Royal United Hospitals Bath NHS
NHS Foundation Trust

Annual Report and Accounts

2015/2016

Royal United Hospitals Bath NHS Foundation Trust

Annual Report and Accounts

2015/2016

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

Contents

Message from the Chairman and Chief Executive

We are proud to share our progress and achievements over the last financial year. We have built on our successes and continued to enhance and develop the services we provide to our patients.

The NHS is facing some fundamental challenges relating to health needs and preferences, changes in treatments, technology and care delivery, and a gap between the funding available and the cost of continuing to provide services in exactly the same way as we do today. The NHS of the future will be about providers working together to deliver the best quality experience and outcomes for patients in a sustainable way.

During the past year we have been working in partnership with Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust to successfully establish Wiltshire Health & Care – a partnership, working together with Wiltshire Council, which will be focused on delivering improved community services in Wiltshire over the next five years. We will be continuing our focus on closer working relationships with providers across the whole of our catchment in the year to come. Further information about working in partnership and our future priorities can be found in the Accountability Report section of this Annual Report.

The year has not been without challenges; we were not alone in facing increasing demand on our A&E services. Despite these pressures we have continued to provide safe, high quality care, and this is thanks to the continued hard work and dedication of our staff. We continued to perform highly on quality aspects of these services; over 95% of patients attending A&E were assessed within eight minutes, and we remained one of the top performing Trusts in the region in ensuring a swift handover between Ambulance and A&E staff.

A particular highlight from 2015/16 has been the development of our new values; Everyone Matters, Working Together and Making a Difference. They were created with almost a 1000 staff, patients and carers who used the feedback from 1000 hours of listening to staff, patients, carers and families about their experience of working and being cared for at the RUH.

We are incredibly proud of our hospitals and what we have achieved for our patients and the communities we serve. This is evidenced by the overwhelmingly positive feedback we continue to receive from the patients we care for. Through our Patient Empowerment Programme we continue to work on shifting the focus from purely reacting to ill health to proactively working to help people live well with long term conditions and to prevent acute illness and injury wherever possible. Details of the steps we have taken to further improve the quality of care we deliver are outlined in the Quality Account section of this report.

We would also like to take this opportunity to thank those individuals and organisations who fundraise towards our ambitious estate redevelopments and smaller scale projects or who donate their time to volunteer and make a positive contribution to the overall experience of visitors to our Trust. Next year looks set to present further challenges both operationally and financially as we continue to work with our health community to see how we can provide more efficient and effective services for our patients. Our dedicated workforce, committed Governors and our 10,000 strong membership base ensures we are well placed to meet these challenges and we look forward to a positive year ahead in the service of our patients and the local communities we serve.

Brian Stables

Chairman

James Scott

Chief Executive

Performance report

Overview of Performance

Statement from the Chief Executive

2015/16 has been a challenging but successful year for our organisation. There is increasing operational and financial pressure on all hospitals combined with significant change throughout the NHS driven by the NHS Five Year Forward View. The RUH continues to address these challenges and opportunities and is committed to maintaining high quality services which are productive and efficient. Like many acute trusts, managing increases in emergency demand represented the Trust's main operational and financial challenge in 2015/16, including meeting the four-hour emergency access target. Despite these challenges the RUH has delivered a year end positon of a £0.4m deficit, excluding exceptional items. This is an improvement on the planned position of a £0.9m deficit.

Further information relating to the operational and financial performance of the Trust over the 2015/16 financial year is outlined in the following report.

Principle activities of the Trust

The Royal United Hospitals Bath NHS Foundation Trust (RUH NHS FT) is a Public Benefit Corporation which is authorised under the National Health Service Act 2006 to provide goods and services for the purposes of the Health Service in England. It was established as an NHS Trust in 1992 and achieved Foundation status in November 2014.

The Trust provides a range of clinical care, which includes general acute, maternity and emergency services to a core population of approximately 500,000 patients, across Bath and North East Somerset, Wiltshire, Somerset and South Gloucestershire. The acquisition of the Royal National Hospital for Rheumatic Diseases on 1 February 2015 further expanded the RUH NHS FT's catchment and portfolio of specialist treatment and rehabilitation activities, attracting patients from other areas of the UK and internationally, particularly for treatment of long term conditions.

In December 2015, further to a successful tender together with other providers, the RUH NHS FT became a founding partner in Wiltshire Health and Care, an Limited Liability Partnership (LLP) which will be responsible for the delivery of integrated adult community health services across Wiltshire from 1 July 2016, for the next five years.

Together our 4,300 dedicated employees deliver high quality services from our hospital sites and local community settings.

Objectives, risks and issues

Our vision: *To Care. To Innovate. To Inspire*.

Our vision is to lead the way in patient care, with a reputation that's built on excellence – in safety and quality of care, in ground-breaking research and services, in the way we develop our people, in our strong relationships with our partners, and in every patient experience.

We are working towards three broad ambitions:

We will be a system leader – We will role model healthcare excellence and innovation and research which inspires others, working with colleagues across health and social care to further improve patient care.

We will be a hospital without walls – We will work together and with other partners to deliver and support the highest quality care - when and where it's needed. We will give every patient a high quality and consistent healthcare experience whether it takes place in their homes, the community or in our hospitals.

We will be a provider of choice – Patients, employees, healthcare professionals and partners will always be able to rely on our excellent service.

During the coming year, we will be continuing our journey and further developing our plans to deliver against these ambitions over the longer term. Key objectives in 2016/17 include:

- Embed the Trust values
- Deliver the RUH redevelopment and Patient Empowerment Programmes
- Encourage cultural change in the adoption of new technology
- Further improve how we use our resources
- Deliver our Safer Six priorities.

The Trust faces a number of operational, strategic and financial challenges which could impact on our ability to deliver against these objectives. Principal risks and uncertainties are described in more detail in the Annual governance statement on page 70 of the annual report and include:

- Supporting and delivering greater integration in service provision between primary, community, secondary and social care.
- Management of flow across the hospital to ensure that it is consistently able to provide capacity for both elective and non-elective services and meets all performance requirements.
- Constructing and maintaining clinical environments that are fit for purpose and reflect the quality of service provision within a constrained capital climate.
- 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 and wider healthcare system.

Going concern

The RUH NHS FT continues to operate in a climate of financial uncertainly within the NHS in England. However, the directors are active in monitoring the challenges that this creates and the Trust has been able to produce a detailed plan for 2016-17 which demonstrates that it will remain financially viable for the next 12 months.

As required by the International Accounting Standards (IAS) 1 (Presentation of Financial Statements), the directors have considered these plans, made reasonable enquiries and have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt a going concern basis in preparing the accounts.

Performance analysis

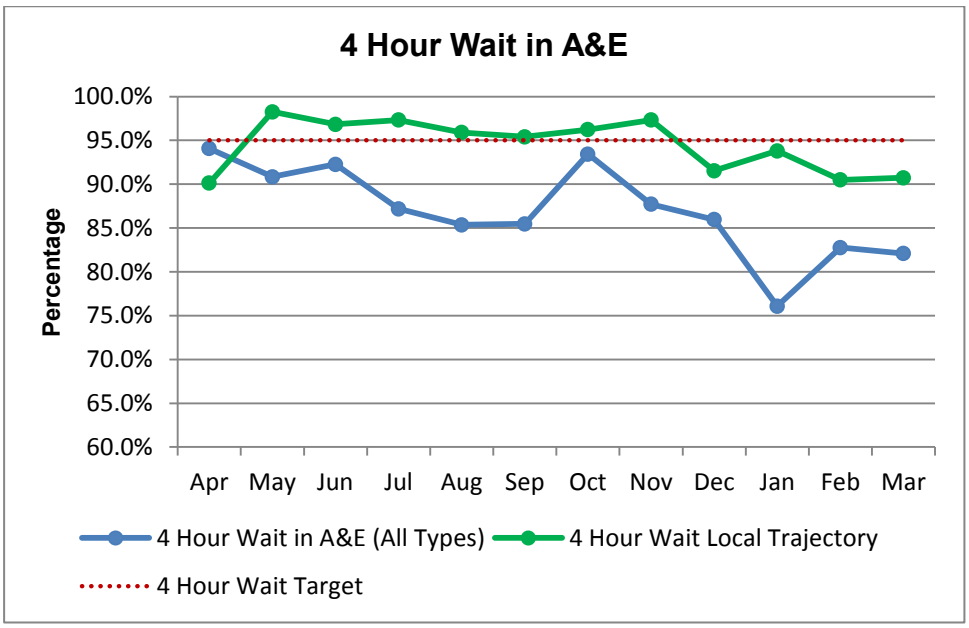
Overview of performance during 2015/16

Operational performance

The Trust produces an integrated balanced scorecard which outlines how it is performing under five domains: Caring, Effective, Responsive, Safe and Well-led. A separate maternity scorecard is produced as this assists in regional and national benchmarking against best practice. The Trust has a well embedded data quality assurance framework in order to ensure a high level of data integrity is maintained.

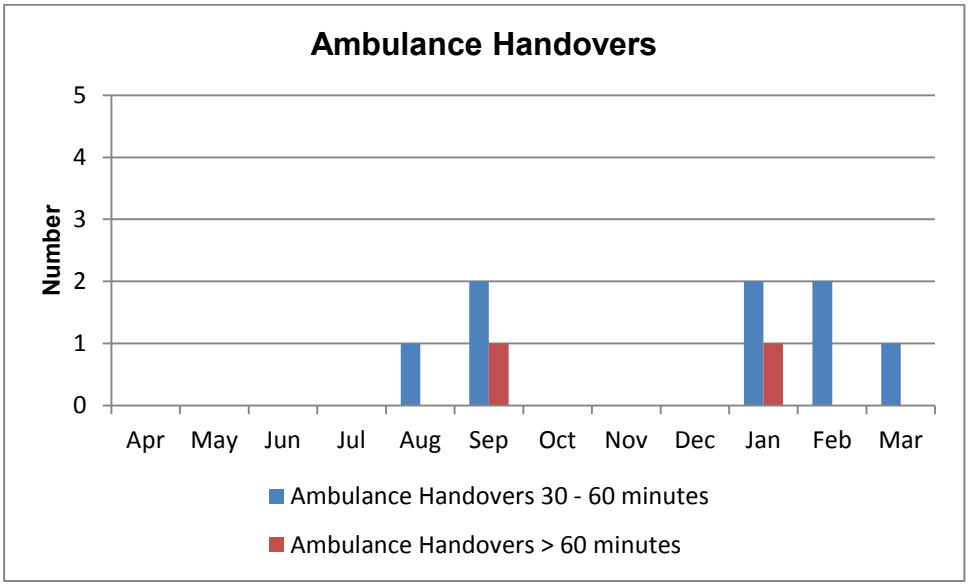
Four hour performance

This access standard has continued to be challenging for the RUH, supported by the wider system, to deliver. The RUH has continued to draw upon the expertise and experience from those urgent care and emergency systems coping more effectively, in order to inform our improvements and planning. RUH performance during 2015/16 is outlined below:



We remain committed to delivering safe and high quality care to our patients, and in particular during the periods of heightened pressure within our emergency department. As such we have revised our urgent care programme and established an Executive Urgent Care Collaborative Board to oversee the actions required for further improvement in this area.

Thanks to the hard work of our staff we perform highly on quality aspects of our A&E services; over 95% of patients attending A&E are assessed within eight minutes, and we remain one of the top performing Trusts in the region in ensuring a swift handover between ambulance and A&E staff; meaning patients arriving by ambulance are brought in quickly and ambulance crews are freed up to respond to 999 calls.



Patient satisfaction with regard to the care that they receive in our Emergency Department (ED) and front door assessment areas remains high. Our emergency department also continues to perform well against the national ED clinical indicators and patient survey.

We are proud to be recognised as a pioneering organisation selected to participate in a ground breaking Flow Programme with the Academic Health Science Network, Health Foundation and Sheffield NHS Foundation Trust; we have created six coach experts across three critical pathways of care – frailty; gynaecology and acute biliary. Our learning will be used to launch a national programme addressing the quality improvement skillset gap across the NHS workforce. The programme is due to complete in September 2016.

18 week Referral to Treatment Time (RTT)

We have worked hard to maintain the delivery of elective care by successfully meeting the access standard for open pathways across the first eight months of the year. However, during the latter part of 2015/16 this became increasingly challenging to sustain due to the increasing demand across most specialties and the competing demands of emergency care.

	2015-2016												Total	
Measure	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**2015-2016**	**2014-2015**
RTT - Open Pathways < 18 Weeks	93.0 %	93.0 %	92.5 %	92.5 %	92.0 %	92.6 %	92.4 %	92.3 %	90.5 %	90.0 %	90.7 %	89.7 %	**91.7%**	**92.3%**
Open Pathways Target	92.0 %	92.0 %	92.0 %	92.0 %	92.0 %	92.0 %	92.0 %	92.0 %	92.0 %	92.0 %	92.0 %	92.0 %		

There has also been significant referral growth of patients with a suspected/diagnosed cancer, where urgency of appointment can significantly impact routine elective work, and as a consequence there has been an increase in our backlog beyond planned levels. We have maintained focus on ensuring those patients with the greatest clinical priority are treated first.

Going into 2016/17 the Trust has detailed by specialty, the actions that will be taken both internally to increase elective capacity and what is required by the wider system in order to reduce and manage demand more effectively.

Cancer performance

The Trust continues to perform well in the majority of the cancer standards with the exception of breast symptomatic patients. The failure to meet this standard was forecast for the latter months due to a decrease in consultant capacity over the course of the year, coupled with a surge in referrals. To maintain patient safety across a period of consultant recruitment, the waiting list has been kept under review and screened by specialists in order to ensure that those patients who have a higher risk of malignancy are seen within the two week standard. Two new consultant posts have been appointed and we expect to be meeting this standard by the end of 2016.

We continue to perform well against the six week diagnostic maximum wait, providing early diagnosis and treatment for our patients.

Maternity indicators

The integrated balanced scorecard and dedicated maternity scorecard report on a number of maternity indicators including the Friends and Family Test, breastfeeding, smoking cessation and midwife to birth ratio. The Trust benchmarks well in the majority of aspects of performance and in particular those metrics relating to the quality and safety of our services. A detailed action plan is in place to help reduce the levels of staff sickness and improvements have been demonstrated over the course of 2015/16.

Financial performance

Overview

From a financial perspective, the Trust has had a challenging but successful year in 2015/16. The national squeeze on public spending continues to create significant financial pressures across the health service. These are in part due to the increasing demand placed on health services from serving an ageing population with growing expectations led by advances in technology and medicines. The Trust continues to address these challenges through commitment to maintaining high quality services which are productive and efficient.

The Trust planned to deliver a marginal deficit, and it achieved its plan. The Trust delivered an overall Continuity of Service Risk Rating (CoSRR) of 3 at the year-end (out of 4, where 1 is high risk and 4 low risk). While the Trust's plan was to maintain a rating of 4 throughout the year, this was not achieved during the year due to the change in August by the regulator Monitor to include donated income within the calculation. Up until that point, income related to donated assets was excluded. The Trust had assumed £2.6m income from donated income in year, however due to the delays in the capital programme the actual outturn was £1.2m, £1.4m lower. This has resulted in the Trust achieving a lower risk rating.

Overall, the Trust received more income from its commissioners than planned and saw significant levels of none elective clinical activity. Like many acute trusts, managing increases in emergency demand represented the Trust's main operational and financial challenge in 2015/16, including meeting the 95% four-hour emergency access target.

Income and expenditure both increased on the previous year across all sites, reflecting a continuing rise in patient activity, not all of which had been planned either by the Trust or by local commissioners. The

table below shows the income and expenditure for the Group (including NHS Charitable Funds) since being authorised as a Foundation Trust.

Surplus/(Deficit) for the Group	**2015/16 £m**	**2014/15 (5 months to 31st March 2015) £m**
Income	292.9	116
Expenditure (before impairments)	(287)	(114.1)
Financing Charges (including absorption gains)	(5.1)	1.3
Surplus/(Deficit) before Impairments	**0.9**	**7.2**
Impairments	(23.5)	(5.5)
Surplus/(Deficit) for the Period	**(22.6)**	**1.7**

The Trust's income from the provision of goods and services for the purposes of the National Health Service is greater than its income from the provision of goods and services for any other purposes. There has not been any significant impact from other income on the provision of goods and services for the purposes of the health service in England.

The delivery of cost and quality improvement programmes, which the Trust calls QIPP, was challenging and the Trust delivered £12.4m against the annual target of £14.1m for the 12 months to 31 March 2016. There was also a reliance on non-recurrent savings which going forward into 2016/17 increases the focus the Trust has to maintain on delivering value for money and efficient services.

Capital investment

The Trust invested £19.7m in infrastructure and equipment during 2015-2016 (£13.4m for 2014/15). This was funded internally, through donations and through a loan from the Department of Health for the ongoing investments in the electronic patient record programme (£9.6m). The programme has sought to achieve a balance between maintaining and replenishing the asset infrastructure, reducing risk and improving the patient experience.

Significant in-year programmes included spends of:

- £3.9m on a new pharmacy building
- £5.6m digital programme, including electronic patient record, IM&T infrastructure.
- £1.3m ward refurbishment programme
- £3.8m medical equipment

Together with the usual infrastructure upgrades and equipment replacement programmes, the Trust has continued to invest in new technology while maintaining the general infrastructure.

During March 2016 the Trust requested the services of an expert valuer to conduct a full site valuation of its land. Details of the revaluation and value of the property plant and equipment are shown in note 15.1 to the Trust's accounts. Under IFRS 13, the basis for valuing land is the depreciated replacement cost method (DRC), the guidance states that although the ultimate objective of the methodology is to produce a valuation of the actual property in its actual location, the initial stage of estimating the gross replacement cost has to reflect the cost of a site suitable for a modern equivalent facility.

Often this will be a site of a similar size and in a similar location to the actual site. However, if the actual site is clearly one that a prudent buyer would no longer consider appropriate because it would be commercially wasteful or would be an inappropriate use of resources, the modern equivalent site is assumed to have the appropriate characteristics. The fundamental principle is that the hypothetical buyer would purchase the least expensive site that would be suitable and appropriate for its proposed operations. Other factors need to be considered in addition to establishing the location of the modern equivalent site. The modern equivalent asset may not require a site as extensive as the actual site. In this respect land is no different to any other asset. If a smaller area is now sufficient to provide the same service, the modern equivalent site will be based on the reduced area required, even if the actual site is larger. On this basis, the RUH land value has been reduced significantly and has resulted in an impairment of £22m.

The Trust follows the 'Better Payments Practice Code' and aims to pay all relevant creditors within 30 days. Performance against this standard is detailed in the Directors' Report on page 14. The Trust also aims to pay smaller creditors as quickly as internal processes allow.

Financial risks 2016/17

2016/17 looks to be a particularly challenging year for the RUH. Over the last few years the Trust has outperformed the healthcare sector, delivering surpluses (planned marginal deficit in 2015/16 related to the acquisition of the RNHRD in 2015) through the continued delivery of savings plans, managing growth in demand through productivity gains where possible combined with robust cost controls. This has been supported by the relatively strong financial position of the Trust's main commissioners and therefore overall the Trust has benefited from being part of a financially stable health economy.

Specifically moving into 2016/17 the key financial risks will be:

- Achievement of the agreed plan in the context of the national austerity challenge, growing demand and financial pressures facing the Trust's main commissioners.
- Delivery of a challenging savings programme (QIPP) programme and savings related to the ongoing business plan associated with the acquisition of the RNHRD in 2015.
- Ability of the commissioners including local CCGs to deliver their QIPP savings to ensure patients avoid unnecessary hospital admissions.

The Trust delivered £12.3m of savings in 2015/16. This is a significant achievement. However, going forward the Trust financial plan relies on delivering at least £14.4m of savings in 2016/17. Like all NHS organisations, the Trust will be required to deliver further considerable efficiency savings over the coming years in the region of between 2-5% each year.

Plans to deliver the in-year target for 2016/17 have been formulated with Trust managers and clinicians.

Given the scale of savings required this remains a significant risk to delivering the overall plan, particularly given the context of year on year increases in emergency patients attending the hospital.

Environmental matters

Our sustainability vision is *to act as a national pilot site, driving positive change within the NHS.* Recognising the need to operate economically and sustainably we are fully committed to taking actions to reduce our impact on the environment. We continue to implement our Sustainable Development Plan and performed well against key targets in 2015/16. Our work on sustainability has been presented to the 'Health Estates and Facilities Management Association' and highlighted in the 'Carter Report' on NHS operational productivity as an example of best practice. Further information can be found in the sustainability section of the annual report on page 148.

Social, community and human rights issues

All Trust policies and procedures are based on national employment legislation, adhere to NHS constitution staff pledges and contain an equality and diversity impact assessment – to ensure upholding of social, community and human rights principles. In addition, our implementation of the Equality Delivery System and the Workplace Race Equality Standard ensures that we have a transparent governance and accountability structure to build on the work in these two areas. During 2015/16 the Trust had no social, community of human rights violation issues.

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

A new fund, worth £2.1billion in 2016/17 has been introduced by the Department of Health to give NHS services the resources it needs as part of the Five Year Forward View to sustain services.

