44,643	77	6,324	575	221,680
Depreciation at start of period for new FTs	-	3,066	54	-	26,668	31	6,438	131	36,388
Transfers by absorption	-	-	-	-	725	34	361	38	1,158
Provided during the year	-	1,704	34	-	1,233	5	369	16	3,361
Impairments	-	4,258	-	-	96	-	-	-	4,354
Reversals of impairments	-	(22)	-	-	-	-	-	-	(22)
Reclassifications	-	(4)	4	-	-	-	-	-	-
Revaluations	-	298	3	-	-	-	-	-	301
Disposals/ derecognition	-	-	-	-	(3,036)	-	(3,615)	-	(6,651)
Accumulated depreciation at 31 March 2015	-	9,300	95	-	25,686	70	3,553	185	38,889
Net book value at 31 March 2015	37,866	117,597	2,811	2,392	18,957	7	2,771	390	182,791

Note 15.2 Property, plant and equipment financing - 5 Months to 31st March 2015

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
Net book value at 31 March 2015									
Owned	37,866	112,289	2,811	1,811	16,561	7	2,771	297	**174,413**
Finance leased	-	-	-	-	126	-	-	-	**126**
Donated	-	5,308	-	581	2,270	-	-	93	**8,252**
NBV total at 31 March 2015	**37,866**	**117,597**	**2,811**	**2,392**	**18,957**	**7**	**2,771**	**390**	**182,791**

Note 16 Donations of property, plant and equipment

During the five month period ending 31 March 2015 the Trust received donations from which assets were purchased to the value of £111,000. These donations were mainly made as follows:
£154,000: Royal United Hospitals Bath Charitable fund
£(43,000): Friends of the Royal United Hospital

An adjustment was made to the donation from the Friends of the RUH for the refurbishment of the Friends café on confirmation from our VAT advisors that VAT for the project is reclaimable. A donation of £104,000 was made by the Royal United Hospitals Bath Charitable fund for RUH redevelopment. The remaining contributions were mainly for the purchase of medical equipment. These charities are registered with the Charity Commission in England and Wales, and further details are available on www.ruh.nhs.uk

Note 17 Revaluations of property, plant and equipment

In accordance with the requirements of the Department of Health, the Trust's estate was last revalued at 31 st March 2014. The valuation was carried out by Mr SM Boshier MRICS, of Boshier and Company, Faversham, Kent, an independent valuer, in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual being consistent with the agreed requirements of the Department of Health and HM Treasury.

The valuation was carried out on the basis of Depreciated Replacement Cost for specialised operational property using the Modern Equivalent Asset methodology and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Land and buildings were restated to current value by the use of indices at the 31st March 2015. The buildings index is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office. On the advice of the independent valuer, land values have not materially moved therefore indexation was not applied at 31st March 2015. The estate had also been subject to a restatement using indices provided prior to incorporatation as a Foundation Trust at the 31st October 2014.

During the accounting period the total reduction in the value of buildings, dwellings and plant & equipment due to revaluations and impairments was £4,755,000. Specific valuations were undertaken by the professional valuers in period for the new IM&T building, Coombe Garden and Friends Cafe developments. Other valuation adjustments were processed following a review of assets on transfer to the Foundation Trust with the adoption of revised accounting policies (see critical judgements), a review the Trusts' estate strategy and affected properties and a review of properties transferred from the Royal National Hospital of Rheumatic Diseases. Initial valuation adjustments was undertaken on the 1st November 2014, adjustments to assets coming in to operation was undertaken as they were brought in to use, and indices applied at the year end.

Impairments are first offset against existing revaluation reserves where the impairment relates to changes in market price with the balance chargeable to the Statement of Comprehensive Income. Where impariments arise from other factors, all the imparement is charged to the Statement of Comprehensive Income, irrespective of revaluation reserve balances held. A transfer within reserves from the revaluation reserve balances up to the level of the impairement is actioned where applicable.

Of the net reduction of £4,755,000 in assets, £729,000 related to valuation adjustment increases taken directly to the valuation reserve and net £5,484,000 relating to impairments and impairment write backs charged to the Statement of Comprehensive Income.