The planning guidance outlines a new approach to help ensure that health and care services are planned by place, rather than around individual organisations. As well as individual operational plans, health and care systems are required to work together to produce a Sustainability and Transformation Plan built around the needs of local populations or 'footprints'.

The RUH Chief Executive has been confirmed by NHS CEO Simon Stevens as a "senior and credible leader who can command the trust and confidence of the system" to lead on the initial planning work for the Bath and North East Somerset, Swindon and Wiltshire footprint. During this time, he will continue with his responsibilities as CEO of the RUH.

Details of overseas operations

The Trust has no branches outside the UK.

Signed

James Scott

Chief Executive (Accounting Officer)

25 May 2016

Accountability Report

Directors' report

This report is prepared in accordance with the NHS Foundation Trust Code of Governance and the NHS Foundation Trust reporting manual 2015/16 published in November 2015.

Directors' responsibility for the annual report and accounts

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

Directors of the Trust

Directors of the Royal United Hospitals bath NHS Foundation Trust during 2015/16:

Brian Stables	Chairman
Michael Earp	Vice Chairman & Senior Independent Director (until 31 October 2015)
Joanna Hole	Non-Executive Director Vice Chairman and Senior Independent Director (from 1 November 2015)
Moira Brennan	Non-Executive Director
Nigel Sullivan	Non-Executive Director
Nick Hood	Non-Executive Director
Jane Scadding	Non-Executive Director (from 1 November 2015)
James Scott	Chief Executive
Sarah Truelove	Deputy Chief Executive & Director of Finance
Tim Craft	Medical Director
Francesca Thompson	Chief Operating Officer
Helen Blanchard	Director of Nursing & Midwifery
Claire Buchanan	Director of Human Resources*
Jocelyn Foster	Commercial Director*
Howard Jones	Director of Estates & Facilities*

*Non-voting members

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

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

Register of interests

Details of company directorships and other significant interests of the Trust board can be found from page 44. 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:

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

- Telephone: 01225 821299 or 01225 826288

Additional Directors' report disclosures

Cost Allocation and Charging Requirements

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

Political Donations

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

Better Payment Practice Code

The Trust is required, by the national "better payment practice code" to aim to pay all valid invoices within 30 days of receipt, or the due date, whichever is the later. Over the 12 months to 31 March 2016, the Trust achieved the following performance:

	Foundation Trust	
	Number	Value £'000
Total bills paid within the year	83,883	188,026
Total bills paid within target	80,568	178,288
Percentage of bills paid within target	96%	95%

Total interest paid to suppliers under the Late Payment of Commercial Debts Act 1998 was £803.

Enhanced quality governance reporting

Patient care and stakeholder relations

During 2015/16 a number of developments and initiatives introduced by the RUH NHS FT have further improved patient experience and quality of care. As the direction of travel for health services continues to move towards providing more integrated care, the Trust continues to build relationships and work with a number of other organisations to reinforce partnership working, stakeholder relations and staff involvement. Highlights are outlined below and further detail can be found in the quality report and performance report sections of this annual report.

Patient care

Information about how we are using our foundation trust status to develop services and improve patient care can be found in the membership section of this report (page 54).

Performance against key healthcare targets and progress towards targets as agreed with commissioners together with details of other key quality improvements can be found in the Quality Accounts on page 83.

Monitoring improvements in the quality of care

From April 2010, all health and adult social care providers who provide regulated services are required by law to be registered with the Care Quality Commission (CQC). The Trust was registered without conditions by the CQC on 1 April 2010.

The CQC undertook a planned inspection of the Trust between 15 and 18 March 2016 and as part of this routine inspection process an unannounced visit was also undertaken on 29 March 2016. The outcome of the inspection will be announced in May/June 2016.
Up until May 2015 the CQC published the Intelligent Monitoring Report for each acute NHS trust on a quarterly basis. This was used by the CQC to monitor the quality of care provided by acute trusts and to target inspections more effectively. NHS acute trusts were grouped into six risk bands based on the risk that people may not be receiving safe, effective, high quality care. Band 1 represented the highest risk with band 6 the lowest. The report was made up of indicators that look at a wide range of information including patient experience, staff surveys and statistical measures of performance. The final Intelligent Monitoring Report, published in May 2015, placed the RUH in the lowest risk banding, band 6.

Quality Governance

The Board of Directors 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, and monitored. Where our performance is below what we expect they also ensure that remedial action is taken to improve services.

The Trust undertook a self-assessment against Monitor's Quality Governance Assurance Framework in spring 2015. The Trust acquired the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust on 1 February 2015. The Quality Governance Assurance Framework review process took account of the quality issues relating to the RNHRD services. The outcome of the review was reported to the June 2015 Board of Directors meeting.

Key areas for further development were identified as:

- Need to ensure that all staff are aware of the Trust's quality priorities. This will be developed through the staff engagement/values work and the Patient Empowerment programme
- Review of specialty governance meetings to ensure consistency of reporting and learning
- Standardisation of good clinical governance practice across all three Divisions, being overseen by the Clinical Governance Committee
- Ward and outpatient infographics being developed to support the visual display of data
- Ensure learning from incidents takes place routinely across the Trust; and
- Improving the timeliness of Root Cause Analysis investigation reports in response to serious incidents.

The Trust undertook a self-assessment against Monitor's Well-Led Governance Framework and reported the outcome to the February 2016 Board of Directors' meeting. The Well-Led Governance Framework has replaced the Quality Governance Assurance Framework. Key areas for development in relation to quality included:

- Promoting and embedding a culture of peer to peer challenge
- Work will continue across 2016 to embed the Trust's new Values and Behaviours.
- Implementing a rota for Executive Director out of hours visits and weekend working
- Taking advantage of the opportunities afforded by being a member of NHS Quest
- The development of patient pathway metrics.

In accordance with Monitor's requirements, the Trust will commission an external review of the Well-Led Governance Framework in 2017.

It is the role of the Clinical and Non-Clinical Governance Committees to "test" our systems and processes in order to assure the Board of Directors that we have robust systems in place for monitoring quality and safety.

The Trust has also developed 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 regular 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 integrated balanced 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.

Each year we ask our members to let us know the topics they would like us to include in our programme of Caring for You events. This year's sessions include:

- Organ Donation
- Mental Health
- Dementia and Alzheimer's
- How to restart a heart
- Neurology
- Behind the scenes in Dermatology

Patient and public involvement activities

During 2015/16, the Trust set up a 3-year 'Patient and Carer Empowerment' programme. This has four key aims, which are:

1. Involve patients and carers in the design of new and existing services
2. Continuously use patient and carer feedback to improve services
3. Encourage and empower patients and carers to be actively involved in their care and treatment
4. Improve patient and carer information

Updates on the programme are provided to our Patient and Carer Experience Group, which, includes patient and carer representatives and members of Healthwatch, the consumer champion for health and social care.

We were delighted to launch our Carer Hub in September 2015. The hub is located in our main Atrium and has been developed to be a point of information for carers across the hospital. Staffed by volunteers and supported by local carers' centres, we recognise the valuable contributions that carers provide to their loved ones whilst in hospital.

This year, patient representatives have been actively involved in developing our 'Discharge Passport' and in the design and development of our Therapies Suite and new Cancer Centre.

In March this year, patients and carers led an assessment of the environment with the annual Patient Led Assessment of the Care Environment (PLACE) inspection.

Through our membership constituency meetings and 'Caring for You' events, we have received feedback on our services and use this information to inform our priorities for the coming year.

We also receive feedback from our patients and carers through the 'Friends and Family Test', and inpatient, outpatient and carers surveys. Themes and trends from the responses are identified and used to inform improvements. These are reported to the Board of Directors through our quarterly patient and carer experience reports.

Improvements in patient/carer information

This year we have continued to improve our patient and carer information across the organisation. To ensure patients are informed about their discharge plans we developed a Discharge Passport, which has proved very successful in supporting patients and their carers when they leave hospital. Recognising the importance of informing and empowering patients to be active in managing their health, we have also successfully developed a catheter passport that provides detailed information, advice and support for patients and their carers who leave hospital with a catheter.

At a Trust wide level, we have improved and standardised the information for patients and carers on our inpatient wards with the development of ward boards; displaying information about staff uniforms, mealtimes, how to provide feedback, who to speak to if patients/carers have a concern and other relevant information.

In addition, we developed and produced a new 'Welcome Guide' for patients and their carers. This provides information about the services patients can access during their stay. A Patient Safety Card was implemented this year and is used to ensure that patients are aware of how to stay safe whilst in hospital.

Our Patient Empowerment programme will see the re-establishment of our health information group led by the Patient Experience team in liaison with the communications team. Staff providing patient information leaflets will be given guidelines on how to develop leaflets that fit with the Trust's corporate branding to ensure uniformity of language and style.

Implementation of the new Accessible Information Standard (AIS) in July this year will ensure that information is provided to patients/carers who have specific communication needs.

Information on complaints handling

A revised process for the handling of formal complaints was agreed and implemented on 1st October 2014. The process focused on resolving patients/carers concerns at an early stage through the Patient Advice and Liaison Service (PALS). For complex complaints, a single point of contact was agreed.

This year, we have seen a reduction in the number of formal complaints compared to the previous year despite increase in activity levels from the first full year of activity including the RNHRD and Maternity services. Similarly, contacts with PALS this year have increased.

Complaints are logged and tracked on DATIX; the Trust's reporting system also used for incident reporting. This allows staff to receive regular updates when responses are due, i.e. within 25 workings days or 40 working days for more complex, multi-specialty complaints.

The Trust currently reports performance against the 25-day local target for all formal complaints it receives or within a timeframe that has been agreed with the complainant. The number of meetings with complainants has increased reflecting the emphasis on early informal resolution; however this has impacted on the completion deadline in some cases.

There has been a continued reduction in the number of complaints reopened this year which it is felt is a direct result of a more thorough and detailed approach to written responses and the open offer to meet with staff.

Clinical leads and managers are responsible for investigating and responding to complaints made in their respective areas. Governance leads and Heads of Nursing/Midwifery have oversight of all complaints, the investigations and the Trust's responses. Complaints are regularly shared at nursing and governance meetings. Encouraging a culture of using patient feedback to drive change is important and staff are asked to provide examples where we have changed practice as a result of patient feedback. This is included in the quarterly patient experience report to Management Board and the Board of Directors.

Stakeholder relations

Academic Health Science Network (AHSN)

The RUH NHS FT continues to work in partnership with the AHSN to explore new opportunities for collaboration and innovation to further improve patient safety and quality of care, and share best practice across the South West. RUH staff have progressed through both the AHSN Health Innovators programme and the AHSN West of England Academy training for Improvement Coaches and are now taking forward their innovations and service improvements within the Trust. A number of our clinical teams have been undertaking specific work streams to support the rapid implementation of innovation and service improvement and share best practice across the NHS. For example, the RUH Maternity team were part of the PreCEPT programme, Prevention of Cerebral Palsy in PreTerm Babies Project (PreCEPT) to support the adoption of research into practice across the South West.

Fit for the Future – public engagement

The Trust has an exciting programme of redevelopment underway to transform our site and further improve the services we provide. We have worked, and continue to work, closely with patients, clinicians, staff, healthcare stakeholders, the local planning authority and the wider community in developing our plans to ensure any new buildings best meet the needs of patients and staff, fit within the existing infrastructure and improve the overall layout of the RUH site.

During 2015/16 there were a number of opportunities to be involved in shaping and contributing to designs, to ensure our new facilities best meet the needs of patients. Initial designs for the new cancer centre and RNHRD & Therapies Centre have been developed with our clinical teams and shared with patients and carers for their suggestions on the flow within the buildings and some of the design of fixtures and fittings. We have also asked our patients and public about our car parking plans. We keep our patients and public up to date on progress of design and construction through our Fit for the Future website and Insight – the Trust's community magazine.

Consultation with local groups and organisations

In order to ensure the continued sustainability of the services currently provided at the RNHRD Mineral Water Hospital site the ability to fully integrate and align services on a single site was a core component of the original business case for the acquisition of the Royal National Hospital for Rheumatic Diseases by the RUH. It will improve efficiency and effectiveness, improving patient experience, ensuring continuity of care, and quality of service delivery as well as increasing value for money from the public purse. Clinicians continue to be integral to planning the future of their services to ensure the delivery of high quality effective care.

The RUH is working with CCG and NHS England Engagement leads and patients to ensure Patient and Public Engagement is carried out in line with the Government's Consultation Principles for Public Bodies (October 2013).

Initial engagement around relocating services commenced in September 2015 to set the context and outline ways in which people could have their say. Engagement with BaNES Health and Wellbeing Select Committee has continued throughout the process with reports and presentations at the committees' July 2015, November 2015 and January 2015 meetings. The proposals have also been presented at the October 2015 Somerset Scrutiny Committee meeting and received a positive response.

Focused clinical and patient and public engagement on the relocation of the Paediatric Rheumatology and Paediatric CFS/ME services from the Mineral Hospital site commenced in October 2015 and ceased on 6th January 2016. Overall respondent's feedback was positive on the service they are currently receiving, and there were positive comments in relation to the proposed new location in the dedicated children's unit on the RUH site. The relocation was endorsed by BaNES Health and Wellbeing Select Committee at a meeting on the 27th January 2016.

In April 2016, engagement around the proposal to relocate the RUH Sexual Health Service commenced and is due to close in June 2016.

Patient and Carer empowerment

As part of our Patient and Carer Empowerment Programme we are strengthening how we receive and use feedback to continue to improve our services; we are encouraging and supporting our teams to involve patients and carers in service change; and we are also reviewing and improving information for our patients and carers, particularly those with sensory impairment or loss and people with learning disabilities.

Wiltshire Health and Care

During 2015/16, the RUH NHS FT was a founder partner in Wiltshire Health and Care LLP which successfully bid to provide enhanced adult community services for the County. The new contract commissioned by Wiltshire Clinical Commissioning Group is worth £40m/yr across a five year term and will launch in July 2016. It involves partners from across the Wiltshire Health and Care system (including primary care, secondary care, social care, voluntary sector) and offers a unique opportunity to develop more joined up pathways of care across hospital and community settings. It retains 820 existing staff within community services, supported by the wider infrastructure and capability of the partnership.

Patients will see an increased focus on health and wellbeing, and enabling patients to live well and manage their conditions at home. There will be more local services and support, reducing the need to travel to acute centres. Individuals will notice fewer organisational boundaries in a "joined up" health service for Wiltshire.

Genomics programme

The South West now has two Genomics Medicine Centres: one based around Exeter and a brand new centre based around Bristol. These two centres are part of the 13 which will assist in the delivery of the unique, innovative and world-leading 100,000 Genomes project.

Sir Bruce Keogh recently wrote that: "We want to become the first country to introduce whole genome sequencing as a mainstream part of our national healthcare system. Better understanding genomics will help us transform how we care for patients, from 'one-size-fits-all' to 'one-size-fits-one'. These 13 NHS Genomics Medical Centres are on their way to bringing genomic diagnostics throughout the NHS in England to the benefit of patients."

RUH representatives are working collaboratively with colleagues across Bristol and Gloucestershire to ensure patients from the Trust can participate in this transformational project. It's planned that the first samples from the RUH to contribute to this programme will begin in September 2016.

Developing care for patients with diabetes in the community

Our Diabetes team has continued to develop our community based model in partnership with GPs in BaNES. This has enabled us to increase our clinic capacity and provide more care, closer to home. We were delighted to be selected as the preferred provider for the BaNES Community Diabetes Specialist Nursing service in early 2016, following a competitive procurement by BaNES Clinical Commissioning Group. This development will enable us to create a joined up, local service that better supports the growing population living with this condition.

Working with partners in Somerset

We are currently working with colleagues in Somerset to take forward the Somerset Together Programme which is designed to change the current commissioning model. Somerset Together will see providers commissioned together to deliver services against a set of specific outcomes co-developed with the local population. It is the first such programme in the country and is attracting national interest from both within the NHS and externally.

Creating our Values

Patients have been engaged and made a crucial contribution in the development of the Trust's new values; Everyone Matters, Working Together, Making a Difference. We invited patients and carers to tell us about their experiences of being cared for at the RUH, what we did well and where we could improve, using a patient survey and listening events called 'In Your Shoes'. This feedback, from 67 patients, carers and their families, informed our values and 18 patients and carers helped us to analyse the feedback to co-create our values and behaviour framework.

Public engagement – our Governors

The Trust's Public Governors have held constituency meetings throughout the year to engage with Members and the Public. Each constituency meeting aims to inform attendees about the Trust, but also seek their views about what could be improved and what is going well. During 2015, the Mendip Governors had the opportunity to engage with Members and the Public as part of the Trust's bid for the Shepton Mallet Health and Wellbeing Campus, the constituency meetings have been well attended and given Mendip residents the opportunity to share ideas about the proposed development which lies at the heart of the local community.

Statement as to disclosure to the auditors

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

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

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

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 2015/16 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.

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.

Income Disclosures

Income from the provision of goods and services for the purposes of health services in England is greater than the income from the provision of goods and services for any other purpose for Royal United Hospitals Bath NHS Foundation Trust. Income was received from other sources including private patients and catering. 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.

Remuneration report

The remuneration report has been prepared in accordance with sections 420 and 422 of the Companies Act 2006; regulation 11, parts 3 and 5 of Schedule 8 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulation 2008; parts 2 and 4 of schedule 8 of the Regulations as adopted by Monitor in the NHS Foundation Trust Annual Reporting Manual 2015/16; and relevant elements of Monitor's Code of Governance.

The following 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.

Annual Statement on Remuneration

Chairman of the Remuneration Committee's annual statement on remuneration

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

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 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, including making decisions about whether to pay the Chief and Executive and any of the individual Executive Directors more than £142,500 per annum, as outlined in the guidance issued by the Cabinet Office, the Committee has regard to the Trust's overall performance, delivery of agreed objectives, remuneration benchmarking data in relation to similar NHS Foundation Trusts and wider NHS and the individual director's level of experience and development of the role.

*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.

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.

**with the exception of the Medical Director who was paid under the terms of the national Consultant contract and was therefore eligible to apply for national or local Clinical Excellence Awards and was excluded from any other bonus payment arrangements.*

The Board of Directors' Nominations and Remuneration Committee met on 27 May 2015 to consider the Chief Executive and Executive Directors' performance bonus for 2014/15. The meeting was chaired by Brian Stables, Chairman, and was attended by Joanna Hole, Non-Executive Director, Moira Brennan, Non-Executive Director, Nigel Sullivan, Non-Executive Director and Nick Hood Non-Executive Director. The Chief Executive attended the meeting but withdrew during the discussion about his performance bonus. The Trust Board Secretary was in attendance and recorded the Committee's discussions and decisions.

The Committee considered the Trust's achievements during 2014/15, including the transfer of maternity services from Great Western Hospitals NHS Foundation Trust to the Trust on 1 June 2014; achieving NHS Foundation Trust status on 1 November 2014; and the acquisition of the RNHRD on 1 February 2015 and agreed that the Chief Executive and the Executive Directors should receive a non-consolidated, non-pensionable 9% performance bonus in respect of the financial year 2014/15.

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) Basic 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.

The Council of Governors' Nominations and Remuneration Committee did not review the Chairman and Non-Executive Directors' allowances in 2015/16.

Remuneration Report

Service Contracts

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

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

Name	NHS FT terms of office*	Current term of Office	Notice period
Brian Stables Chairman	01-Nov-2014-31-Mar-2016	1-Apr-2016-31-Mar-2019	3 months
Michael Earp Non-Executive Director	01-Nov-2014-31-Oct-2015	*Term of office expired on 31 October 2015*	3 months
Joanna Hole Non-Executive Director	01-Nov-2014-31-Oct-2015	01-Nov-2015-31-Oct-2018	3 months
Moira Brennan Non-Executive Director	01-Nov-2014-31-Jan-2016	01-Feb-2016-31-Jan-2018	3 months
Nigel Sullivan Non-Executive Director	01-Nov-2014-31-Jul-2016	01-Nov-2014-31-Jul-2016	3 months
Nick Hood Non-Executive Director	01-Nov-2014-31-Jul-2016	01-Nov-2014-31-Jul-2016	3 months
Jane Scadding Non-Executive Director	01-Nov-2015-31-Oct-2018	01-Nov-2015-31-Oct-2018	3 months
James Scott Chief Executive Director	01-Jun-2007	N/A	6 months
Sarah Truelove Deputy Chief Executive & 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 & 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 & Facilities**	03-Nov-2008	N/A	6 months

**Upon authorisation as an NHS Foundation Trust on 1 November 2014, the Council of Governors appointed the existing Chairman and Non-Executive Directors in accordance with the requirements of the NHS Foundation Trust's Constitution.*

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

Disclosures in accordance with the Health and Social Care Act

Director and governor expenses

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

Directors' expenses

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

Governors' expenses

Governors are not remunerated, but are entitled to claim expenses for costs incurred whilst undertaking duties for the Trust as a Governor (for example, travel expenses to attend Council of Governors' meetings). A total of £1,714.59 was paid to 8 Governors (out of 22 Governors) in the period from 1 April 2015 to 31 March 2016. The RUH was authorised as a Foundation Trust 1 November 2015, for the five months to 31 March 2015 £873 was paid to seven Governors (out of 21 Governors).

Senior Managers Remuneration

Remuneration for Senior Managers for 2015-16: **Subject to audit**

	Salary and Fees (bands of £5,000)	Salary and Fees for Clinical Duties (bands of £5,000)	Start (s) or Leave (l) Date	Annual Performance Related Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
James Scott Chief Executive	180-185	0	-	15-20	77.5-80	270-275
Sarah Truelove Deputy Chief Executive & Director of Finance	135-140	0	-	10-15	-	150-155
Francesca Thompson Chief Operating Officer	115-120	0	-	10-15	5-7.5	130-135
Helen Blanchard Director of Nursing & Midwifery	120-125	0	-	5-10	35-37.5	155-160
Timothy Craft Medical Director	115-120	65-70	-	0	82.5-85	270-275
Howard Jones Director of Estates & Facilities	105-110	0	-	5-10	-	110-115
Claire Buchanan Director of Human Resources	100-105	0	-	5-10	7.5-10	115-120
Jocelyn Foster Commercial Director	105-110	0	-	5-10	22.5-25	135-140
Brian Stables Chairman	45-50	0	-	0	-	45-50
Moira Brennan Non-Executive Director	10-15	0	-	0	-	10-15
Michael Earp Non-Executive Director	5-10	0	31/10/15(l)	0	-	5-10
Jane Scadding Non-Executive Director	5-10	0	1/11/15 (s)	0	-	5-10
Joanna Hole Non-Executive Director	10-15	0	-	0	-	10-15
Nicholas Hood Non-Executive Director	10-15	0	-	0	-	10-15
Nigel Sullivan Non-Executive Director	10-15	0	-	0	-	10-15

Remuneration for Senior Managers for 2014-15 (part year, 5 months to 31/03/2015)

	Salary and Fees (bands of £5,000)	Salary and Fees for Clinical Duties (bands of £5,000)	Start (s) or Leave (l) Date	Annual Performance Related Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
James Scott Chief Executive	70-75	0	-	0	60-62.5	135-140
Sarah Truelove Deputy Chief Executive & Director of Finance	55-60	0	-	0	-	55-60
Francesca Thompson Chief Operating Officer	45-50	0	-	0	5-7.5	55-60
Helen Blanchard Director of Nursing & Midwifery	50-55	0	-	0	25-27.5	80-85
Timothy Craft Medical Director	15-20	50-55	-	0	17.5-20	90-95
Howard Jones Director of Estates & Facilities	40-45	0	-	0	-	40-45
Claire Buchanan Director of Human Resources	40-45	0	-	0	10-12.5	50-55
Jocelyn Foster Commercial Director	40-45	0	-	0	5-7.5	50-55
Brian Stables Chairman	15-20	0	-	0	-	15-20
Moira Brennan Non-Executive Director	5-10	0	-	0	-	5-10
Michael Earp Non-Executive Director	5-10	0	-	0	-	5-10
Joanna Hole Non-Executive Director	5-10	0	-	0	-	5-10
Nicholas Hood Non-Executive Director	5-10	0	-	0	-	5-10
Nigel Sullivan Non-Executive Director	5-10	0	-	0	-	5-10

No Senior Manager received any payments in respect of taxable benefits or long term performance related bonuses in either 2014-15 or 2015-16.

The annual performance related bonuses are usually paid in the first quarter of the following financial year; hence no such bonus was reported in the prior year Foundation Trust accounts and annual report.

Total Pension Entitlement

	Real Increase in Pension at Pension Age (bands of £2,500)	Real Increase in Pension Lump Sum at Pension Age (bands of £2,500)	Total Accrued Pension at Pension Age at 31 March 2016 (bands of £5,000)	Lump Sum at Pension Age, Related to Accrued Pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2015	Real Increase in Cash Equivalent Value Transfer**	Cash Equivalent Transfer Value at 31 March 2016	Employer's Contribution to Stakeholder Pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
James Scott Chief Executive	2.5-5	12.5-15	70-75	215-220	1,347	104	1,467	26
Francesca Thompson Chief Operating Officer	0-2.5	2.5-5	35-40	105-110	754	31	794	17
Helen Blanchard Director of Nursing & Midwifery	0-2.5	5-7.5	35-40	105-110	624	50	681	16
Timothy Craft Medical Director	2.5-5	12.5-15	75-80	225-230	1,465	112	1,595	27
Claire Buchanan* Director of Human Resources	0-2.5	0	25-30	80-85	497	11	514	14
Jocelyn Foster* Commercial Director	0-2.5	0	5-10	15-20	105	21	127	15

*Claire Buchanan and Jocelyn Foster transferred to the 2015 Pension Scheme from the 1st April 2015, the change in terms and conditions led to there being no increase in their lump sum from that date.

The Government announced in its Budget on 16 March 2016 that the discount rate for unfunded pension schemes would reduce with immediate effect, which will have an impact on CETV factors. However, as the new CETV factors are not yet available, NHS Pensions have used the existing factors effective on 15 March 2016 to calculate CETVs. PWC are of the opinion that using the existing CETV factors is a reasonable approach, but suggest that the approach taken is disclosed in the Remuneration Report.

** This value reflects the increase in CETV as at the 31 March 2016 using the CETV at 1 April 2015 with 1.2% inflation applied.

Fair Pay Multiple

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 for the highest paid director in the Royal United Hospitals Bath NHS Foundation Trust for the year to 31 March 2016 was £195,000-£200,000 (five months to 31 March 2015: £175,000-£180,000). This was 7.1 times the (five months to 31 March 2015: 6.6) median remuneration of the workforce, which was £27,866 (five months to 31 March 2015: £26,822).

In 2015-16, four (five months to 31 March 2015: four) employees received remuneration in excess of the highest paid director. Remuneration ranged from £15,100 to £223,779 (five months to 31 March 2015: £15,100 to £243,307).

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

The increase in the ratio in 2015-16 relates to the remuneration of the highest paid director. Due to the shortened period of reporting for 2014-15 as a result of the Trust being granted Foundation Trust status, the pro-rata remuneration of the highest paid director did not include the annual performance related bonus. The bonus is usually paid in the first quarter of the following financial year.

Payments for loss of office

There have been no payments made to any senior manager during 2014-15 and 2015-16 for loss of office.

Payments to past senior managers

No payments or awards were made to past senior managers during the reporting period.

Signed

James Scott

Chief Executive

25 May 2016

Staff report

Analysis of staff numbers

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

Average number of employees (WTE basis)	**2015/16**
Medical and dental	512
Administration and estates	795
Healthcare assistants and other support staff	956
Nursing, midwifery and health visiting staff	1,198
Scientific, therapeutic and technical staff	513
Healthcare science staff	152
Social care staff	0
Agency, Bank and other contract staff	241
Total average numbers	**4,367**
Of which	
Number of employees (WTE) engaged on capital projects	23

Gender analysis

The number of male and female, senior managers and employees as at 31 March 2016:

Staff Group	**Female**	**Male**	**Total**
Directors	5	3	8
Other Senior Managers	70	34	104
Other employees	3804	1096	4900
Total	3879	1133	5012

Sickness absence data

The Trust has robust procedures in place for the management of sickness absence with regular reporting at departmental, divisional and Board of Directors level.

The sickness absence rate for 2015/16 was 2.6%.The average number of working days lost to sickness absence was 9.5.

Staff policies and actions applied during the financial year:

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 persons during 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

Engaging and consulting our employees

A number of actions have been undertaken in the financial year to provide employees systematically with information on matters of concern to them, 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 which include:

- Face-to-face meetings and briefing sessions
- 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
- 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 own private Twitter account which all staff can join

- Membership magazine – Insight Magazine is distributed to members, and our local community and is available across the Trust every quarter and updates the Trust's membership on service developments, proposals and plans
- The Innovation panel to support and empower staff to put forward and implement ideas for innovation and service improvement.

Our recently refreshed Workforce Strategy 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.

Health and safety performance and health and wellbeing

During the reporting period between 1 April 2015 and 31 March 2016 the Trust had one health and safety Improvement Notice. In February 2016 the Health and Safety Executive confirmed it was satisfied that the Trust has fully complied with this Improvement Notice.

All staff have access to an Occupational Health service including an Employee Assistance scheme providing confidential counselling services for employees and their families and over the past year a Health and Wellbeing Strategy has been developed with a focus on delivering the following aim:

Provide a working environment in which we care for our staff and know that in doing this, they are supported to provide outstanding care for our patients, each other, and their environment. This will be achieved by supporting staff to assess and take responsibility for their own health and wellbeing and providing prevention, intervention and rehabilitation services.

The results of our recent NHS Staff Survey clearly identified areas where we are doing well in terms of supporting staff to maintain their health and well-being:

- (Not) experiencing harassment, bullying or abuse from staff
- (Not) working extra hours
- Reporting violence
- (Not) experiencing work-related stress
- (Not) attending work when feeling unwell
- Action on health & wellbeing
- (Not) experiencing physical violence from staff
- Reporting harassment, bullying or abuse from staff.

But there are also areas where we need to improve:

- Experiencing physical violence from patients, relatives, or the public
- Experiencing harassment, bullying or abuse from patients, relatives or the public
- Opportunities for flexible working.

How we support staff to maintain their health and wellbeing in the face of these challenges is outlined below:

- Provision of a comprehensive Occupational Health Service
- Access to dedicated psychological support services
- Access to a Staff Physio Acute Assessment & Self-Management Service
- Spiritual and pastoral care through the Hospital Chaplaincy service
- Schwartz rounds and Trauma Risk Management (TRiM)
- On site gym, squash courts, cycle schemes
- Open air swimming pool
- Programme of health and wellbeing campaigns.

The Trust has further demonstrated its commitment to delivering improved health and wellbeing to its employees by signing up to the Workplace Wellbeing Charter, which is an opportunity for employers to demonstrate their commitment to the health and wellbeing of their workforce in the following areas:

- Leadership
- Attendance management
- Health & Safety
- Mental health & wellbeing
- Smoking & tobacco related ill health
- Physical activity
- Healthy eating
- Alcohol & substance abuse

When monitoring and reporting on health and safety the Trust uses the Health and Safety Executive's Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (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 CQC Standards which includes the CQC regulations 2009 and the Health and Social Care Act 2008, regulation 2014.

Information on policies and procedures with respect to countering fraud and corruption

The Trust has policies in place with respect to countering fraud and corruption. We take a proactive approach to raising awareness of the potential for fraud amongst our staff and work closely with the counter fraud service to ensure preventative measures are in place. The Trust is compliant with the NHS Protect Standards for Providers 2015/16: Fraud, Bribery and Corruption, and engages an NHS Protect accredited Counter Fraud Specialist to produce the Counter Fraud elements of the Organisational Crime Profile and produces a supporting counter fraud work plan.

Staff survey

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 3.80 in 2015.

The national average score for acute trusts in 2015 was 3.79 which means that the RUH score was average when compared with similar trusts.

The Trust's focus for staff engagement in the year 2015/16 has been to co-create a set of values with staff, patients, carers and families which set out a shared ambition for how each and every one of us will behave now and in the future. The values were co-created with almost 1000 staff, patients, carers and their families using feedback from 1000 hours of listening to staff, patients, carers and their families about their experience of working and being cared for at the RUH.

The values were launched in January 2016 and work on a long term plan to embed the values is the focus for our staff engagement activity for the years ahead. The plan will be informed by the key themes arising from the staff survey results outlined below.

Learning from staff feedback

The key method for learning from our staff for the previous year has been the values listening events which provided a wealth of data from which to build the staff engagement plan which focuses on how the values will be embedded.

The Trust gains feedback from new staff via 'Fresh Eyes'. Every month the Trust invites its new starters to share their feedback in a facilitated session called Fresh Eyes. The data is shared with the Staff Experience Steering Group, which provides strategic leadership to the staff engagement programme of work.

Monitoring arrangements for the Trust's staff engagement work is through the Trust's governance committees, Management Board and the Trust Board of Directors.

Summary of performance – NHS Staff Survey

All staff across the Trust were invited to complete the annual NHS Staff Survey and a total of 2,302 responses were received, a response rate of 48%, which was above average for acute trusts in England and reflects the hard work and effort that has been put in place throughout 2015 to engage with staff, during what has been another year of significant organisational change and operational challenges.

Whilst it is difficult to compare our results against 2014/15, as at that time we were two separate organisations prior to our acquisition of the RNHRD, it is worth noting that response rates were 57% for RUH and 61% for RNHRD respectively.

Areas of improvement and deterioration outlined below:

Summary of Performance	2015/16		2014/15		Assessment
Response Rate	RUH	National Average	RUH	National Average	
	48%	41%	57%	42%	Deterioration
Top four ranking scores	2015/16		2014/15		Assessment
	RUH	National Average	RUH	National Average	
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	91%	87%	91%	87%	No change
Percentage of staff appraised in the last 12 months	88%	86%	85%	85%	Improvement
Percentage of staff experiencing discrimination at work in the last 12 months	10%	10%	11%	11%	Improvement
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	24%	26%	22%	23%	Deterioration

Bottom four ranking scores	2015/16		2014/15		Assessment
	RUH	National Average	RUH	National Average	
Staff satisfaction with the quality of work and patient care they are able to deliver	3.80	3.93	-	-	Not comparable to 2014
Quality of non-mandatory training, learning or development	3.97	4.03	-	-	Not comparable to 2014
Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.61	3.70	-	-	Not comparable to 2014
Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	17%	14%	20%	14%	Improvement

Addressing areas of concern and our future priorities

Our staff survey results offer us a framework upon which to further improve staff experience and engagement - addressing areas of concern and further building on areas in which we are performing well.

We have developed a Staff Engagement/Values Embedding Programme for 2016/17. Areas of priority will include embedding our new values into our day-to-day activities and behaviours, further improving recognition of the achievements of our employees and ensuring staff at all levels have the opportunities to make improvements to further enhance staff experience and patient care.

A new initiative will be introduced in the coming year which will provide an opportunity for frontline staff to meet informally over coffee with the Chief Executive each month. This will enable the CEO to hear first-hand from staff about what's working well, and what we could be doing even better.

In addition, these staff as well as new staff will be asked to complete the RUH15 questionnaire, a set of 15 questions, which will help the Trust gauge the extent to which a member of staff feels engaged. The information will be used to help the Trust identify actions to further improve the experience of staff.

Progress against key priority areas of the programme will be kept under regular review and monitored quarterly by the Board of Directors.

Expenditure on consultancy

Expenditure on consultancy, as defined in the Department of Health's Manual for Accounts 2015/16, during 2015/16 was £584k.

Off-Payroll engagements

Statement on trust policy on the use of off payroll arrangements

From time-to-time the Trust uses the services of individuals who are self-employed or who trade through their own Ltd company. During the year the Trust received services from 26 such individuals. Seven of these individuals charged an equivalent daily rate of £220 or more and had been engaged by the Trust for a period of more than six months. Those engagements are set out in the table below. The Trust has sought and received assurances from these individuals that they are paying the correct amount of UK tax and have not been involved in tax avoidance schemes.

Off-payroll engagements as of 31 March 2016, for more than £220 per day and that last for longer than six months:

No. of existing engagements as of 31 March 2016	7
Of which…	
No. that have existed for less than one year at the time of reporting	2
No. that have existed for between one and two years at the time of reporting	2
No. that have existed for between two and three years at the time of reporting	0
No. that have existed for between three and four years at the time of reporting	0
No. that have existed for four or more years at the time of reporting	3

All existing off-payroll engagements have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, in all cases, assurance was sought and received.

New off-payroll engagements that last for longer than six months, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day:

No. of new engagements that last for longer than six months, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	4
No. of the above which include contractual clauses giving the Trust right to request assurance in relation to income tax and National Insurance obligations	4
No. for whom assurance has been requested	4
Of which…	
No. for whom assurance has been received	4
No. for whom assurance has not been received	
No. that have been terminated as a result of assurance not being received.	

Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016:

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure **must** include both off-payroll and on-payroll engagements.	15

Governance of the Trust

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 practice 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 has timely access to all relevant operational, financial, regulatory and quality information. Upon appointment to the Board of Directors, all directors (executive and non-executive) are fully briefed about their roles and responsibilities. Ongoing development is provided collectively 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 Executive and Non-Executive Director attendance at meetings of the Council of Governors; attendance at joint Board and Council away day events; participation in meetings involving members, such as at the Annual Members Meeting, at the Members' *Caring for You* events; and Executive Director attendance at Governor Constituency meetings.

Appointment of a New Non-Executive Director

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 31st 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 Directors' 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, no Non-Executive Director will term more than nine years. Removal of the Chairman or another Non-Executive Director shall require the approval of three quarters of the members of the Council of Governors.

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 page 44. 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 2015/16 this was undertaken by Non-Executive Directors, the Executive Team and the members of the Council of Governors' Nominations and Remuneration Committee as part of the

discussions around the appointment of a new Non-Executive Director to replace Michael Earp whose term of office ended on 31 October 2015. 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 2015 to discuss strategic 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, which 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, which provide an opportunity for the Board to debate strategic issues in an informal setting. The Board of Directors also has a programme of Board Seminars 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 ongoing development.

The Board of Directors undertook a self-assessment against Monitor's Well-Led Governance Framework in February 2016. The Trust will undertake an external Well-Led Governance Review during 2017 in line with Monitor's guidance.

Board Committees

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

Management Board

The Management Board is chaired by James Scott, Chief Executive and has delegated powers from the Board of Directors to oversee the day to day management of an effective system of integrated governance, risk management and internal control across the whole 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

In addition to its standing items of business, including debtor and creditor analysis, internal audit recommendation tracker, financial risks on the Board Assurance Framework, Internal Audit Reports, External Audit Reports and Counter Fraud progress reports, the Audit Committee has reviewed risk management systems and processes, the Capita/CHKS Audit on reference costs because the Trust had been identified as a national outlier on the basis of its low reference costs and the capital planning, prioritisation, authorisation and post project evaluation processes.

The Audit Committee is also responsible for monitoring the external auditor's independence and objectivity, including the effectiveness of the audit process. It can make recommendations for the appointment of external auditors for consideration by the Council of Governors who have the responsibility for appointing the Trust's external auditors.

Grant Thornton, the Trust's current external auditors were appointed in September 2012. In line with Monitor's guidance which recommends that NHS Foundation Trusts should undertake a market testing exercise for the appointment of external auditors at least once every five years, the October 2015 meeting of the Council of Governors agreed the tender process for External Audit Services.

It was agreed by the Council of Governors that external auditors would be appointed using the procurement tendering process as set out in the Trust's Standing Financial Instructions. An audit appointment working group was established which included representation from:

- Two Governors
- Non-Executive Directors from the Audit Committee
- Director of Finance
- Assistant Director of Finance
- Head of Financial Services
- Head of Procurement.

Following publication of the invitation to tender, four firms submitted tenders in an acceptable format. A sub-group of the audit appointment working group reviewed and scored the tender submissions on price. The four firms were invited to make presentations to the full working group. On the results of the tender process, the working group recommended the appointment of Deloitte. The Council of Governors approved the appointment of Deloitte as the Trust's external auditors with effect from 1 April 2016.

<u>Non-Clinical Governance Committee (NCGC)</u>

The NCGC is chaired by Joanna Hole, Non-Executive Director. The NCGC focuses primarily on providing assurance to the Board that the Trust has a robust framework for the management of risks arising from or associated with estates and facilities, environment and equipment, health and safety, workforce, reputation management, information governance, business continuity, business development and other non-clinical areas as may be identified.

Clinical Governance Committee

The Clinical Governance Committee was chaired by Michael Earp, Non-Executive Director until his retirement on 31 October 2015. From 1 November 2015, Nick Hood, Non-Executive Director has chaired the Clinical Governance Committee. 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 September 2015 meeting considered medical records, risk management systems and the Trust's work around improving Outpatient Services overseen by the Outpatient's Steering Group

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 was chaired by an Independent Trustee until December 2015. From January 2016, the Charities Committee is chaired by Moira Brennan, Non-Executive Director. 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 Royal National Hospital for Rheumatic Diseases on 1 February 2015, the RNHRD charitable funds are 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, focused 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.

The Commercial Transactions Steering Group 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. It subsequently provided oversight for RUH's interests in the development of Wiltshire Health and Care. The Board of Directors agreed to amend the Commercial Transactions Steering Group's Terms of Reference in November 2015 to include overseeing any property sales.

Fit for the Future Board

The Board of Directors approved the establishment and the terms of reference of a new Fit for the Future Board in February 2016. The Board is chaired by the Chief Executive and its members include two Non-Executive Directors. The primary objective of the Fit for the Future Board is to shape, review and challenge the Trust-wide transformation programme across key themes including transformation, acute and community integration, productivity and implementing the recommendations from Lord Carter's review of NHS efficiency.