At the 31st March 2015 the application of indices applied to Trust assets resulted in increases to Trust assets of £3,676,000 which was taken to the revaluation reserve. The total impairment reduction to assets was £8,431,000 of which £2,947,000 was taken directly to the revaluation reserve.

The impact of the new IM&T building, Friends Café and Coombe Garden developments brought in to operation was a net valuation reduction of £867,000, taken directly as impairments.

The review of buildings and equipment against the estate strategy resulted in £2,050,000 being charged to impairments. This included £1,036,000 on the reduction of the existing pharmacy building, and £578,000 on the North Wing. Equipment in the pharmacy building was also impaired (£96,000).

Other impairment adjustments included the review of opening balances against the 31st March 2014 valuation (£3,095,000) and changes in underlying market equivalent valuation methods (£2,419,000). These impairments adjustments were under £1m against each property impacted.

Asset lives

The economic lives for the Trust's main categories of property, plant and equipment fall between the ranges indicated below:

Buildings excluding dwellings: Between 6 and 78 years
Dwellings: Between 20 and 50
Plant and machinery: Between 5 and 25 years
Transport equipment: Between 5 and 7 years
Information technology: Between 4 and 7 years
Furniture and fittings: Between 4 and 16 years

Other

All of the values included for property, plant and equipment relate to their value for continuing NHS use. Consequently none of the values are at open market value.

There are no material assets which were temporarily idle at 31 March 2015.

Note 18 Investments - 5 Months to 31st March 2015

Group	Other investments
	£000
At start of period for new FTs	**6,038**
Transfers by absorption	268
Movement in fair value	251
Disposals	(41)
Carrying value at 31 March 2015	**6,516**

Note 19 Analysis of charitable fund reserves

The Royal United Hospital Charitable fund has been consolidated within this set of accounts

	31 March 2015 £000	1 November 2014 £000
Unrestricted funds:		
Unrestricted income funds	1,019	1,100
Restricted funds:		
Restricted income funds	6,302	5,799
	7,321	**6,899**

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 20 Disclosure of interests in other entities

The Royal United Hospital Bath NHS Foundation Trust has no interests in any subsidiaries, joint arrangements, associates or unconsolidated structured entities.

Note 21 Inventories

	Group						Trust					
	1 November 2014	Transfers by absorption	Additions	Inventories recognised as an expense in the period	Write-down of inventories (including losses)	31 March 2015	1 November 2014	Transfers by absorption	Additions	Inventories recognised as an expense in the period	Write-down of inventories (including losses)	31 March 2015
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Drugs	1,880	47	12,033	(11,652)	-	2,308	1,880	47	12,033	(11,652)	-	2,308
Work in progress	-	-	-	-	-	-	-	-	-	-	-	-
Consumables	2,381	3	13,041	(12,932)	(40)	2,453	2,381	3	13,041	(12,932)	(40)	2,453
Energy	110	3	12	(40)	-	85	110	3	12	(40)	-	85
Inventories carried at fair value less costs to sell	-	-	-	-	-	-	-	-	-	-	-	-
Other	29	-	122	(123)	-	28	29	-	122	(123)	-	28
Inventories held by NHS charitable funds	-	-	-	-	-	-	-	-	-	-	-	-
Total inventories	4,400	53	25,208	(24,747)	(40)	4,874	4,400	53	25,208	(24,747)	(40)	4,874

Inventories recognised in expenses for the year were £24,747k . Write-down of inventories recognised as expenses for the year were £40k .

Note 22.1 Trade receivables and other receivables

	Group		Trust	
	31 March 2015 £000	1 November 2014 £000	31 March 2015 £000	1 November 2014 £000
Current				
Trade receivables due from NHS bodies	12,531	11,261	12,531	11,261
Other receivables due from related parties	2,659	901	2,659	1,083
Provision for impaired receivables	(803)	(223)	(803)	(223)
Deposits and advances	22	-	22	-
Prepayments (non-PFI)	2,519	2,440	2,519	2,440
Accrued income	768	519	768	519
VAT receivable	211	182	211	182
Other receivables	46	278	46	278
Total current trade and other receivables	**17,953**	**15,358**	**17,953**	**15,540**
Non-current				
Provision for impaired receivables	(248)	(235)	(248)	(235)
Accrued income	1,594	1,507	1,594	1,507
Total non-current trade and other receivables	**1,346**	**1,272**	**1,346**	**1,272**