Board of Directors Membership and Attendance –1 April 2015 to 31 March 2016

	Board of Directors (11 meetings)	**Audit Committee** (4 meetings)	**Non-Clinical Governance Committee** (4 meetings)	**Clinical Governance Committee** (5 meetings)	**Joint Clinical and Non-Clinical Governance Committee** (1 meeting)	**Board of Directors Nominations and Remuneration Committee** (1 meeting)	**Commercial Transactions Steering Group** (9 meetings)	**Charities Committee** (5 meetings)	**Fit for the Future Board** (3 meetings)
Brian Stables Chairman	11/11	-	-	1/1	-	1/1	8/9	5/5	-
Michael Earp Deputy Chairman and Senior Independent Director	5/6	1/2	-	2/3	1/1	0/1	-	-	-
Jane Scadding Non-Executive Director	4/5	-	-	1/2	0/0	0/0	-	-	2/2
Moira Brennan Non-Executive Director	11/11	4/4	-	-	-	1/1	9/9	4/4	-

	Board of Directors (11 meetings)	**Audit Committee** (4 meetings)	**Non-Clinical Governance Committee** (4 meetings)	**Clinical Governance Committee** (5 meetings)	**Joint Clinical and Non-Clinical Governance Committee** (1 meeting)	**Board of Directors Nominations and Remuneration Committee** (1 meeting)	**Commercial Transactions Steering Group** (9 meetings)	**Charities Committee** (5 meetings)	**Fit for the Future Board** (3 meetings)
Joanna Hole Non-Executive Director	10/11	3/4	4/4	-	1/1	1/1	-	1/1	-
Nicholas Hood Non-Executive Director	9/11	0/2	-	4/5	1/1	1/1	6/9	-	-
Nigel Sullivan Non-Executive Director	7/11	-	1/4	-	1/1	1/1	-	-	-
James Scott Chief Executive	11/11	-	-	-	-	1/1	7/9	-	2/3
Sarah Truelove Deputy Chief Executive & Director of Finance	9/11	3/4	-	-	-	-	7/9	5/5	3/3
Helen Blanchard Director of Nursing & Midwifery	9/11	-	-	4/5	1/1	-	-	0/5	1/3
Claire Buchanan Director of Human Resources	9/11	-	3/4	-	1/1	0/1	-	-	2/3
Tim Craft Medical Director	10/11	-	-	3/5	1/1	-	-	-	1/3
Jocelyn Foster Commercial Director	10/11	-	3/4	-	0/1	-	7/9	-	2/3

	Board of Directors (11 meetings)	**Audit Committee** (4 meetings)	**Non-Clinical Governance Committee** (4 meetings)	**Clinical Governance Committee** (5 meetings)	**Joint Clinical and Non-Clinical Governance Committee** (1 meeting)	**Board of Directors Nominations and Remuneration Committee** (1 meeting)	**Commercial Transactions Steering Group** (9 meetings)	**Charities Committee** (5 meetings)	**Fit for the Future Board** (3 meetings)
Howard Jones Director of Estates & Facilities	10/11	-	4/4	-	1/1	-	1/1	-	2/3
Francesca Thompson Chief Operating Officer	11/11	-	3/4	-	1/1	-	-	-	2/3

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 Governors 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.

The Board of Directors

Chair and Non-Executive Directors

Brian Stables, Chairman (Appointed: 1 April 2010)

Brian was previously a Foundation Trust Network Board Member and Trustee, and prior to this held the position of Non-Executive Director and Vice Chairman of NHS Wiltshire. He has an MBA and is a Fellow of the Chartered Institute of Management Accountants (FCMA). Brian is also a Director of Profex Associates Ltd - Management Consultancy, an Associate Lecturer, Open University MBA Programme, a Trustee of Wiltshire Air Ambulance Charitable Trust, and a Trustee of Wiltshire Mind.

Moira Brennan, Non-Executive Director (Appointed: 1 February 2008)

Moira is on the Trust's Board of Directors' Nominations and Remuneration Committee, the Charities Committee and Commercial Transactions Steering Group. She is Chair of the Audit Committee, and is the Whistle Blowing Contact and sustainability champion. Moira has a BSc (Hons) in Business Administration and is a Fellow of the Institute of Chartered Accountants in England and Wales. She brings experience of working in finance gained over 20 years in the private sector. Outside the Trust Moira is Chair of Bathampton Parish Council, Treasurer of Bathampton Village Hall, a Trustee of St John's Hospital and a Member Nominated Trustee of the Royal Mail Senior Executive Pension Plan.

Joanna Hole, Non-Executive Director, Vice Chairman and Senior Independent Director* (Appointed: 1 April 2011) *Vice-Chairman and Senior Independent Director from 1 November 2015

Joanna is Chairman of the Non-Clinical Governance Committee, a member of the Audit Committee, and on the Board of Directors' Nominations and Remuneration Committee. She is an alumna of Cranfield University School of Management and has held a number of senior positions within the Ministry of Defence which include; Head of Safety, Sustainable Development and Continuity (civilian and military), Director of Business Continuity and Deputy Director of HR Development Framework (civilian).

Nigel Sullivan, Non-Executive Director (Appointed: 1 August 2012)

Nigel serves on the Non-Clinical Governance Committee, the Board of Directors' Nominations and Remuneration Committee and the Fit for the Future Board. Nigel has a BSc (Hons) and a Post Graduate Diploma in Personnel Management. He has held senior positions in a range of private sector organisations, and his current role is Group HR Director of Talk Talk Group plc. He is Director of West Four Apartments Company Limited.

Nicholas Hood, Non-Executive Director (Appointed: 1 August 2012)

Nicholas is Chair of the Clinical Governance Committee and sits on the Board of Directors' Nominations and Remuneration Committee as well as the Commercial Transactions Steering Group and the Audit Committee. He is a Safeguarding Champion. Nicholas has an Honorary Doctorate MBA and is an Honorary Fellow of the Institution of Water and Environmental Management. He is Life Vice-President of @Bristol, Fellow of World Wildlife Fund and a member of First Group Strategic Advisory Board. Previous roles include; Chairman of Walk-the-Walk, Deputy Chairman of Brewin Dolphin plc, Chairman of MIHT, Chairman of Winterhur UK, Director of National Westminster Bank (western board), Member of the HRH the Prince of Wales Council for the Duchy of Cornwall, and Chairman of Wessex Water Authority, Chairman of Wessex Water plc.

Michael Earp, Non-Executive Director, Vice Chair & Senior Independent Director (Appointed: 1 December 2004 – retired 31 October 2015)

Michael was Vice Chairman of the Trust, serving on the Remuneration Committee and the Audit Committee, and Chairman of the Clinical Governance Committee, he was also 'Quality' Champion. Michael has an HND in Business Studies, is a Graduate of Chartered Institute of Marketing, and past Associate of Chartered Institute of Secretaries and Administrators. He is manager of his own residential property business and part-time management consultancy. Michael previously held senior posts at Woodmansterne Publications, Andrew Brownsword Collection and Bonhams Fine Art Auctioneers and Valuers.

Jane Scadding, Non-Executive Director (Appointed 1 November 2015)

Jane serves on the Clinical Governance Committee, the Board of Directors' Nominations and Remunerations Committee, and Fit for the Future Board. She has a BA (Hons) in French and

Management Studies, and is MCIPS qualified and Fellow of Chartered Institute of Procurement and Supply. Jane's previous appointments included Chief Procurement Officer for Wincanton plc, Global Procurement Director for capital and construction in Glaxo Smithkline and European Procurement Director for Pharmaceuticals in Smithkline Beecham. Jane is a Trustee for Bath and Wiltshire School Sports Trust.

Executive directors (voting)

James Scott, Chief Executive (Appointed 1 June 2007)

James was previously Chief Executive of Yeovil Hospital, a wave 1A NHS Foundation Trust, Director of Operations at Chase Farm Hospital and held a number of senior roles in London hospitals such as St Mary's Paddington and Hammersmith. He has a BA (Hons) in History and a Diploma in Health Services Management. James is Vice Chair and Company Director of the West of England Academic Health Science Network, and Senior Responsible Officer for the BaNES, Swindon and Wiltshire Sustainability and Transformation Plan.

Sarah Truelove, Director of Finance & Deputy Chief Executive (Appointed June 2013)

Sarah was previously Director of Finance and Deputy Chief Executive of Gloucestershire Hospitals NHS Foundation Trust, Director of Finance at Gloucestershire PCT, and held a number of senior roles in commissioning and acute hospitals. Sarah has a BA (Hons) in politics and is a Member of the Chartered Institute of Public Finance and Accountancy. Sarah is married to the Chief Finance Officer for Wiltshire Clinical Commissioning Group and School Governor at The Corsham School.

Dr Tim Craft, Medical Director (Appointed August 2010)

Tim's previous roles at the RUH were as Deputy Medical Director, Chair of the Specialty Division, Clinical Director of Anaesthesia and Critical Care Medicine, Clinical Director of Operations and Director of Operations. He has MBBS (London), FRCA and is a Health Foundation Leadership Fellow. Tim is Director and shareholder of Anaesthetic Medical Systems (AMS) Ltd., and Director and shareholder of 10 Bar Ltd.

Francesca Thompson, Chief Operating Officer (Appointed September 2006)

Francesca was previously the Trust's Director of Nursing, and Board Director of Nursing at Great Western Hospitals NHS Foundation Trust. She is a registered nurse and a registered Midwife (lasped), is a Fellow of Improvement Faculty NHS Institute for Innovation and Improvement and has an MSc in Social Sciences. Her daughter is registered with the Trust's temporary Bank Staff.

Helen Blanchard, Director of Nursing & Midwifery (Appointed August 2013)

Helen was previously Chief Nursing Officer and Director of Infection Prevention and Control at Worcestershire Acute Hospitals NHS Trust, Director of Nursing and Quality at Hereford County Hospitals NHS Trust, and held a number of senior nursing and midwifery roles in Acute Trusts. She is a Registered General Nurse and District Nurse, a lecturer/practice educator and has an MSc in Nursing Studies. She has no declared interests.

Executive directors (non-voting)

Claire Buchanan, Director of Human Resources (Appointed October 2013)

Claire was previously Acting Director, and Deputy Director of Workforce and OD at University Hospitals Bristol NHS Foundation Trust, and held a various senior HR positions at United Bristol Healthcare NHS

Trust. She has an MA in Human Resource Management and is a Chartered Fellow of the Institute of Personnel and Development. She has no declared interests.

Jocelyn Foster, Commercial Director (Appointed July 2012)

Jocelyn was previously Director of Business Strategy for Kent County Council, Strategy Director at (Parcelforce) Royal Mail, Strategic and Corporate Development Director at Leicestershire Partnership NHS Trust, and has previous public and private sector experience in business strategy, planning, transformation and new business development. Jocelyn is a Chartered Marketer, has an MBA, DPhil, and BSc (Hons) in Biological Sciences. Jocelyn's declared interests are as follows: Chair of Trustees, Apex Works, Complaints Panellist - Dental Complaints Service, Trustee of the Disabilities Trust, and she has a financial interest in Veloscient Ltd (facilitating structured data capture for a range of markets, including healthcare).

Howard Jones, Director of Estates & Facilities (Appointed November 2008)

Howard was previously Director of Estates and Facilities at East Kent Hospitals NHS Foundation Trust. He has a BEng (Hons) MSc C Eng, an MSc in Corporate Real Estate Management and is a Chartered Engineer with a degree in Environmental Engineering. He has no declared interests.

The 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 (CoG) 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.

2015 Governor Elections

During 2015 the Trust held two elections to fill two vacancies on the Council of Governors. Four members of staff put themselves forward for election to fill the vacancy left by Julian Hunt, Staff Governor. Phill Lunt, Network Analyst, was voted by staff to be the new Staff Governor. Phill's term began on 17th July 2015 and will run until 31st October 2017.

Adrian Bligh, Public Governor for the North Wiltshire Constituency stepped down from his role as a Governor in June 2015. Five members from North Wiltshire put themselves forward for election to fill the vacancy and in September, Chris Callow was voted by North Wiltshire Members to be the new Public Governor for North Wiltshire. Chris' term began on 11th September 2015 and will run until 31st October 2016.

The election reports can be seen below.

Register of Governors

The register of Governors for the period 1 April 2015 to 31 March 2016 is:

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	Stood down June 2015
Chris Callow	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	Stood down April 2015
Phill Lunt	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 Katie Hall	BaNES Council	Stood down May 2015
Cllr Vic Pritchard	BaNES Council	June 2015 - 31 October 2017
Dr Stephen Rowlands	Wiltshire CCG	Stood down June 2015
Christine Reid	Wiltshire CCG	July 2015 – October 2015
Dr Andrew Girdher	Wiltshire CCG	January 2016 - 31 October 2017
Cllr Keith Humphries	Wiltshire Council	31 October 2017
Mark Humphriss	University of Bath	31 October 2016

During the Council of Governors meeting held on 2nd December 2015, the Chairman announced that following the completion of all Governor 1:1 meetings it had been agreed that Ian Bynoe would be reappointed as Lead Governor for another term of office (1 year). The Council of Governors agreed that an election would be held in November 2016 to appoint the next Lead Governor, and the successful Governor would be appointed for a two year term.

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 and 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.

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.

Board Monitoring Group

Since September 2015 a small group of Public Governors regularly began attending meetings of the Board of Directors (BoD). The aim of the Board Monitoring Group is to improve how the Council of

Governors holds the Non-Executive Directors (NEDs) to account for the performance of the Board. Attendance at meetings and reading the Board papers has enabled Governors to see the Board in action and in particular the NEDs questioning Executive Directors. During the Governor Away Day in February 2016, it was agreed that the Board Monitoring Group had been successful in its aim and a small group of Governors would continue to be assigned the responsibility of attending BoD meetings and report to CoG with suggestions for the priority issues to be raised with Non-Executive Directors. It was also agreed that at least two of the CoG seminar meetings per year would be held with NEDs in order to provide assurance on the work of their respective Board Assurance committees.

Council of Governor Meetings

The Council of Governors has met on the following occasions:

- 2nd June 2015 – scheduled meeting
- 8th October 2015 – scheduled meeting
- 2nd December 2015 – scheduled meeting
- 8th March 2016 – scheduled meeting

The following table summarises Governor attendance at Council of Governor meetings 1st April 2015 – 31 March 2016:

Name	Constituency	Attendance
Public Governors		
Amanda Buss	City of Bath	4 of 4
Dominic Tristram	City of Bath	2 of 4
Helen Rogers	North East Somerset	2 of 4
Nick Houlton	North East Somerset	3 of 4
Michael Welton	Somerset (Mendip)	4 of 4
Ian Bynoe	Somerset (Mendip)	4 of 4
Jan Taylor	North Wiltshire	3 of 4
Adrian Bligh	North Wiltshire	1 of 1
Chris Callow	North Wiltshire	3 of 3
Jane Shaw	South Wiltshire	3 of 4
Phil Morris	South Wiltshire	3 of 4
Bill Aiken	Rest of England & Wales	4 of 4
Staff Governors		
Elizabeth Brown	Staff	3 of 4
Phill Lunt	Staff	2 of 3
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 Vic Pritchard	BaNES Council	3 of 4
Dr Stephen Rowlands	Wiltshire CCG	1 of 1
Christine Reid	Wiltshire CCG	0 of 1

Dr Andrew Girdher	Wiltshire CCG	0 of 1
Cllr Keith Humphries	Wiltshire Council	1 of 4
Mark Humphriss	University of Bath	3 of 4

The following table summarises Non-Executive Director attendance at Council of Governor meetings 1st April 2015 – 31 March 2016:

Name	**Title**	**Attendance**
Non-Executive Directors		
Moira Brennan	Non-Executive Director	4 of 4
Michael Earp	Senior Independent Director	2 of 2
Joanna Hole	Senior Independent Director	4 of 4
Nick Hood	Non-Executive Director	1 of 4
Jane Scadding	Non-Executive Director	2 of 2
Nigel Sullivan	Non-Executive Director	1 of 4

The Chief Executive attended all Council of Governor meetings, it was agreed at the June 2015 CoG meeting that Executive Directors would only attend if they were invited by the CoG to present.

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 Chairman, Brian Stables.

The Council of Governors Nominations and Remuneration Committee comprises the following members:

Name	**Title**
Brian Stables	Chairman
Adrian Bligh	Public Governor, North Wiltshire (until March 2015)
Jan Taylor	Public Governor, North Wiltshire (until January 2015)
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 (until 31 October 2015)
Joanna Hole	Senior Independent Director (from 1 November 2015)

During 2015/16 the Committee has undertaken the following work:

- Participated in the appointment process for a new Non-Executive Director and made a recommendation on the appointment for the Council of Governors' approval
- Participated in the appointment process for a new Vice Chairman made a recommendation on the appointment for the Council of Governors' approval and recommended to the Board of Directors that the same person be appointed as the Senior Independent Director
- Discussed succession planning for appointing to forthcoming Non-Executive Director vacancies to ensure that the membership of the Board of Directors was regularly refreshed
- Participated in the re-appointment process of the Chairman and other Non-Executive Directors
- Reviewed the results of the Chairman's appraisal and developed the process for the Chairman's appraisal from 2016 in consultation with the Senior Independent Director
- Made a recommendation to the Council of Governors in respect of the Chairman's objectives for 2015/16 in his role as Chairman of the Council of Governors
- Reviewed the outcome of the Chairman's appraisal of the Non-Executive Directors.

Governor working groups

Governors continue to fulfil both their statutory and non-statutory duties through their established working groups. 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 working group does not have decision-making powers, but will make recommendations for the approval of the full Council of Governors. The Group is chaired by Helen Rogers, Public Governor for North East Somerset, and its meetings are also attended by other Governor representatives, Jocelyn Foster, Commercial Director, and 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 working group does not have decision-making powers, but will make recommendations for the approval of the full Council of Governors. The Group is chaired by Jan Taylor, Public Governor for North Wiltshire, and its meetings are also attended by other Governor representatives and Helen Blanchard, Director of Nursing and Midwifery.

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 working group does not have decision-making powers, but will make recommendations for the approval of the full Council of Governors. The Group is chaired by Phil Morris, Public Governor for South Wiltshire, and its meetings are also attended by:

- 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:

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

- Telephone: 01225 821299 or 01225 826288

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 community 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 2016:

Category	**Actual 31 March 2016**	**Target 31 March 2016**
Public	10,284	10,000
Staff	4,859	4,500
Total	15,143	14,500

Constituency breakdown	**As at 31 March 2016**
City of Bath	2,157
North-East Somerset	1,804

Mendip	1,154
North Wiltshire	1,608
South Wiltshire	2,085
Rest of England and Wales	1,476
Staff	4,859

Membership size and movements		
Public constituency	**Last year (2015/16)**	**Next year 2016/17 (predicted)**
At 1 April	9,072	10,284
New members	1,550	1,014
Members leaving	334	300
At 31 March	10,284	11,000
Staff constituency	**Last year (2015/16)**	
At 1 April	4,796	4,859
At 31 March	4,859	-

Public Constituency	**Number of members**	**Eligible membership**
AGE		
0-16	28	151,521
17-21	737	49,205
22+	8,609	575,907
ETHNICITY		
White	8,842	728,501
Mixed	57	9,462
Asian or Asian British	139	11,684
Black or Black British	81	4,764
Other	24	1,865
Unknown	1,141	n/a
SOCIO-ECONOMIC GROUPING		
AB	3,039	60,698
C1	3,001	69,365
C2	2,072	48,403
DE	2,100	45,242
Unknown	72	n/a
GENDER		
Male	3,643	382,809

Female	6,614	393,823
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 to 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 established to support the Trust in growing and developing its membership, evolving methods of communication and engagement with the members and the local community including hard to reach and under-represented 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 10,285 local people registered as members of the Trust, and a further 4,859 staff members. This is an audience of 15,144 people to seek views and opinions from.

The Trust has 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

Throughout 2015 Governor Constituency meetings have gone from strength to strength in order to seek the views of their constituents. In 2015/16 there were eight constituency meetings across the region.

Each constituency meeting aims to inform attendees about the Trust, but also seek their views about what could be improved and what is going well.

Caring for You Events

Our Caring for You events are designed exclusively for our members and give them 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 local communities.

Past events have included tours of the operating theatres and dermatology department, neurology, 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 our work.

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).

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

Ref No	Code Provision	Annual Report and Accounts Section
A.1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions taken by each of the Boards, and which are delegated to the executive management of the Board of Directors.	Section on Board of Directors (page 36)
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 Committee Membership and Attendance (pages 36-42)
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 47)

Ref No	Code Provision	Annual Report and Accounts Section
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 50)
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 36)
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 (page 44)
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 36)
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 Council of Governors' Nominations and Remuneration Committee (page 51)
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 Council of Governors' Nominations and Remuneration Committee (page 51)
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 (page 44)
B.5.6	Governors should canvas 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 47)
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	This power has not been exercised

Ref No	Code Provision	Annual Report and Accounts Section
	(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)	
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 36)
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.
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 70)
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 70)
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 70)
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	Section on governance (page 39)

Ref No	Code Provision	Annual Report and Accounts Section
	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.	
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
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 53)
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 49)
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 47)
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 54)
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	Council of Governors and Board of Directors Section (page 44)

Ref No	Code Provision	Annual Report and Accounts Section
	the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 7.33 as directors' report requirement.	

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

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

Code Ref	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 receives a monthly operational performance scorecard.
A.1.6	The board should report on its approach to clinical governance.	**Confirmed:** the Trust undertook an internal review against the Quality Governance Assurance Framework. The outcome of the self-assessment was reported to the June 2015 Board of Directors meeting. The Trust also undertook an interview review against the Well Led Governance Framework. The outcome of the self-assessment was reported to the February 2016 Board of Directors meeting. 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	**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

Code Ref	Narrative in the Code	RUH Compliance
	behaviour in public life.	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 2014 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 NHS Litigation Authority. 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.
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. The current Vice-Chairman and Senior Independent Director took up office on 1 November 2015 following the retirement of the previous Vice Chairman and Senior Independent Director on 31 October 2015 who 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

Code Ref	Narrative in the Code	RUH Compliance
		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.
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:** The Trust has undertaken appropriate checks to assure itself that every member of the Board of Directors meets the "fit and proper persons" criteria as described in the provider license. Governors have confirmed that they meet the requirements of the Fit and Proper Persons as set out in Monitor's Provider Licence.

Code Ref	Narrative in the Code	RUH Compliance
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:** The Council of Governors and the Nominations and Remuneration Committee agreed the appointment process of a new Non-Executive Director to replace Michael Earp, Non-Executive Director, whose term of office ended on 31 October 2015.
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.
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. The Council of Governors' Nominations and Remuneration Committee took account of the views of the Board of Directors when considering the skills, experience and qualifications for the new Non-Executive Director.
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	**Confirmed:** The Board of Directors' minutes provide evidence of executive and non-

Code Ref	Narrative in the Code	RUH Compliance
	executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.	executive directors' challenge. In addition, the Board 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.
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.

Code Ref	Narrative in the Code	RUH Compliance
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.
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 agreed the tender process for appointing new external auditors in consultation with the Audit Committee.
C.3.6	The NHS Foundation Trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS Foundation Trust.	**Confirmed:** The Council of Governors approved the appointment of new external auditors for a three year period (1 April 2016-31 March 2019).
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

Code Ref	Narrative in the Code	RUH Compliance
		Concerns Policy.
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 Board of Directors 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 measures the level of risk at the Trust using the financial and governance frameworks as set out in the Risk Assessment Framework. The continuity of services rating, and governance rating are the measures used by Monitor to evaluate whether or not we are meeting the commitments we have made as an NHS Foundation Trust to run our services effectively.

The continuity of services rating is a finance measure which is focuses on:

- Liquidity, how many days expenditure the Trust holds in cash or cash equivalents
- Capital servicing capacity, the number of times the Trust's operating surplus covers the interest it has to pay on its debt
- Income and expenditure margin, the degree to which the organisation is operating at a surplus/deficit, and
- Variance from plan in relation to I&E margin, variance between a Foundation Trust's planned I&E margin in its annual forward plan and its actual I&E margin within the year.

The continuity of service rating is scored 1-4 where 1 is high risk and 4 is low risk. A change in year in the way this rating is calculated impacted on the Trust's ability to achieve its planned overall rating of 4, despite having delivered against its original financial plan and as detailed in the financial performance section of this report. The Trust's overall continuity of service rating was 3 at the end of the 2015/16 financial year.

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 (e.g. external regulators such as the Health and Safety Executive);
- Quality governance indicators; and
- Continuity of service rating.

The governance 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

2015-16	Annual Plan	Q1	Q2	Q3	Q4
Continuity of Service Rating	4	3	3	3	3
Governance Rating	Green	Red	Green	Red	Red

2014-15	Annual Plan	Q1	Q2	Q3	Q4
Continuity of Service Rating	4	n/a	n/a	4	4
Governance Rating	Green	n/a	n/a	Green	Green

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 on the 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/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

25 May 2016

Annual governance statement 2015/16

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Royal United Hospitals Bath NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Royal United Hospitals NHS Foundation Trust for the year ended 31 March 2016 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 Royal United Hospitals Bath NHS Foundation 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 Royal United Hospitals Bath NHS Foundation 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 2016. 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.

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.

The Trust's Internal Auditors conducted a review of Committee Governance Effectiveness in 2015/16 and concluded that: "The Trust has a clear governance structure in place. Skilled and experienced executives and non-executives provide a good level of challenge and exhibit a wide understanding of Trust issues" (January 2016).

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.

Staff Empowerment and Risk Management Training

Risk management training is provided through the induction programme for all new staff. The corporate training programme ensures that all new staff 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. This includes public governors' constituency meetings, regular member newsletter, and the Annual Members Meeting
- **Partner organisations**, including clinical commissioning groups, voluntary sector and local universities
- **Staff** – staff engagement meetings, staff survey and team briefings.
- **Public and service users** – patient surveys, Patient and Carer Experience Group and Patient Advice and Liaison Service.

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 the Trust 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 Board of Directors also receives a quarterly Incidents, Claims and Inquests report which contains more detailed analysis of trends and learning and is considered in the private Board of Directors' meeting.

The Trust's Internal Auditors conducted a "deep dive" review of the Royal National Hospital for Rheumatic Diseases' risk management systems and processes post acquisition in February 2016. The Internal Auditors gave "significant assurance" and stated that: "there is good evidence of strong controls regarding the integration of the RNHRD, specific committees and groups have been given ownership of the integration process with consultation on both sides."

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 Board Assurance Framework was reviewed quarterly by the Board of Directors. Each risk was 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. Strategic risks are also regularly reviewed at the Board of Directors' Strategy Away Day which is held quarterly.

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.

The Trust has achieved level 2 of the Information Governance Toolkit in 2015/16.

From 1 April to 31 March 2015, the Trust had 15 serious information governance incidents requiring investigations involving personal data The incidents were reported to the Information Commissioner's Office (ICO). There were 52 other personal data breaches. During the same period, the Trust had 52 other personal data related incidents. 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 taken to minimise the risk of a recurrence.

A programme of proactive Information Risk Management audits take place across the year and staff are required to complete annual information Governance refresher training. This training includes any lessons learnt from incidents that have occurred.

During the year, a Patient Correspondence Working Group was convened to focus on root causes of patient correspondence breaches and a campaign was launched to further minimise risks called “Check, Check and Check again.”

Plans are also in place for 2016/17 to implement a new word processing package into the Trust’s main patient administration system. This use of new technologies will significantly reduce the risk of errors occurring with patient correspondence. Any errors that do occur will, going forward, be reported as part of Trust’s performance measurement and subjected to regular review. The Trust sends out in the region of 10,000 letters each week.

In March 2016, the Trust agreed with the Information Commissioners Office (ICO) that an Information Risk Review would be completed by the ICO in the new financial year to provide an independent assessment of the Trust’s controls in place.

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 2015/16 has been developed in line with relevant national guidance.

The Quality Board receives regular updates about clinical quality and was 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 account priorities 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 2015/16 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 reviews the implementation status of all National Institute for Clinical Excellence guidance and Central Alerting System guidance to risk assess any development areas for the Trust and to take action to implement recommendations.

The Board of Directors receives an annual mortality review report which compares the Trust’s hospital standardised mortality rate (HSMR) with other comparable Trusts. The Trust uses clinical outcome data to assess and improve services with participation in national audits as well as undertaking local audits.

The Trust's Internal Auditors reviewed data quality in 2015/16 and concluded that: "There are clear governance structures and monitoring mechanisms in place to maintain data quality." The Trust's Internal Auditors gave a rating of "significant assurance with minor improvement opportunities" following their review of Data Quality (February 2016).

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.

The Trust's Internal Auditors reviewed the Trust's Clinical Audit Effectiveness in 2015/16 and gave a rating of "significant assurance with minor improvement opportunities" (September 2015).

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 Care Quality Commission conducted an announced inspection of the Trust in March 2016. The inspection report is due to be published in May/June 2016.

Quality Governance Arrangements

The Trust has strong quality governance arrangements in place, including ambitious Trust-wide "safer six" patient safety and quality priorities, designed, approved and monitored by the Board of Directors; ten executive director sponsored projects of "must-do's" informed by business unit priorities, CQUIN or as a response to stakeholders; and 15 divisional patients safety priorities. The Divisional

Leadership teams are invited to present updates on their safety priorities to the Board of Directors twice a year.

The Board of Directors is responsible for ensuring the quality and safety of services provided by the Trust and has developed a robust quality governance structure and reporting mechanisms to ensure that quality objectives are identified, monitored and, where performance is below the expected standard, action is taken to address the issue.

The Trust conducted a self-assessment against Monitor's Quality Governance Framework and reported the results to the June 2015 Board of Directors meeting. The Trust also conducted a self-assessment against Monitor's Well-Led Framework and reported the results to the February 2016 Board of Directors meeting.

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 and Carer Experience Group and the Clinical Outcomes Group – as well as the Divisional Clinical Governance Groups.

The Trust's participation in national and regional patient safety initiatives sets the tone for the rest of the organisation and demonstrates that quality improvement is a top priority.

The Chief Executive is the Vice-Chair of the West of England Academic Health Science Network. The Trust has recently become a member of NHS Quest, a member network for NHS Foundation Trusts who wish to focus relentlessly on improving quality and safety.

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 team of 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 2015/16. As part of the review, the auditors performed detail testing on five specific indicators relating to the Emergency Department (four hour ED wait, average time to assessment, average time to treatment, trolley wait times and data capture for attendance types). The Internal Auditors gave a rating of "significant assurance with minor improvement opportunities" (February 2016).

The Trust's Internal Auditors also reviewed the effectiveness of administrative processes within Gastroenterology and Ophthalmology outpatient services in 2015/16. The Internal Auditors made nine recommendations for improvement and gave a rating of "partial assurance with improvements required" (November 2015). The Trust developed an action plan and has now implemented the recommendations.

Capabilities and culture

The Trust has established the Quality Improvement Centre 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.

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 Patient Advice Liaison Service contacts
- Monthly Board of Directors' patient story at every meeting and matron presentations;
- Quarterly Patient Feedback and Incident, Claims and Inquest reports to the Board of Directors
- Executive and Non-Executive Directors patient safety visits
- Member and patient feedback at the Annual Members Meeting and Governor Constituency meetings
- 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 three clinical and operational risks at its February 2016 meeting as:

- **Capacity and flow:** This risk relates to the Trust's ability to manage within its bed base and maintain timely flow of patients out of the Emergency Department, Medical Assessment Unit and Surgical Assessment Unit, to ensure that the Trust is able to offer a high quality service to non-elective patients. The Urgent Care Collaborative Board is leading the work to address this risk, which focuses on:
    - Providing alternatives to admission at the front door of the hospital
    - Minimising delays to care for inpatients
    - Good discharge planning for all patients.

- **Registered Nurse vacancies:** Recruiting to Registered Nurse vacancies has always been viewed as a high priority in the Trust. However despite very proactive recruitment initiatives in place; the Trust like many other Trusts, is faced with a consistent 'gap' in its registered nursing workforce.

  Some wards are finding this more of a challenge than others, but these 'hot spot' wards have been identified, action plans are in place to support these areas and the majority of these wards have now appointed Registered Nurses that will be starting work with the Trust over the coming months.

  To try and reduce the number of vacancies, the Trust is taking actions over and above the usual on-going recruitment plans and use of bank/pool staff. For example, the Trust has recently recruited Registered Nurses from Italy. The Trust has also invested in developing the new role of Ward Assistant Practitioners (Band 4).

- **Backlog maintenance and the risk of an ageing infrastructure:** Whilst significant investment has been made in recent years, some of the Trust's older engineering infrastructure continues to present a risk to business continuity and the provision of a safe environment, which requires careful ongoing mitigation. Consequently, this should be considered as one of our top three risks probably until RUH North is demolished and the Cancer Centre build is complete.

The Trust's top three business risks are:

- Failure to respond to changes in Commissioner environment
- Failure to deliver QIPP
- Failure to sustain performance.

The Trust's other key risks include:

- The risk of failing to deliver the planned financial surplus which could impact on the Trust's ability to deliver its Estates Strategy
- Health and Safety Executive Improvement Notice – regarding legionella and the subsequent inquest into the death of an RUH patient with legionella
- 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 continue to be managed throughout 2016/17.

Principal risks to compliance with Monitor's Provider Licence Condition 4 (governance) and actions identified to mitigate the risks

Monitor's NHS Provider's Licence requires NHS Foundation Trusts to meet the compliance standards for finance and governance as set out in Monitor's Risk Assessment Framework. The Trust has complied

with Monitor's requirements for finance but due to a number of operational performance challenges, the Trust has failed to meet the Emergency Department four hour wait standard during 2015/16 and to meet the target for reducing the number of cases of C.difficile. In quarters 2, 3 and 4, the Trust also failed to meet the cancer two week wait to first outpatient appointment for breast symptomatic patients.

The principal risks to compliance with the provider licence condition 4 (NHS Foundation Trust governance) are set out below. The Board of Directors reviews its performance against the requirements of Monitor's Risk Assessment Framework on a quarterly basis. Where the Trust has not met the performance standards, the Board assures itself that there are robust plans in place to improve performance. An exception report is considered by the Board of Directors and is forwarded to Monitor. Monitor's governance rating for the Trust is "under review" because of failure to meet the access standards.

Accident and Emergency Four Hour Wait Standard

Due to sustained operational pressures during 2015/16, the Trust did not meet the Accident and Emergency four hour wait standard. The Trust developed an Urgent Care Improvement Plan in response to recommendations made by the Emergency Care Intensive Support Team. The Urgent Care Improvement Plan has three work streams: front door; specialities; and back door. Each work stream is led by an Executive Director.

The Trust has also developed a four-hour remedial action plan to improve performance against the four hour accident and emergency standard which was submitted to the Trust's local Commissioner and Monitor on 8 February 2016.

Progress on delivering the Urgent Care Improvement Plan and the Remedial Action Plan is reported to the Board of Directors each month so progress and performance can be monitored.

Cancer two week wait to first outpatient appointment for breast symptomatic patients

The standard was not achieved in quarters 2, 3 and 4 due to capacity issues caused by difficulties in recruitment to either substantive or locum posts. The Associate Medical Director for Cancer Services put in place actions to mitigate any risk to patients, including the Breast Team triaging all referrals according to clinical suspicion of cancer. All patients with a clinical suspicion of cancer receive an appointment within two weeks of referral. The Trust has also recruited two Breast Radiologists who will start work later in the year.

Referral to Treatment Target – Incomplete pathways

The Trust failed to meet the Referral to Treatment (incomplete pathways) target from December 2015 to March 2016. The failure was anticipated and agreed with the Trust's Commissioners in advance due to the expected impact of non-elective pressures and reduced elective activity over Christmas. Performance has also been exacerbated by a norovirus outbreak and by the Junior Doctors ongoing strike action.

C. difficile

Whilst we reported 58 cases of C.difficile during 2015/16, not all of these cases are deemed attributable to the Trust. Performance against this standard is measured against the cumulative target, which led to failure at year end, with 32 cases confirmed as Trust attributable at the end of March. Additional cases are still out to appeal or awaiting review before an outcome is decided. The Trust has developed an improvement plan and contributed to plans across the health community to reduce the number of cases. The Trust has also commissioned an external peer support review of its systems and processes in relation to C.difficile in November 2015, and has developed a comprehensive action plan to implement the recommendations of this peer review.

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 2014/15 was 89.9 which indicated that the cost of the Trust providing healthcare was 10.1% below the national average.

Internal audit has reviewed the systems and processes in place during the year and has 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.

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.

In February 2016, the Board of Directors established the Fit for the Future Board with representation from two Non-Executive Directors. The Fit for the Future Board will oversee the Trust's response to the Carter Efficiency Review recommendations and will report to the Board of Directors on progress.

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's Assurance Framework provides me with evidence of the effectiveness of controls that manage the risks to the organisation achieving its strategic objectives, have been reviewed and are being actively managed. Internal Audit provides me with an opinion about the effectiveness of the assurance framework and the internal controls reviewed as part of the Internal Audit plan. Work undertaken by Internal Audit is reviewed by the Assurance Committees (Audit, 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.

The Head of Internal Audit's opinion for the period based 1 April 2015 to 31 March 2016 is that:

"Significant assurance with minor improvement opportunities can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control."

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
- Internal Audit of Committee Governance and Effectiveness
- Quality Governance Framework Self-Assessment
- Well-Led Framework Governance Self-Assessment.

Conclusion

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

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

Signed

James Scott

Chief Executive

25 May 2016

Accountability report signed

James Scott

Chief Executive (Accounting Officer)

25 May 2016

Quality Accounts 2015/16

Part 1

Statement on Quality from the Chief Executive

Our Board of Directors are committed to providing services of the highest quality, that are patient centred, accessible and support recovery and maintain good health. We work closely with service users, their carers, our partners in other agencies and third sector colleagues to deliver integrated care in the right place and at the right time by staff with the right skills.

February marked the first anniversary of the RUH and RNHRD joining together and it has been a very successful year. With a more secure financial future in place, the RNHRD continues to thrive, with notable achievements including celebrating the 100th fatigue management programme, achieving two significant research grants and gaining recognition as a Lupus UK Centre of Excellence.

This year, we launched our Trust values and hundreds of staff, clinicians and managers, patients, carers and governors attended a series of events to co-create the values. Our values convey the things we heard make the most difference to patients, carers, and staff, and the ways people said we could keep improving. They set out our ambition for how our staff, patients, carers, families said they want each and every one of us to behave now and in the future. We know that many of our staff live these values most of the time but our staff, patients, carers and families told us we don't consistently live these values.

Our values are: **Everyone Matters, Working Together, Making a Difference.**

Our values are displayed throughout our hospitals. They are actively promoted among staff and will be embedded in the way we recruit and welcome new staff, in our performance management and reward and recognition systems, at team meetings, in skills based development programmes for managers, leaders and teams.

Like many other acute Trusts this year, we have been facing huge pressures on our Emergency Department with increasing admissions and an ageing population. We remain committed to delivering high quality safe care to our patients at all times. We recognise the impact that periods of continued pressure have on our staff and thank them for all their dedication and support throughout the year.

I believe that the information contained in the Quality Accounts is an accurate reflection of the care we provided in this year.

Signed

James Scott

Chief Executive and Accounting Officer

25 May 2016

Part 2

Our approach to quality

Why are we producing a Quality Account?

All NHS trusts are required to produce an annual Quality Account, to provide information on the quality of services to service users and the public.

The Trust welcomes the opportunity to demonstrate how well we are performing, taking into account the views of service users, carers, staff and the public, and comparing our progress against the previous year and where we can, against the national average. We can use this information to make decisions about our services and to identify areas for improvement.

We have set out in this Quality Account how well we have performed against local and national priorities including how well we progressed with those areas we highlighted as our improvement priorities for 2015/16.

How do we improve Quality?

We have decided to adopt a standardised approach to quality improvement. This is designed to encourage and support our staff by providing them with the tools they need to make sustained improvements without waiting for permission. 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.

We want to ensure that we continuously improve our services so that they are safe, effective, caring, well-led and responsive using standardised quality improvement methods where appropriate.

During 2015, we developed a standardised quality improvement methodology for the Trust, which supports our quality strategy. The model is made up of two elements: a quality improvement training programme (Quality Service Improvement Redesign – QSIR) which provides training for all our staff, and we re-launched our Quality Improvement Centre (QIC). Staff in the QIC offer a wide range of skills, including leadership, stakeholder and staff engagement, clinical and nursing, training, research, education, clinical audit, project management, data analytical and administrative support. The QIC works with patients, carers and members of the public as well as permanent staff members on specific projects to improve the quality of care we provide.

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.

How we chose our priorities

We developed our priorities in consultation with the public, our patients, Foundation Trust members, Healthwatch, Commissioners and Trust staff through our Annual General Meeting, membership constituency meetings and workshops. We also assessed our progress against last year's priorities and identified that in some areas, there is still more work to be done and therefore some of our priorities will continue this year.

Part 4

Priorities for improvement – looking back on last year

Priority 1: Sepsis

What we said we would do:

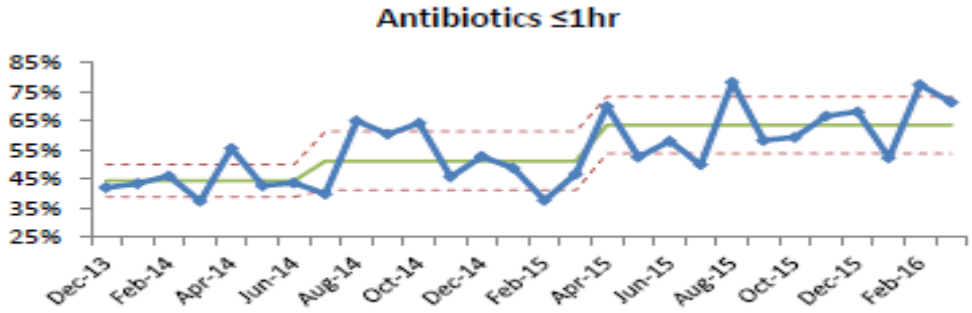
- deliver the national Commissioning for Quality and Innovation (CQUIN) scheme on the screening of all patients at risk of severe sepsis and collate monthly measures
- further improve the delivery of antibiotics within an hour in patients with severe sepsis and monitor performance monthly
- integrate with other patient safety work streams to improve early decision-making and escalation for patients deteriorating from severe sepsis and other critical conditions
- integrated pathway of care
- continue to increase awareness and share experience regionally with second sepsis masterclass

How did we do?