Note 22.2 Provision for impairment of receivables

	Group 5 Months to 31st March 2015	Trust 5 Months to 31st March 2015
	£000	£000
At start of period for new FTs	**458**	**458**
Transfers by absorption	82	82
Increase in provision	566	566
Amounts utilised	(7)	(7)
Unused amounts reversed	(48)	(48)
At 31 March	**1,051**	**1,051**

Overseas payments and salaries overpayments are always considered impaired due to the difficulty in recovering these amounts. All receivables with debt collectors are included and any NHS receivables subject to an ongoing long term dispute are also included.

Note 22.3 Analysis of impaired receivables

Group	31 March 2015
	Trade receivables
Ageing of impaired receivables	**£000**
0 - 30 days	747
30-60 Days	43
60-90 days	53
90- 180 days	69
Over 180 days	139
Total	**1,051**

Ageing of non-impaired receivables past their due date	
0 - 30 days	10,212
30-60 Days	1,384
60-90 days	1,100
90- 180 days	935
Over 180 days	508
Total	**14,139**

Trust	31 March 2015
	Trade receivables
Ageing of impaired receivables	**£000**
0 - 30 days	747
30-60 Days	43
60-90 days	53
90- 180 days	69
Over 180 days	139
Total	**1,051**
Ageing of non-impaired receivables past their due date	
0 - 30 days	10,212
30-60 Days	1,384
60-90 days	1,100
90- 180 days	935
Over 180 days	508
Total	**14,139**

Note 23 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	
	5 Months to 31st March 2015	7 Months to 31st October 2014	5 Months to 31st March 2015	7 Months to 31st October 2014
	£000	£000	£000	£000
At start of period for new FTs	**9,564**	**10,493**	**8,527**	**9,198**
Transfers by absorption	852	-	852	-
Net change in year	263	(929)	231	(671)
At 31 March	**10,679**	**9,564**	**9,610**	**8,527**
Broken down into:				
Cash at commercial banks and in hand	30	18	30	18
Cash with the Government Banking Service	10,649	9,546	9,580	8,509
Total cash and cash equivalents as in SoFP	**10,679**	**9,564**	**9,610**	**8,527**
Bank overdrafts (GBS and commercial banks)	-	-	-	-
Drawdown in committed facility	-	-	-	-
Total cash and cash equivalents as in SoCF	**10,679**	**9,564**	**9,610**	**8,527**

Note 24 Trade and other payables

	Group		Trust	
	31 March 2015 £000	1 November 2014 £000	31 March 2015 £000	1 November 2014 £000
Current				
NHS trade payables	808	1,492	808	1,492
Amounts due to other related parties	16	-	16	-
Other trade payables	3,424	5,202	3,196	5,202
Capital payables	1,155	1,853	1,155	1,853
Other taxes payable	3,339	1,609	3,339	1,609
Other payables	3,885	1,684	3,885	1,684
Accruals	8,218	7,622	8,218	7,622
PDC dividend payable	92	-	92	-
Trade and other payables held by NHS charitable funds	36	(6)		-
Total current trade and other payables	**20,973**	**19,456**	**20,709**	**19,462**

Note 25 Other liabilities

	Group		Trust	
	31 March 2015 £000	1 November 2014 £000	31 March 2015 £000	1 November 2014 £000
Current				
Deferred goods and services income	1,527	-	1,527	-
Total other current liabilities	**1,527**	-	**1,527**	-

Note 26 Borrowings

	Group		Trust	
	31 March 2015 £000	1 November 2014 £000	31 March 2015 £000	1 November 2014 £000
Current				
Loans from the Department of Health	990	990	990	990
Obligations under finance leases	89	119	89	119
Total current borrowings	**1,079**	**1,109**	**1,079**	**1,109**
Non-current				
Loans from the Department of Health	9,235	6,440	9,235	6,440
Obligations under finance leases	80	70	80	70
Total non-current borrowings	**9,315**	**6,510**	**9,315**	**6,510**