The national CQUIN for Sepsis consisted of 2 parts: the first part was to ensure that 90% of all patients with a risk of sepsis were screened on admission. This was achieved in March 2016. The second part was to administer antibiotics in an hour in those patients admitted with severe sepsis or septic shock. We have improved the management of patients admitted with severe sepsis over the period 2015/16.

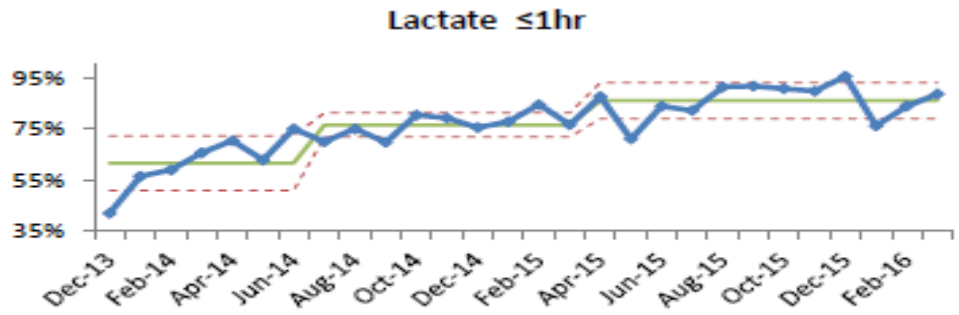
We improved the percentage of patients receiving antibiotics in an hour from an average of 51% of patients in March 2015 to an average of 65% of patients by end of March 2016 as outlined below.

Percentage of patients admitted with severe sepsis who receive antibiotics in an hour



Over 90% of these patients also had a blood 'lactate' taken, this is a key indicator to determine whether the patient has severe sepsis, helping to increase the speed with which we are able to identify these patients.

Percentage of patients admiited with severe sepsis who have a lactate taken within an hour



The improvement in antibiotics since the start of the campaign to increase awareness and improve early treatment in January 2014 has resulted in 331 more patients receiving antibiotics in an hour. Timely antibiotics are an essential part of treatment for severe sepsis and this improvement can be extrapolated to saving 82 lives over that time.

Links with community hospitals, southwest ambulance service and GPs have been further developed, supported by the West of England Academic Health Science network (WEAHSN). The aim has been to develop integrated pathways across all systems in the region and a recent AHSN regional meeting demonstrated the increased awareness of sepsis and use of screening tools in all areas.

The Trust co-hosted 2 sepsis master classes this year. In June 2015 the event focused on surgical sepsis and sepsis in the community and February 2016 a further event was hosted concentrating on paediatrics and maternal sepsis and was attended by national speakers. Both events featured a very powerful patient story.

During 2015/16 we have focused our work in surgery, maternity and paediatrics and have developed new systems to increase antibiotic delivery to patients on chemotherapy who become unwell. This involves the patients carrying a standard prescription for antibiotics, which can then be given to them immediately if they become unwell and require admission to hospital.

World Sepsis Day was celebrated in September 2015 with various training opportunities and sepsis promotions, as well as encouraging staff to tweet a *'Selfie for Sepsis'*, encouraging more widespread awareness.

The national CQUIN target for sepsis is continuing in 2016/17 and has been expanded to include sepsis screening for inpatients as well as on admission together with ensuring timely delivery and review of antibiotics in those patients receiving them. We plan to implement protocols to ensure sepsis screening is reliable for inpatients and achieve the CQUIN targets set

We plan to continue our work and further increase delivery of antibiotics in an hour to all patients with severe sepsis, but include data for inpatients and paediatric and maternity patients as well

New sepsis NICE guidelines are due to be published in July 2016 and training tools will be updated with the new guidelines. This will be promoted with a new awareness campaign, and we plan that a minimum of 80% of staff will receive the updated training by March 2017.

We would like to increase awareness of sepsis in the public and are planning a public awareness campaign on world sepsis day

We will continue to work with colleagues in the community and primary care to develop integrated pathways and common screening tools and work towards standardising processes across the region, with the continued support of the west of England Academic Health Science Network.

Priority 2: Improve the care of patients with diabetes

What we said we would do:

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

diabetic ketoacidosis are treated to nationally recognised best practice standards

- increase staff reporting of any errors in diabetes care and ensure that staff learn from all incidents

How did we do?

Given that approximately 20% of all inpatients in the RUH have diabetes and following the success of the Acute Diabetes Team (ADT) on Medical Assessment Unit, we rolled out the ADT to high density diabetes wards around the hospital; Surgical Assessment Unit, Acute Stroke Unit, Coronary Care Unit, Cardiac ward and Robin Smith ward in February 2015. This is a team of Diabetes Specialist Nurses, bringing expertise to the patient as not all our patients can be managed on a specialist diabetes ward.

Our intention was to improve efficiency and quality of diabetes care for patients by taking the specialist team to the patient and intervening before errors occurred.

The ADT attended the target wards each day and reviewed diabetes patients and created a care plan for their admission. They also coordinated discharge when appropriate.

The six month project involved 446 patients and spanned 5518 bed days.

The project was successful and delivered the results below. There were significant reductions in medication errors and hypoglycaemic rates. There were also large reductions in length of stay for diabetes patients in comparison to those on the same wards without diabetes. All of these are improvements in the care of our patients with diabetes.

Results on the 5 diabetes "high density" wards at 6 months

Aim at outset	Results at 6 months
Increase % of diabetes pts seen by ADT to 60-70%	85%
Reduce hypoglycaemic episodes by 50%	50% reduction
Reduce medication errors by 50%	36% reduction
Reduce average length of stay for patients with diabetes	Reduction of 3.5 days per patient on target wards
Increase qualification for Best Practice Tariff	> 50% uplift

A business case for the continuation of the project is being presented to the Board of Directors in May 2016.

A quality improvement project seeking to further improve patient safety in inpatients with diabetes is also being undertaken in 2015/16. This is being delivered with support from

quality improvement scientists in Salford hospital (Haelo) and the West of England Academic Health Science Network (WEAHSN).

Priority 3: Reduce the occurrence of Acute Kidney Injury (AKI)

What we said we would do:

- establish an AKI e-alert system (whereby if laboratory results indicate a potential case of AKI, this will be flagged to the patient's clinician
- establish a multidisciplinary Steering Group
- create an e-learning package
- implement a care bundle approach for the management of AKI
- raise awareness within the Trust
- raise awareness among our healthcare partners, including GPs
- reduce the incidence of AKI in hospital inpatients
- review the Trust's clinical guidelines

How did we do?

Acute Kidney Injury (AKI), previously referred to as acute renal failure, is a sudden and recent reduction in a person's kidney function and is not caused as a result of a physical blow to the body.

Up to 100,000 deaths occur each year in hospital associated with acute kidney injury. Evidence suggests that up to 30% could be prevented with the right care and treatment (NCEPOD. Adding insult to injury, 2009). Our aim for 2015/2016 was to improve early detection of AKI and prevent any further decrease in kidney function, improving outcome for these patients.

In May 2015 we established a multi-disciplinary steering group, which has played a vital part in driving improvement in AKI management. We established an alert for AKI, which will flag from analysis of blood results of kidney function and this went live in July 2015. This system now provides an immediate electronic identification of patients with AKI.

This also enabled us to be able to identify all patients with AKI and on average there are 64 inpatients a week at the RUH, of which 2/3 were admitted with an AKI. This is similar to national statistics.

We updated our guidelines for AKI and launched an awareness and training campaign called '**UR'INE TROUBLE**' in November 2015.

As part of this campaign we developed a simple 10-minute training package to improve management of AKI and by March 2016 over 500 clinical staff have been trained,

representing 25% of those needing the training. This was been achieved by holding AKI cafes and training events as well as taking the training to the staff using our 'tea – trolley' training methodology.

We have also identified AKI champions on many of the wards who will continue to deliver the training to their ward areas. The training has also been embedded annually in the induction programme for foundation doctors, in the monthly training drills for the maternity wards and the preceptorship programme for newly qualified nurses.

For further training we have linked in to the national Kidn-e elearning programme, which, was developed in partnership with the Royal College of Physicians. It is available free of charge, to all clinicians in the NHS. We encourage all of our Doctors, Medical staff and AKI champions to complete the online training for a more in-depth learning.

The training package raised awareness of AKI as well as educating staff about the interventions required to prevent further damage to the kidneys, which we have developed into an AKI bundle of care.

We have also undertaken some focused work on delivery of the AKI bundle and in January and February 2016; improvement has been seen in all aspects. In particular performing a medication review in 65% of patients compared to 40% baseline and Senior review in 87% patients compared to 60% baseline. A sticker has also been developed for the medication charts to alert staff that the patient has an AKI as well as development of safety magnets to increase awareness.

We have raised awareness of AKI amongst our healthcare partners across BANES and have improved information in the discharge summary for GPs, in particular with medication review being documented in 92% patients compared to a baseline of 15%. It is particularly important to raise awareness outside of the hospital as two thirds of our patients with AKI have developed the disease in the community. It is also important, as patients who have had an AKI are more likely to develop another AKI within the following year.

Priority 4: Discharge from hospital

What we said we would do:

- develop and implement multidisciplinary ward standards for discharge planning, and discharge
- working with patients and carers, develop a passport for discharge
- develop competencies in discharge and discharge planning for clinical staff
- involve patients and carers in the discharge process focusing on their ongoing needs
- ensure timely discharge of patients at the end of their life and who wish to die at

home

- assess the discharge process developed in collaboration with our community partners, patients and carers

How did we do?

This year we committed to improving the discharge planning process for patients in particular around the experience that patients have at the point that they leave hospital.

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

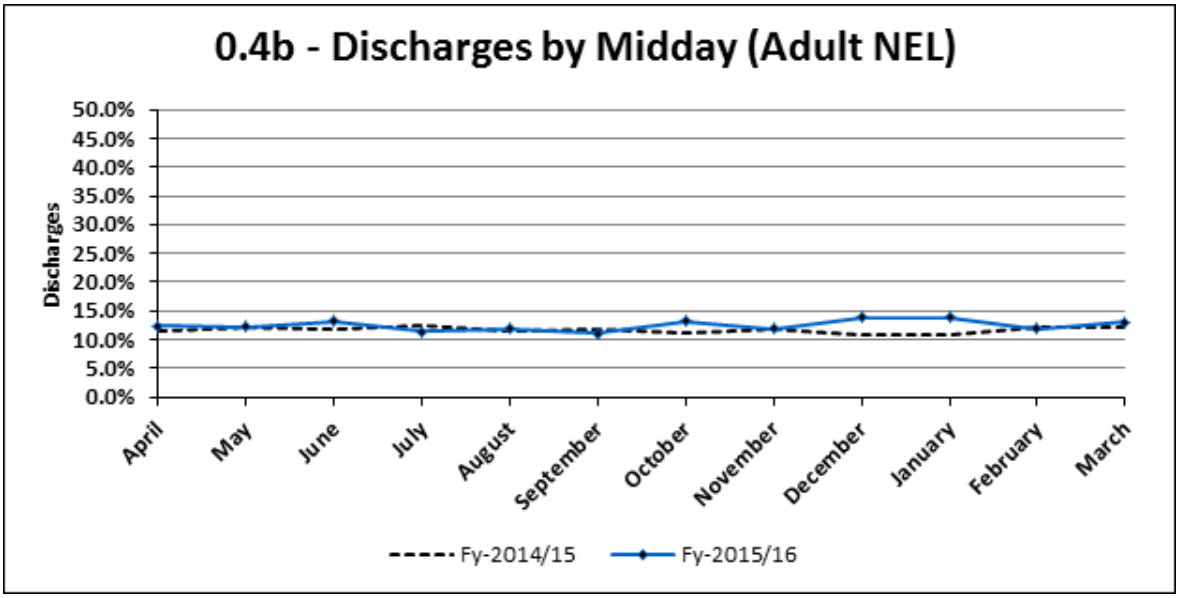
In July 2015 we held two patient and carer engagement events to understand their experiences of discharge and to also present to them the concept of a patient held discharge passport. These events have helped to shape the content and structure of the passport, which was rolled out across four pilot wards at the end of September 2015. A further patient and carer engagement event was held in February 2016 to review progress of the passport and its content prior to rolling it out onto more ward areas. Overwhelmingly the response to the passport from the patients and carers has been positive. A selection of comments from the February focus group showed that patients and carers felt:

- *Passport info very good.*
- *It was particularly interesting to see the amount of work that has gone into this project with first class results.*
- *The current version of the Discharge Passport, with minor modifications, is a very worthwhile document giving patient's greater involvement and confidence on leaving hospital.*
- *From previous meeting, all of discussed points have been taken into consideration.*
- *Impressed with the amount of effort put into this project.*

It is also especially important to ensure that discharge is timely and well managed. We have undertaken a number of activities to standardise the discharge process culminating in the introduction of "seven core standard for discharge planning"

1. *Follow the white board and ward round standards.*
2. *Work towards each patients estimated date discharge and time (EDDT)*
3. *Aim to discharge 30% of your total discharge by 12:00 hrs*

   For 2015/16 our year to date performance was 12.5% for non-elective patients against a baseline measure of 11.7%. The table below is the 2015/16 performance against the previous year:



4. *Always consider whether the discharge can be nurse /therapy led*
5. *All next day's discharge including potentials to be given to the site team by 16:00hrs*

   A number of temporary initiatives have been put in place during 2015/16 to communicate potential and confirmed discharges to the site team before 4pm. In March and April 2016 we had a phased launch of the Discharge Tracker Board. This is a function within Millennium, the system used by the RUH, where by patients who have a potential or a confirmed discharge for that day or the next day can be highlighted by the ward teams and communicated to the site team electronically. This process provides the site team with the numbers of potential and confirmed discharges on each ward as well as providing them with additional information about whether the patient is waiting for any part of the discharge process such as medication or transportation, it also provides the site team with an estimated time for the patients discharge. This system is currently being embedded across the Trust and compliance is being monitored.

6. *Always communicate the discharge plan with the patient, family and carers.*
7. *Keep the live bed board status up to date.*

We also committed to improving the coordination of discharge planning patients with end of their life care needs. To support this we have undertaken a survey to understand how confident staff feel about discharging patients nearing the end of their life. Consequently educational material has been developed including: Ambassadors for End of Life Care workshop on discharge planning and an End of Life Care eLearning module with a discharge planning case study. Resources have been developed to support ward staff (intranet and ward resource folder) with information on services available within the community and information to support coordination of discharge planning in end of life care.

A 'multidisciplinary discharge plan' has been developed to support coordination of discharge planning for CHC Fast Track and rapid discharge to preferred place of care. This is being rolled out for use across the wards. Working with our colleagues in the community, we have been able to try out new ways of working to ensure that patients who are nearing the end of their life and discharged on a Friday are proactively contacted by a GP (BaNES CCG). We have also commenced a pilot for completion of the Community Treatment Escalation plan document, which spans both BaNES and Wiltshire. Working with our community partners extends beyond patients being discharged nearing the end of their life. A project is underway to create an Integrated Discharge Service within the RUH; this project will lead to health and social care services from across BaNES, Wiltshire and Somerset working as one "integrated team."

Priorities for 2016/17

Priority 1: to continue to reduce the occurrence of Acute Kidney Injury (AKI)

Having raised awareness of AKI within the Trust and with our healthcare partners across BANES, we recognise that there is still more work to do and therefore will be continuing with this as a priority in 2016/17. This year, we plan to:

- Continue to embed AKI bundle of care and show improvement in delivery of each step.
- Spread improvement work to all areas
- Train 90% clinical staff with AKI teaching tool
- Decrease the incidence of the more severe cases of AKI (grade 2 and 3)
- Ensure GP communication occurs in all patients who have an AKI by embedding the electronic AKI alert automatically into discharge summary.
- Review fluid balance charts and hydration charts to further increase early detection of AKI
- Develop patient information leaflets
- Link with North Bristol Trust, Renal Centre to ensure AKI guidance is maintained and up to date

Priority 2: improve the outcomes for stroke patients

A stroke is a serious, life threatening medical condition that occurs when the blood supply to part of the brain is cut off. Strokes are a medical emergency and urgent

treatment is essential because the sooner a person receives treatment for a stroke, the less likely damage is to occur.

There are two types of strokes – ischaemic (clot) and haemorrhagic (bleed); about 85% of all strokes are ischaemic. Stroke occurs approximately 152,000 times per year in the UK; that is one every 3 minutes 27 seconds.

Around one in every four people who has a stroke will die within a year, and those who do survive are often left with long-term medical problems. Some people need to have a long period of rehabilitation following their stroke and may require support adjusting to living with the effects of their stroke.

There are approximately 650 acute stroke patients admitted to the RUH each year.

The RUH opened a dedicated 26 bedded Acute Stroke Unit (ASU) in 2011 and commenced seven day consultant input and seven day therapy support. D bay is a dedicated hyper-acute bay on the ward which manages newly diagnosed stroke patients and patients who have had thrombolysis (clot busting treatment for patients that have suffered a stroke and who meet the clinical criteria for treatment).

The Trust provides 24/7 ‘thrombolysis’, in the Emergency Department. This is further supported by the stroke team.

From April 2015, three dedicated stroke Medical Nurse Practitioners were a welcome addition to the team. These nurses are based both on the ward and also in-reach into the Emergency Department and Medical Assessment Unit. They assess patients as soon as they arrive in the Emergency Department and ensure that they follow the stroke pathway as efficiently as possible.

We aim to admit patients directly from the Emergency Department to the Acute Stroke Unit within 4 hours of arrival. We also aim to keep all stroke patients on the unit for their entire hospital admission.

The team also provides a well-established TIA clinic. This runs seven days per week, seeing high-risk patients within 24 hours and low risk patients within seven days.

Our aims for 2016/17

- To develop a second hyper-acute bay on the Acute Stroke Unit to ensure that there is always an admit bed on the ward for new patients and ensure that we make sure that men and women are provided with separate accommodation except where it is in the best interests of the patient clinically
- To build on the work previously undertaken with the local Clinical Commissioning Groups (CCG's) and community teams to improve the pathway for stroke patients to ensure swift and efficient discharge;
- To continue to partake in the data collection for the Stroke Sentinel National Audit Programme and see improvement in our performance;
- To work with the Cardiac and Stroke Network who are reviewing and developing the model of care for stroke thrombolysis and Hyper-Acute Stroke Units (HASUs) within the South West

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 table on the page overleaf 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.

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.

			2014/15				2015/16		
			Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
SSNAP Performance	Domain 2: Stroke Unit - level (team-centred)	RUH	D	D	D	E	C	D	C
	Domain 2: Stroke Unit - score (team-centred)	RUH	65.2	63.4	60.7	55.7	71.0	63.5	72.7
	2.1 Proportion of patients directly admitted to a stroke unit within 4 hours of clock start	RUH	49.6%	44.4%	43.2%	37.9%	57.4%	50.0%	63.0%
		National	58.0%	59.8%	56.9%	53.6%	58.7%	61.8%	59.8%
	2.2 Median time between clock start and arrival on stroke unit (hours:mins)	RUH	04:00	04:04	04:11	04:37	03:50	04:00	03:28
		National	03:36	03:33	03:41	03:49	03:36	03:28	03:35
	2.3 Proportion of patients who spent at least 90% of their stay on stroke unit	RUH	86.0%	85.7%	79%	79.3%	85.7%	80.5%	85.1%
		National	83.5%	84.3%	83.4%	82.1%	84.0%	86.1%	85.6%

Priority 3: to continue to improve the experience of patients and carers at discharge

Having made progress on improving the discharge planning process for patients in particular around the experience that patients have at the point that they leave hospital, we wish to continue and expand on this work for 2016 /17.

Our aims for 2016 /17 are:

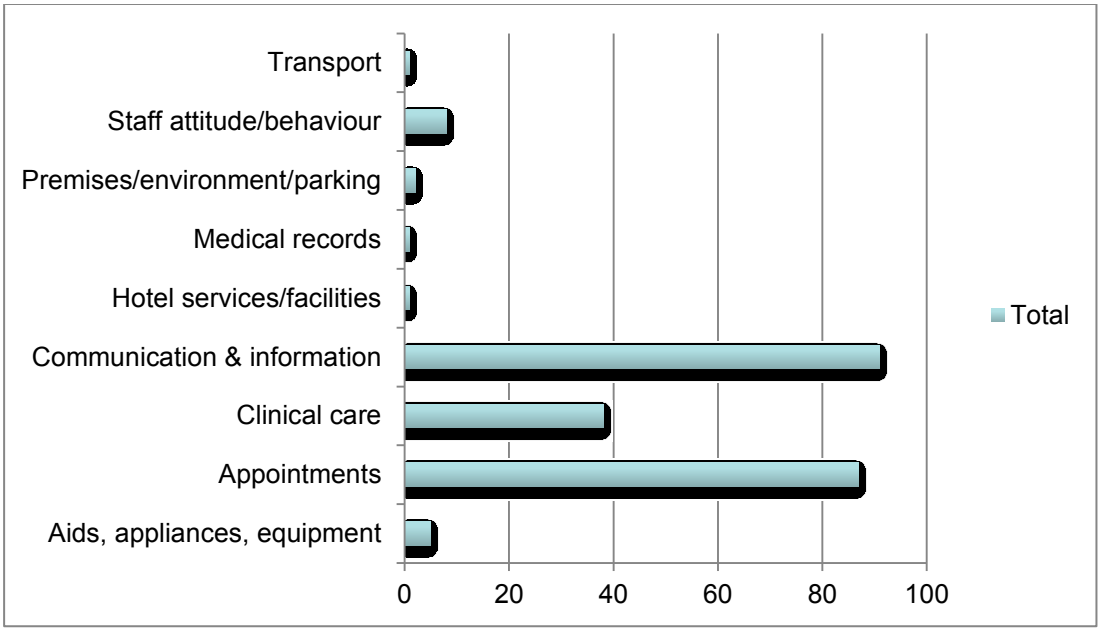
- Develop and cascade a training programme for staff around the essential elements that constitute the planning of a safe and timely discharge
- Improve the timeliness of medications to take home by proactively ordering medicines for patients due to be discharged and monitoring this through patient surveys

- Further develop cross boundary working within the Integrated Discharge Service
- Monitor patient outcomes in relation to discharge planning at the end of life
- Embed the multidisciplinary team discharge plan for patients at the end of life.

Priority 4: to improve our communication with patients and carers attending our Outpatient departments

Approximately, 360,000 patients attend outpatient appointments every year. Evidence from patient feedback demonstrates that the majority of concerns raised by patients regarding their outpatient appointment relates to our communication with them. The Trust received 91 enquiries between October to December 2015 via the Patient Advice and Liaison Service (PALS), of which 87 enquiries related to appointments.

In addition, the listening events (In Your Shoes) we held with patients when developing our values along with analysis of feedback about the RUH on NHS Choices identified better communication as a high priority for patients and carers.



The table above covers PALS contacts between October and December 2015.

The themes from the PALS enquiries reveal that patients struggle to get through by telephone to the relevant departments to arrange appointments (specifically the Pain clinic and Orthodontics during this sample timeframe). A proportion of PALS enquiries are due to patients finding that the appointment letters are not clear or that they receive multiple letters for one appointment.

Meridian surveys and Outpatient Friends and Family test results show that patients/carers are not always informed by staff on arrival about how long they will have to wait to be seen when attending their outpatient appointment.

Our aims for 2016/17:

Hold a week-long event termed ‘The Outpatient 15 steps challenge’ where each outpatient department will undertake an assessment with patient representatives of every aspect of the department. The “15 steps challenge” concept is derived from the NHS Innovation and Improvement’s productive care work stream. From car parking, signage and the welcome from the receptionist, to the level of clinical care provided during a consultation – the whole patient pathway during an appointment will be reviewed from a patient perspective. During the week, full support will be provided to the outpatient areas from estates and the information technology team to fix problems first hand.

- The findings from the 15 steps challenge event will be used to develop an improvement plan and this will be monitored through the Trust’s Outpatient Steering Group. Some actions may require hospital wide solutions – i.e. changes to car parking/signage/IT processes.

- Complete an outpatient accreditation programme, which will assess each outpatient department against a number of criteria (split into the 5 CQC domains) to promote uniformity between different outpatient departments.

- Launch the patient portal – a website for patients to view parts of their medical records and clinic correspondence.

- Begin the centralisation of the outpatient booking team functions that are currently split across the Combe Park and Royal National Hospital for Rheumatic Diseases (RNHRD) to improve access for patients who have appointment queries.

Part 5

Statements of Assurance from the Board

Mandatory Statement 1

During 2015/16 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 Royal United Hospitals Bath NHS Foundation Trust has reviewed all the data available to them on the quality of care in all nine relevant health services.

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 2015/16. 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

Mandatory Statement 2

During 2015/16, 31 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 Hospital Bath NHS Trust participated in 97% national clinical audits and 100% national confidential enquiries, of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Royal United Hospital Bath NHS Trust participated in, and for which data collection was completed during 2015/16 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
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)		
Acute Pancreatitis	Yes	100%
Mental Health in General Hospitals	Yes	Still ongoing
Mental Health conditions in young people	Yes	Still ongoing
Chronic Neurodisability (Cerebral Palsy)	Yes	Still ongoing
Acute		
Case Mix Programme	Yes	100%
Emergency use of oxygen	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	61.36% to date (based on estimated caseload)
National Joint Registry (NJR)	Yes	100%
Non-invasive ventilation (adults)	N/A	No data collection in 2015/16
Procedural Sedation (Adults) in ED	Yes	100%
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	83-100% (presented as a range by TARN)

Vital signs in Children (care in emergency departments)	Yes	100%
National Complicated Diverticulitis Audit (CAD)	N/A	Eligible to those trusts that were included within the initial cohort of patients identified during 2014/15 when the audit was not on the Quality Accounts list
Venous thromboembolism (VTE) risk in lower limb immobilisation (care in emergency departments)	No	Withdrew – implementation of policy after data collection closed
Blood and Transplant		
National Comparative Audit of Blood Transfusion programme: • Lower GI • 2016 Audit of Red Cell & Platelet transfusion in adult haematology patients	Yes (Red cell)	100% for Red Cell
Cancer		
Bowel cancer (NBOCAP)	Yes	100%
Lung Cancer (NLCA)	Yes	100%
National Prostate Cancer Audit	Yes	100%
Oesophago-gastric cancer	Yes	In progress (data collection closes 15 April 2016)
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	100%
Congenital heart disease (Paediatric cardiac surgery)	N/A	N/A
Coronary angioplasty	Yes	100%
National Adult Cardiac Surgery Audit	N/A	N/A
National Cardiac Arrest Audit (NCAA)	Yes	100%
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		
Adult Asthma	N/A	Not collecting data in 2015/16
Diabetes (Adult) includes National Diabetes Inpatient Audit	Yes	Commenced Jan 15 Bedside Audit questionnaires = 99 submitted Patient Experience questionnaires: 48 submitted
Diabetes (Paediatric)	Yes	100% (data submission for 2015/16 not yet open)
Inflammatory bowel disease	Yes	Participation through the PANTS study (awaiting data from the RCP)
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD)	Yes	100%
Renal replacement therapy (Renal Registry)	N/A	N/A
Rheumatoid and early inflammatory arthritis	Yes	100%
Mental Health		
Prescribing Observatory for Mental Health (POMH)	N/A	N/A
Older People		
Falls and Fragility Fractures Audit Programme	Yes	100%
Sentinel Stroke National Audit Programme	Yes	90%+
Other		
Elective surgery (National PROMs Programme)	Yes	Groin Hernia: 162 Hip Replacement: 259 Knee Replacement: 215 Varicose Vein: 17

		(only inpatients) (April 2015 – October 2015)
National Audit of Intermediate Care	N/A	N/A
National Ophthalmology Audit	Yes	Commenced (data collection closes August 2016)
Women's & Children's Health		
Paediatric Asthma	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric pneumonia	N/A	Not running until November 2016
Paediatric intensive care	N/A	N/A
UK Cystic Fibrosis Registry	Yes	100%

The reports of 17 national clinical audits were reviewed by the provider in 2015/16 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:

- **The NCEPOD report that reviewed deaths of patients admitted to ICU with Sepsis** was published in November 2015 with a number of recommendations with which the Trust is compliant. A specific audit of patients admitted to ICU with sepsis is currently being undertaken to compare with the data in the report.

- **Epilepsy 12:** The RUH achieved good compliance with the performance standards with the exception of referral to a specialist nurse. An epilepsy nurse has been appointed since the audit was completed which will enable compliance with this standard.

- **National Chronic Obstructive Pulmonary Disease (COPD) Audit:** Improvements in patient flow within the hospital would ensure a higher proportion of COPD patients are managed on the Respiratory ward and 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. Teaching through a number of forums (e.g. Medical Grand Round, F1 teaching, clinical guidelines etc.) will be rolled out to ensure trainees recognise the need for all COPD patients to have an initial ABG on admission and an appropriate ceiling of care in place.

- **National audit of inpatient falls:** The Trust met 23 of the 35 (67%) of the organisational standards required by Trusts. Areas for improvement included

access to safe footwear, evaluation of vision and assessment for fear of falling. Safe footwear was reviewed with funding for slippers provided through the Innovation Panel. Whilst this showed qualitative benefits and positive anecdotal reports no measurable benefit was found. It was suggested that through education and the Falls Leads we emphasise the importance of documenting the individual's visual impairment on the Falls and Mobility Care Plan. The 'fear of falls' assessment is now included on the hospital electronic patient record, Millennium.

- **National Hip Fracture Database:** The Trust was rated green for 12 of the 14 (86%) standards. Improvement was identified with regard to mortality 2011-13 (crude and casemix adjusted). The anaesthetists at the RUH have produced an Enhanced Recovery Framework for anaesthetic practice for hip fracture patients to standardise and improve anaesthetic care. The department has audited adherence to the framework and it is likely that this has contributed favourably to the improved hip fracture mortality rate.

- **National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis:** The Trust is slightly below the national level for referral to a Rheumatology service within three working days of the patient presentation to their GP (for patients with suspected persistent synovitis affecting the small joints of the hands or feet). We have included identifying early inflammatory arthritis (EIA) in a number of GP training days and will continue to flag this up as important to investigate and refer in a timely fashion.

The reports of 52 local clinical audits were reviewed by the provider in 2015/16 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:

- **Specific Learning Difficulties (SLD) Audit:** As a result of the audit findings, an initial 30-minute orthoptic appointment is booked prior to a new SLD appointment to filter out those with orthoptic issues as opposed to visual stress/tracking difficulties. A new timetable was in place in April 2016.

- **Acute Pain Service Observations:** The Acute Pain Service undertakes a yearly audit on the completion of the acute pain service observations on the patient's observation chart. Whilst performance has increased overall, the audit has highlighted the need to increase the understanding and awareness of observations for healthcare assistants and plans are in place to continue the study sessions. Attendance at the study sessions is now mandatory and attendance will be monitored by the Pegasus database. The weekly training sessions are also open to registered nurses and student nurses.

- **Infliximab (review) and adalimumab for the treatment of Crohn's disease Audit (NICE):** The Trust was not compliant in one area and that was in making sure patients are aware of the *'Understanding NICE guidance'* booklet. The department has reviewed the leaflet and it has been decided to use the leaflet and information about the drug produced by the national patient support group, Crohn's and Colitis UK, as it provides more comprehensive information about the

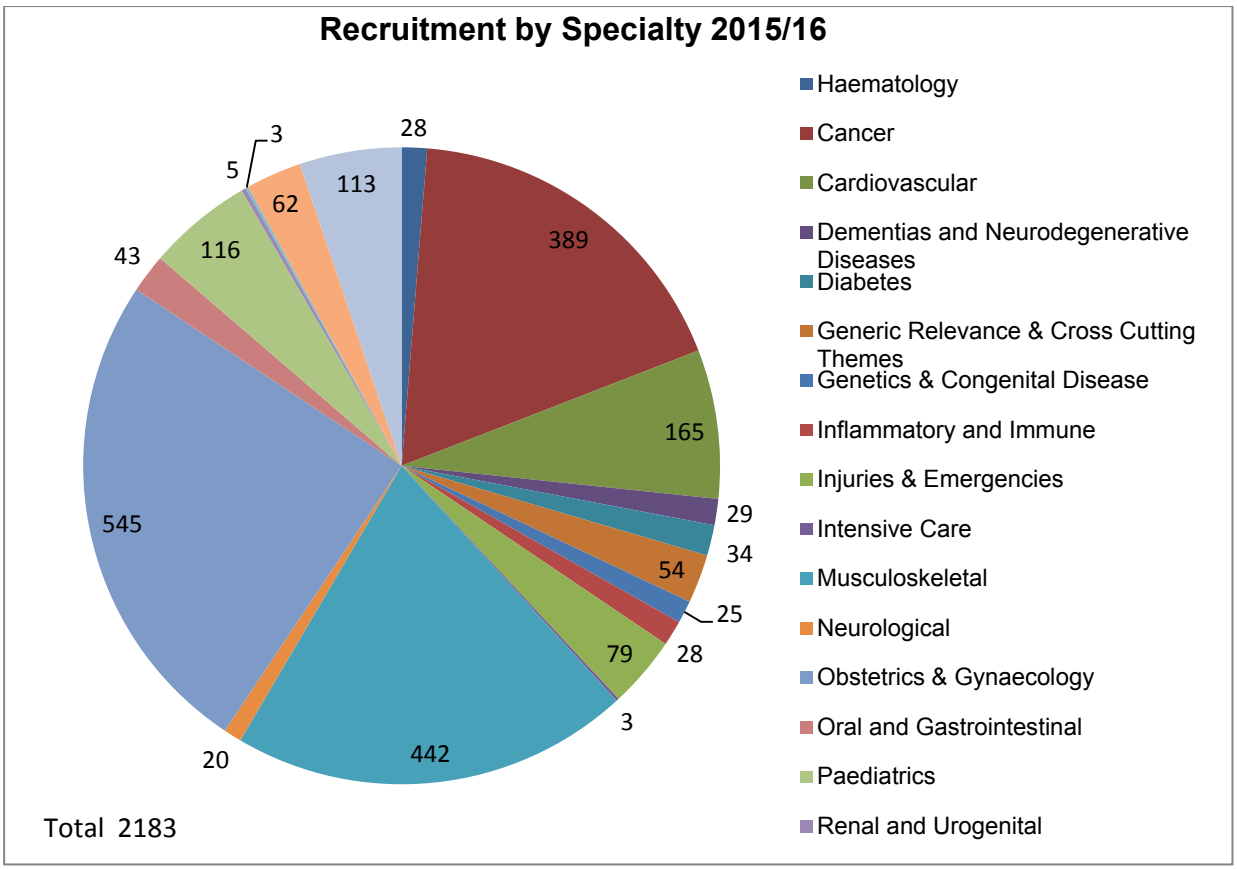
condition. All patients are given this leaflet.

- **Health Record Content Audit 2015/16:** The audit identified a number of areas for improvement in relation to record keeping. Training for staff has been updated to include the areas for improvement identified in the audit. An elearning training package on health records is also being developed.

- **Maternal and Neonatal Transfers from Midwifery Led Care to Consultant Care:** A poster has been created to highlight areas requiring improvement and promoting the use of Situation, Background, Assessment, Recommendation (SBAR). This includes recording that the reason for transfer has been discussed and consent obtained. The poster also includes information for the public on individual transfer rates and ambulance waiting times to enable patients to make an informed choice on the place of birth.

Mandatory Statement 3

The number of patients receiving relevant health services provided or sub-contracted by the Royal United Hospitals Bath NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was **2183.**



Research is essential in contributing to the Trust's commitment to provide high quality care. It is the ambition of Trust to see research taking place across the whole of RUH,

giving as many patients as possible the opportunity to be involved and to have access to treatments that would otherwise not be available to them.

There has been a continued increase during 2014-15 as in previous years, of the amount and complexity of research taking place across the entire organisation.

Within Rheumatology the focus for research during the year has been to ensure the most appropriate skill mix within the specialty to enable the team to maximise its patient involvement by allocating projects appropriately to members. A large multi-centre programme grant commenced and an initial preliminary qualitative project has been completed alongside a considerable amount of set up work to ensure the main trial starts well, later in 2016. A number of new commercial trials have been set up and the team successfully recruited to two trials in Connective tissue disease and Spondylarthropathy.

Research within cancer services continues to thrive and the past year has allowed a range of new research studies to open, including a large study to evaluate the national Prostate Cancer Survivorship Programme and other innovative treatment trials such as a study that utilises “hyperthermic” (heated) chemotherapy for bladder cancer, others using ground breaking gene profiling to match treatments to the different subtypes of cancer and numerous studies to improve outcomes and treatment options for leukaemia patients. Over 40 research projects run within this service per year and involve a number of national and internal academic collaborations.

The Chronic Fatigue/ME service continues to succeed with the award of a major National Institute for Health Research grant to evaluate the delivery of its specialist service to paediatric populations, not currently served by a specialist NHS service. Another trial hosted by the RUH also began this year to compare different types of treatment offered to these children and is collaborating with hospitals in Newcastle and Cambridge.

Our team of research midwives have been instrumental in supporting a large regional study aiming to determine which is the best drug to use to reduce the risk of excessive bleeding after childbirth. Over 400 women have volunteered for this study during the year at RUH and it is hoped that another 1000 women cared for at RUH will take part in this important study over the next 18 months. When known, the results of this study will directly influence the care of women across all of our birthing units.

The Pain service have continued to work on an international project establishing a core set of patient reported outcome measures (questionnaires), which will form a standard for use in research trials in the future. Further funding is being sought to progress this work. Development work to establish research across the acute pain services delivered on the RUH site combined with the more tertiary services provided at the RNHRD has been ongoing.

This year has also seen further growth of the research portfolio within Cardiovascular Disease, with specialists across both Cardiology and Stroke working together to improve the range of studies, and as such treatments available to the many patients treated here each year.

Research capacity within our Older Person's Unit has increased throughout the year. A number of Clinicians employed here at RUH also have Research Fellow positions at The University of Bristol and will be working to increase the research on offer to this important group of patients. Research is ongoing, and planned, for studies into slowing disease progression, diagnosis and reduction of falls for patients with Parkinson's disease and also trialling different drug treatments that may prevent bone fractures in older people when they fall. We have been an active partner of the national "Join Dementia Research" campaign, which allows people to register their interest in participating in dementia research and be matched to suitable studies, with the aim of improving knowledge and treatments for people living with dementia.

Grants often follow a 3-5 year cycle with staff obtaining grants, working on the projects for 2-4 years and then working to apply for further funding to follow on from grants that are due to end. Following a period of great success in terms of number of grant awards last year, 2015-16 saw a reduction in number, but nevertheless achieved significant success with the following applications made by members of RUH staff being awarded:

Dr Esther Crawley (Paediatric Chronic Fatigue) – £999,977.80 collaborative grant hosted by the University of Bristol - NIHR Health Technology Assessment grant 'Investigating the effectiveness and cost effectiveness of using FITNET to treat paediatric CFS/ME in the UK'. This study will evaluate the provision of specialist NHS services in a novel format for children with CFS/ME across England.

- **Dr Raj Sengupta (Rheumatology) -** £642,822 Collaborative grant hosted by University of Aberdeen from Arthritis Research UK. 'Do non-steroidal anti-inflammatory drugs (NSAIDs) reduce the appearance of sacroiliac joint bone marrow oedema on MRI, in spondyloarthritis?'

- **Dr John Pauling (Rheumatology)** - £25,000 to set up a regional South West Systemic Sclerosis network and registry. This network brings together clinicians treating patients and funds a registry, which will contribute to identifying patients wishing to partake in research.

- **Prof Candy McCabe (Pain) -** £23,415 University of the West of England, QR funding for Dr Alison Llwellyn 'Optimising the dissemination and impact of chronic pain research'

Further applications have been submitted and are awaiting a decision:

Dr William Tillett – (Rheumatology) Grant circa £175,000 studying function and radiological progression in patients with Psoriatic Arthritis (IMPAIR).

Dr Raj Sengupta (Rheumatology) Grant circa £245,000 studying prognostic markers in Spondyloarthritis. (PROMISE)

Prof Candy McCabe (Pain) Grant circa £50,000 evaluating the introduction of the Standard outcome measures for CRPS internationally and the development of an electronic capture tool.

James Willis (Cardiology) Grant circa £167,000 for a study will look at the non-invasive assessment of ischaemia. This NIHR Fellowship award was submitted and the

interview stage but was not awarded on this occasion. On a very positive note it was requested that the application be re-submitted, planned for April 2016.

It is well recognised that people who participate in research often have better outcomes and improved experience, and this extends to patients treated in research active hospitals. Offering wide ranging opportunities for patients to take part in research allows us to gather data and evidence that could potentially change practice, which will lead to further improvements in the quality of care that we can offer to our local community.

Mandatory Statement 4

A proportion of the Royal United Hospitals Bath NHS Foundation Trust's income in 2015/16 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. This year, it is anticipated that the Trust will receive £5.4m in CQUIN payments out of a possible £5.6m, which represents 96% achievement.

Mandatory Statement 5

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 2015/16.

Mandatory Statement 6 was removed from the Regulations in 2011.

Mandatory Statement 7

The RUH has not participated in any special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission undertook an announced inspection of the Trust in March 2016. At the time of writing this report, we have not received the outcome from the inspection.

Mandatory Statement 8

The Royal United Hospitals Bath NHS Foundation Trust submitted records during 2015/16 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 99.9

% 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 outpatient care 100

% for accident and emergency care 100

*Based on Provisional April 2015 to January 2016 SUS Data at the Month 10 Inclusion Date

Mandatory Statement 9

Royal United Hospitals Bath NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was 88% 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.