Note 27 Finance leases

Trust as a lessee

	Group	Trust
	31 March 2015	31 March 2015
	£000	£000
Gross lease liabilities	**173**	**173**
of which liabilities are due:		
- not later than one year;	89	89
- later than one year and not later than five years;	84	84
- later than five years.	-	-
Finance charges allocated to future periods	(4)	(4)
Net lease liabilities	**169**	**169**
of which payable:		
- not later than one year;	89	89
- later than one year and not later than five years;	80	80
- later than five years.	-	-
Total of future minimum sublease payments to be received at the SoFP date	**-**	-
Contingent rent recognised as an expense in the period	-	-

Note 28.1 Provisions for liabilities and charges analysis

Group	Pensions - other staff	Other legal claims	Agenda for change	Other	Total
	£000	£000	£000	£000	£000
At start of period for new FTs	**855**	**100**	**1,019**	**439**	**2,413**
Transfers by absorption	-	30	-	30	**60**
Arising during the year	28	66	1,121	24	**1,239**
Utilised during the year	(27)	(54)	(11)	(58)	**(150)**
Reversed unused	(26)	(27)	(981)	(167)	**(1,201)**
Unwinding of discount	11	-	-	-	**11**
At 31 March 2015	**841**	**115**	**1,148**	**268**	**2,372**
Expected timing of cash flows:					
- not later than one year;	64	84	593	238	**979**
- later than one year and not later than five years;	777	-	555	-	**1,332**
- later than five years.	-	31	-	30	**61**
Total	**841**	**115**	**1,148**	**268**	**2,372**

Note 28.2 Clinical negligence liabilities

At 31 March 2015, £84k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Royal United Hospitals Bath NHS Foundation Trust

Note 29 Contractual capital commitments

	Group	Trust
	31 March 2015	31 March 2015
	£000	£000
Property, plant and equipment	1,717	1,717
Total	1,717	1,717

Note 30 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 NHS Foundation Trust has with CCGs and other NHS England bodies and the way those Commissioners are financed, the NHS Foundation 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 NHS Foundation 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 Foundation Trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Foundation Trust's standing financial instructions and policies agreed by the board of directors. Foundation Trust treasury activity is subject to review by the Foundation Trust's internal auditors.

Currency risk

The Foundation Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Foundation Trust has no overseas operations. The Foundation Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Foundation 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. The Foundation Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Foundation Trust's revenue comes from contracts with other public sector bodies, the Foundation Trust has low exposure to credit risk. The maximum exposures as at are in receivables from customers, as disclosed in the trade and other receivables note."

Liquidity risk

The Foundation Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Foundation Trust funds its capital expenditure from funds internally generated and loans from the Department of Health. The Foundation Trust is not, therefore, exposed to significant liquidity risks.

Note 30.1 Financial assets

Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2015					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	19,299	-	-	-	19,299
Other investments	-	-	-	-	-
Other financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	9,610	-	-	-	9,610
Financial assets held in NHS charitable funds	7,585	-	-	-	7,585
Total at 31 March 2015	36,494	-	-	-	36,494

Note 30.2 Financial liabilities

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2015			
Borrowings excluding finance lease and PFI liabilities	10,225	-	**10,225**
Obligations under finance leases	169	-	**169**
Total at 31 March 2015	**32,400**	-	**32,400**

Note 30.3 Maturity of financial liabilities

	Group	Trust
	31 March 2015 £000	31 March 2015 £000
In one year or less	21,603	21,603
In more than one year but not more than two years	2,383	2,383
In more than two years but not more than five years	3,960	3,960
In more than five years	4,454	4,454
Total	32,400	32,400

Note 30.4 Fair values of financial assets at 31 March 2015

	Group		Trust	
	Book value £000	Fair value £000	Book value £000	Fair value £000
Non-current trade and other receivables excluding non financial assets	1,346	-	1,346	-
Other investments	6,516	-	6,516	-
Other	-	-	-	-
Non-current financial assets held in NHS charitable funds	-	-	-	-
Total	7,862	-	7,862	-

Note 30.5 Fair values of financial liabilities at 31 March 2015

	Group		Trust	
	Book value £000	Fair value £000	Book value £000	Fair value £000
Non-current trade and other payables excluding non financial liabilities	-	-	-	-
Provisions under contract	1,393	-	1,393	-
Loans	9,315	-	9,315	-
Other	-	-	-	-
Non-current financial liabilities held in NHS charitable funds	-	-	-	-
Total	10,708	-	10,708	-

Note 31 Losses and special payments

Group and Trust	2015 Total number of cases Number	2015 Total value of cases £000
Losses		
Total losses	-	-
Special payments		
Extra-contractual payments	-	-
Extra-statutory and extra-regulatory payments	-	-
Compensation payments	-	-
Special severence payments	-	-
Ex-gratia payments	9	3
Total special payments	9	3
Total losses and special payments	9	3
Compensation payments received		-

Note 32 Transfers by absorption

On the 1st February 2015 the Royal United Hospitals NHS Foundation Trust acquired the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust and the Royal National Hospital for Rheumatic Disease Charitable Fund. The net assets transferred by absorption were valued at £7.034 million, this has been recognised in the SOCI as a gain from absorption.

Note 33 Related parties

During the year none of the Department of Health Ministers, Royal United Hospital Bath NHS 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 Hospital Bath NHS Trust

The Department of Health is regarded as a related party. During the 5 month period to 31 March 2015, 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	Income 5 months to 31st March 2015 £000	Expenditure 5 months to 31st March 2015 £000	31st March Receivables £000	31st March Payables £000
Wiltshire CCG	35,720	-	2,468	-
Bath and NE Somerset CCG	32,300	1	1,779	-
Somerset CCG	11,110	-	498	-
South Gloucestershire CCG	2,940	-	600	-
North Somerset CCG	178	-	-	-
Bristol CCG	521	-	129	-
Gloucestershire CCG	197	-	37	-
Swindon CCG	157	-	61	-

NHS England Organisations	Income 5 months to 31st March 2015 £000	Expenditure 5 months to 31st March 2015 £000	31st March Receivables £000	31st March Payables £000
Bristol, North Somerset, Somerset and South Gloucestershire Area Team (including Specialised Commissioning)	16,002	-	3,836	-
Bath, Gloucester, Swindon and Wiltshire Area Team (including Specialised Commissioning)	2,250	-	303	-
Wessex Area Team (including Specialised Commissioning)	1,687	-	1,923	-

NHS Trusts and Foundation Trusts	Income 5 months to 31st March 2015 £000	Expenditure 5 months to 31st March 2015 £000	31st March Receivables £000	31st March Payables £000
North Bristol NHS Trust	496	381	374	234
University Hospitals Bristol NHS Foundation Trust	723	313	69	112
Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (pre acquistion)	164	-	-	-
Salisbury NHS Foundation Trust	70	35	95	8
Portsmouth Hospitals NHS Trust	-	84	-	3
Avon and Wiltshire Mental Health Partnership Trust	278	74	264	48
Great Western Hospitals NHS Foundation Trust	478	922	178	376
Somerset Partnership NHS Foundation Trust	64	111	4	-
Gloucestershire Hospitals NHS Foundation Trust	2	670	5	-

Other Agencies	Income 5 months to 31st March 2015 £000	Expenditure 5 months to 31st March 2015 £000	31st March Receivables £000	31st March Payables £000
NHS Litigation Authority	-	1,449	-	-
Health Education England	4,303	50	19	-
Public Health England	-	564	-	651
NHS Blood and Transplant	11	546	-	-
Department of Health	117	23	9	133
Sirona Care and Health				

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. The audited accounts of the Charitable Funds are available at www.ruh.nhs.uk.

Chief Executive James Scott is Vice - Chairman of West of England Academic Health Science Network. Royal United Bath NHS Trust provided a Finance and Human Resources functions for a fee of £200k.

Director of Finance and Deputy Chief Executive Sarah Truelove is married to the Chief Executive Officer of Wiltshire CCG.