Mandatory Statement 10

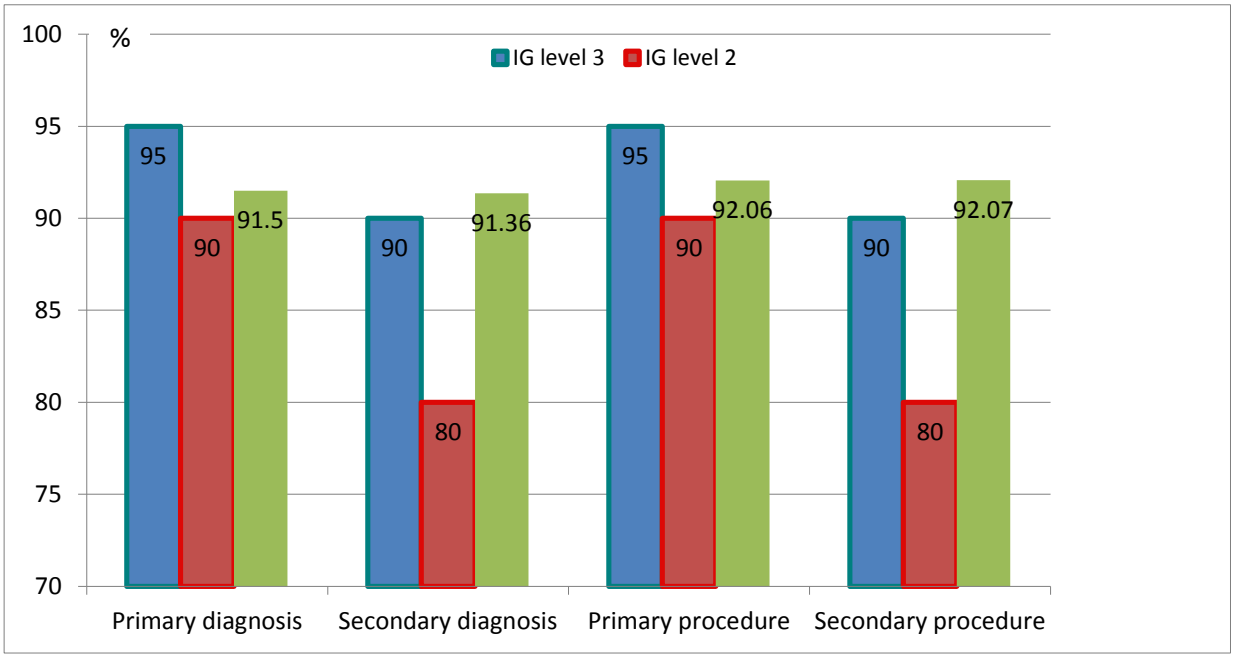
Clinical coding translates the medical terminology written in a patient's health record describing a patient's diagnosis and treatment into a standard, recognised code. The accuracy of this coding is a fundamental indicator of the accuracy of the patient's records and underpins payments and financial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

The 2015/2016 Clinical Coding audit report was commissioned by the Head of Clinical Coding in order to comply with Information Governance (IG) requirement standard 12-505. It is a summary of coded data at Royal United Hospitals, Bath NHS Foundation Trust comprising 200 consultant episodes from a variety of specialties audited during the period 1st April 2015 to 31st December 2015.

The audit was carried out by the Head of Coding and the Professional Lead who are both HSCIC approved auditors, and it is a combined result of several different audits undertaken throughout the year as part of the department's rolling internal coding audit program.

The Royal United Hospitals Bath NHS Foundation Trust was not subject to the Payment by Results Clinical Coding audit by the Audit Commission during this reporting period.

The diagram on the following page indicates the percentage of accuracy of coded data achieved at RUH compared to the accuracy levels required to meet IG standards.



The RUH Clinical Coding audit for 2015/2016 achieved IG standard level 2.

Correct Primary Diagnoses (%)	Correct Secondary Diagnoses (%)	Correct Primary Procedures (%)	Correct Secondary Procedures (%)
91.50	**91.36**	**92.06**	**92.07**

Mandatory Statement 11

The Royal United Hospitals Bath NHS Foundation Trust will be taking the following actions to improve data quality:

Continue to embed the use of the Data Quality Assurance Framework implemented during 2015/16 as a way of assessing the quality of information reported to the Board. This process assigns a confidence rating to Monitor's key performance standards based on the outcome and frequency of data quality audits.

Continue to incorporate Data Quality in the Internal Audit Programme, ensuring that the quality of information remains a high priority for the Trust.

Continue the work of the Data Quality Steering Group, which meets regularly to oversee data quality within the Trust. The group monitors data quality issues and receives the outcomes of audits and external data quality reports to support resolution of issues and improvement work. The meetings are attended by staff from the information department and staff working in operational roles to make sure that the Trust maintains high quality and accurate patient information to support patient care.

Part 6 – Review of Quality Performance

This section of our Quality Accounts provides an overview of the quality of care we provided in 2015/16. 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.

In consultation with stakeholders, the Board has selected three indicators from 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.

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.

Patient safety

The three patient safety indicators are:

1. Falls
2. Infections
3. Pressure ulcers

Falls

	Trust local target	2015/16 Performance	Did we achieve in 2015/16 against our target?	2014/15 Performance
Falls assessment completed within 24 hours (average per month)	95%	96.1%	✓	96.8%
Number of falls resulting in harm (average per month)	1	3	✗	1
Falls resulting in harm per 1000 bed days	N/A	0.15	N/A	0.05

We are confident that the data we use to monitor falls is an accurate way of looking at falls within our organisation. Falls resulting in harm relates to those categorised as moderate and above. Falls assessments are completed on our Patient Administration System and monitored by our senior nursing team. When falls occur they are reported via our incident reporting tool, and are monitored through our falls group, with the learning shared across the organisation. The rate of falls resulting in harm at the Trust is below the National Patient Safety Association (NPSA) benchmark.

We have a Falls group in place to monitor all falls within the Trust. This includes reviewing the results of all root cause analyses conducted to investigate falls that have occurred. This process is used to learn from incidents, identify themes and trends and look for potential improvements. During 2015/16 we rolled out a Falls bundle, a suite of documentation to highlight those most at risk, which has now been in place since September 2015. Falls leads have been identified on all wards, and they are supported by a Quality Improvement Facilitator and a Senior Nurse.

Infections

		RUH Target (National)	2015/16 Total[1]		Have we improved on 2014/15 (actual cases)?	2014/15 Total[2]		Did we achieve in 2014/15 against our national target?	Were we better than the 14/15 national rate in 15/16? (actual cases)[3]
			Reported	Actual		Reported	Actual		
Clostridium difficile	Total infections	22	58	31	✗	29	27	✓	N/A
	Rate per 100,000 bed days	10.9	25.8	13.8	✗	13.5	12.6	✓	✓
MRSA	Total infections	0	3		✗	2		✗	N/A

1. In 2015/16 we reported 58 cases of Clostridium difficile, however 22 of these have since been found not to be attributable to the Trust. At the time of reporting 5 are still awaiting the outcome of review or appeal by the CCG's. Because of this both reported and actual figures are shown above.

2. In 2014/15 we reported 29 cases of Clostridium difficile; however 2 of these cases were not Trust attributable. The nationally published rate per 100,000 bed days is based on the number reported instead of the actual, as this has been calculated using the total number of reported cases.

3. National data is not yet available for 2015/16, but we can compare ourselves to last year to give an idea of where we are nationally. This has been done based on the actual number of Trust attributable cases to date, and so could change once we know the outcome of the cases under review or appeal. The national rate for 14/15 was 15.1.

We are confident that our data on infections is accurate. Mandatory surveillance is undertaken by the Trust for blood stream infections caused by MRSA, MSSA and 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.

In the coming year we will continue to take forward improvement actions identified during a peer support review of Clostridium difficile infections that took place this year. The Trust invited this review to look at how infections are managed and to identify possible learning and actions. Feedback from the peer review team was overall very positive and the Trust was commended on the work around Clostridium difficile. The team helpfully identified areas where the Trust could go even further such as the strengthening of antimicrobial stewardship, targeted training for clinical staff on the management of patients with the infection, improvements in environmental cleaning and adopting a whole health economy approach to improve clinical effectiveness.

We are disappointed to have had 3 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. A new risk assessment for patients who are at high risk of having MRSA has been developed and this is implemented at the point of admission. All high risk patients are treated as though they have MRSA until their initial screening results are known. This initiative was commenced on December 2015 and there have been no further Trust apportioned cases since then.

Pressure Ulcers

		2015/16					2014/15		2013/14	
		2015/16 Trust local target	2015/16 Total	2015/16 Average per month	Did we achieve in 2015/16 against our local target?	Have we improved on 2014/15 in 2015/16?	2014/15 Total	2014/15 Average per month	2013/14 total	2013/14 Average per month
Grade two	Grade two	24	27	2	✗	✓	31	3	191	16
	Device related	N/A	23	2	N/A	✗	15	1		
	Total	N/A	51	4	N/A	✗	46	4		
Grade three		0	1	0	✗	✓	4	0	12	1
Grade four		0	0	0	✓	The Same	0	0	3	0

Performance against our target for Grade 2 pressure ulcers was on track until February this year, when there was a slight increase in the number of pressure ulcers. However, whilst the target for Grade 2 pressure ulcers was not met in 2015-2016, the Trust achieved a further 13% reduction in the number of avoidable hospital acquired pressure ulcers from 31 in 2014-15 to 27 in 2015-16.

A programme of work was put in place in 2014-2015 called 'Rapid Spread'. This programme aimed 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.

The Rapid Spread work led to significant reductions of avoidable hospital acquired pressure ulcers over the last 2 years. The second phase of the project in 2015-2016 focused on further reducing avoidable pressure ulcers and re-invigorating the work of the programme.

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.

Clinical effectiveness

The three clinical effective indicators are:

1. Sepsis
2. Cancer access targets
3. Hospital Standardised Mortality Ratio (HSMR)

Sepsis

		2015/16					Have we improved on 2014/15?	2014/15
		Q1	Q2	Q3	Q4	Total		
Percentage of patients with antibiotics given and lactate measured within one hour	Performance	61%	61%	65%	66%	60%	✓	48%
	Did we meet our CQUIN target?	✓	✓	✓	✓	N/A	N/A	✓
Screening[1]	Performance	39%	70%	81%	90%	70%	N/A	
	Did we meet our CQUIN target?	✓	✓	✓	✓	N/A		
Percentage of patients with the sepsis proforma completed[2]	Performance	66%	71%	75%	77%	73%	✓	73%
	Did we meet our CQUIN target?	N/A	N/A	N/A	N/A	N/A	N/A	

1. The sepsis screening measure was only introduced in 2015/16 as part of the National CQUINs. Because of this, data is only available from Q1 15/16 onwards.

2. The percentage of patients with the sepsis proforma completed was not a CQUIN in 2015/16.

Sepsis is one of our Quality Account priorities for 2015/16; further detail on our sepsis work is detailed on page 87.

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 targets

		Royal United Hospitals Bath NHS Foundation Trust							National
	Measure	Target	2015/16 RUH Total	Did we achieve in 15/16?	2014/15 RUH Total	Did we achieve in 14/15?	2013/14 RUH Total	Did we achieve in 13/14?	2015/16 National total [1]
Two week wait	From GP referral to 1st outpatient appointment	93.0%	93.3%	✓	93.7%	✓	95.5%	✓	93.9%
	From GP referral to 1st outpatient appointment - breast symptoms	93.0%	86.6%	✗	95.1%	✓	97.3%	✓	93.0%
31 day wait	From diagnosis to first treatment for all cancers	96.0%	99.5%	✓	98.4%	✓	99.2%	✓	97.6%
	From diagnosis to subsequent treatment - surgery	94.0%	99.7%	✓	98.0%	✓	97.9%	✓	95.6%
	From diagnosis to subsequent treatment - drug treatments	98.0%	100.0%	✓	100.0%	✓	100.0%	✓	99.5%
	From diagnosis to subsequent treatment - radiotherapy treatments	94.0%	99.9%	✓	99.0%	✓	99.9%	✓	97.5%
62 day wait	From urgent referral to treatment of all cancers	85.0%	89.6%	✓	90.0%	✓	89.9%	✓	82.4%
	From referral to treatment from a screening service	90.0%	96.3%	✓	97.0%	✓	91.7%	✓	93.4%

1. National data is not yet available for the full 15/16 year, national totals are for the period April 2015 to Jan 2016.

We did not achieve our target for the two week wait breast symptomatic target in 2015/16. We maintained performance against the target until December 2015, when our capacity to see all referrals within the two week timeframe was impacted by staffing. This affected breast symptomatic patients, but has not affected patients with suspected cancer. Patients are clinically triaged, and any referred as urgent suspected cancer or any upgraded at triage are offered an appointment within two weeks and are managed against the two week wait suspected cancer target.

Actions were taken to run additional sessions in the week and at weekends, as well as recruiting to posts to increase staffing levels.

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. Our reporting process and data quality were audited in May 2015 as part of the 2014/15 Quality Accounts, and has been subject to review as part of our Internal Audit Programme. We also use a range of reports to monitor and manage patient pathways with our cancer team.

Hospital Standardised Mortality Ratio (HSMR)

			2015/16		2014/15		2013/14	
		National Average	April to December		April to March		April to March	
			HSMR value	Were we within expected range?	HSMR value	Were we within expected range?	HSMR value	Were we within expected range?
HSMR	Overall	100	95.7	✓	101.9	✓	99.7	✓
	Weekday	100	94.1	✓	100.9	✓	98.1	✓
	Weekend	100	100.4	✓	105.1	✓	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 of this year.

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 HSMR values for April to December this year

are within the expected range for overall, weekday and weekend mortality rates. We were also within the expected range in 2014/15 and 2013/14.

Patient experience

The **four** patient experience indicators are:

1. Referral to Treatment (RTT)
2. Patient Surveys
3. Friends and Family Test (FFT)
4. Emergency Department – Four Hour waiting times

Referral to Treatment (RTT)

	Royal United Hospitals Bath NHS Foundation Trust							National
Measure	**Target**	**2015/16 RUH Total**	**Did we achieve in 15/16?**	**2014/15 RUH Total**	**Did we achieve in 14/15?**	**2013/14 RUH Total**	**Did we achieve in 13/14?**	**2015/16 National total [2]**
Admitted patients (inpatients) treated within 18 weeks of referral[1]	N/A	61.7%	N/A	85.8%	✗	89.4%	✗	87.2%
Non-admitted patients (outpatients) treated within 18 weeks of referral[1]	N/A	91.8%	N/A	94.1%	✗	96.0%	✓	94.1%
Incomplete pathways - patients waiting no longer than 18 weeks for treatment	92.0%	91.7%	✗	92.3%	✓	93.2%	✓	92.6%

1. There was a change to the national waiting time standards for referral to treatment in August 2015, which led to the admitted (inpatients) and non-admitted (outpatients) indicators no longer being monitored against a target. Performance for 2015/16 is reported here for completeness.

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

The Trust failed to achieve the incomplete pathways target in 2015/16. Performance was maintained until December 2015, when the Trust began to experience significant pressures. The failure of the target was agreed in advance with the Trust's commissioners, as increased pressure was anticipated moving into the winter months.

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 and referral to treatment data for open pathways (patients not yet treated) have been audited as part of the 2014/15 and 2015/16 Quality Accounts. Our patient pathways are subject to thorough checking by a dedicated validation team, and we have a range of reports available to monitor and manage patient pathways on a daily basis.

Patient Surveys

National Children's Inpatient and Day Case Survey – 2014

		Comparison with other Trusts	
Measure	**Number of questions**	**% of questions better than average**	**% of questions worse than average**
Going to hospital	4	0%	0%
The hospital ward	8	13%	0%
Hospital staff	21	10%	0%
Facilities for parents and carers	3	33%	0%
Pain	2	0%	0%
Operations and procedures	5	0%	0%
Leaving hospital	8	25%	0%
Overall	8	50%	0%

We are confident that our patients have been given the opportunity to take part in the National Children's Inpatient and Day Case 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 confidential. 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.

There were 327 patients discharged in August 2014 that were eligible to be surveyed, and we had a response rate of 31.5%. This covered patients aged 15 and under (with parents surveyed for patients aged 0-7 years).

Overall, 96% of parents rated care 7 or more out of 10 and 89% of children and young people rated care 7 or more out of 10. The Trust was amongst the **best performing Trusts on 7 questions –** parents saying they felt that their child was safe on the ward; staff were friendly, introduced themselves and treated the parents/child with respect and dignity. Parents also said that they were not told different things by different people and children said that knew what to do when they left hospital.

There **were no questions where the Trust was in the worst performing category.**

Areas identified for improvement relate to the upgrading of facilities for adolescents and a review of the food available for children and not being given a choice of date for their planned admission.

National Inpatient Survey – 2014

Measure	2014 RUH Overall Score	Number of aspects of care surveyed	Comparison with other Trusts		
			Overall section comparison	% of areas better than average	% of areas worse than average
Overall experience of being an inpatient	8.3/10	1	Same	0%	0%
Overall views of care and services	5.5/10	4	Same	0%	0%
The emergency/A&E department	8.5/10	2	Same	0%	0%
Waiting lists and planned admissions	9.1/10	3	Same	33%	0%
Waiting to get to a bed on a ward	7.9/10	1	Same	0%	0%
The hospital and ward	8.2/10	11	Same	9%	0%
Doctors	8.9/10	3	Same	0%	0%
Nurses	8.5/10	4	Same	0%	0%
Care and treatment	7.8/10	10	Same	0%	0%
Operations and procedures	8.5/10	6	Same	0%	0%
Leaving hospital	7.4/10	15	Same	0%	0%

We are confident that our patients have been given the opportunity to take part in the National Inpatient 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 confidential. 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.

There were 850 patients discharged between September 2014 and January 2015 that were eligible to be surveyed, and we had a response rate of 51%.

There were **no questions where the Trust had significantly scored significantly lower in 2014 compared to 2013.**

Areas for improvement identified this year include reviewing and monitoring the cleanliness of wards and bathrooms, ensuring patients are given enough privacy when being examined and making sure that staff encourage patients to speak up if they are worried about any aspect of their care.

National Maternity Survey – 2015

	Measure	Number of questions	Comparison with other Trusts: Overall section comparison	% of questions better than average	% of questions worse than average
Antenatal[1]	The start of your care in pregnancy	2	Same	0%	0%
	Antenatal check-ups	5	Worse	0%	40%
	During your pregnancy	5	Same	0%	0%
Labour and birth	Labour and birth	4	Same	0%	0%
	Staff	8	Same	25%	0%
	Care in hospital after the birth	7	Same	0%	0%
Postnatal[1]	Feeding	3	Same	33%	0%
	Care at home after birth	16	Same	0%	13%

1. Due to the nature of maternity services, women may receive antenatal and postnatal care from other providers, therefore responses for these sections of the survey may not all relate to the Royal United Hospitals Bath NHS Foundation Trust.

We are confident that our patients have been given the opportunity to take part in the Care Quality Commission (CQC) National Maternity 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 confidential. 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.

There were 340 patients eligible to be surveyed, and we had a response rate of 47%.

The survey showed that the Trust scored:

- **Better** on 3 questions
- **Worse** on 4 questions
- **About the same** on 43 questions

In the section on labour and birth, the RUH scored **better on 2 questions**. In particular, we were pleased that mothers said that they were treated with respect and dignity and that they had confidence and trust in the staff caring for them during the labour and birth. The other question where the Trust performed well was that midwives and other health professionals gave active support and encouragement to mothers to breastfeed their babies.

There were **two questions in particular** where the Trust scored **'in the worse performing'** category and these related to antenatal care and midwives listening to mothers and being aware of their medical history.

There were **two questions** where the Trust scored in the **'worst performing category'** for postnatal care and these relate to the midwives awareness of the mother's medical history and that of the baby and mothers being given information about contraception.

Friends and Family Test (FFT)

			Royal United Hospital			National	
Measure			**2015/16 RUH Total**	**Have we improved on 2014/15?**	**2014/15 RUH Total [1]**	**How do we compare to National?**	**2015/16 National total [2]**
Inpatients	**Response rate**		21.6%	✗	44.7%	✗	24.9%
	Percentage of patients that would recommend the RUH to friends and family		97.0%	✓	96.4%	✓	95.0%
A&E	**Response rate**		11.3%	✗	20.2%	✗	14.0%
	Percentage of patients that would recommend the RUH to friends and family		96.0%	✗	97.5%	✓	88.0%
Maternity	**Antenatal care**	**Percentage of patients that would recommend the RUH to friends and family**	94.0%	✗	97.1%	✓	88.0%
	Birth	**Response rate**	24.4%	✓	21.7%	✓	22.6%
		Percentage of patients that would recommend the RUH to friends and family	97.0%	✗	99.4%	**About the same**	97.0%
	Postnatal ward	**Percentage of patients that would recommend the RUH to friends and family**	98.0%	**About the same**	97.4%	✓	94.0%
	Postnatal community provision	**Percentage of patients that would recommend the RUH to friends and family**	99.0%	✓	97.4%	✓	98.0%
Outpatients	**Percentage of patients that would recommend the RUH to friends and family**		94.2%	-	-	✓	92.0%

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.

The Outpatient FFT was only introduced in 2015/16, so historic information is not available for this measure.

2. The latest published data is only available up to January 2016, so 2015/16 national performance is currently April 2015 to January 2016 only.

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.

The Trust has seen a decline in the FFT response rate this year and is working with matrons and ward managers to improve the response rates over the coming months.

Emergency Department – Four Hour waiting times

	Royal United Hospitals Bath NHS Foundation Trust							National
Measure	**Target**	**2015/16 RUH Total**	**Did we achieve in 15/16?**	**2014/15 RUH Total**	**Did we achieve in 14/15?**	**2013/14 RUH Total**	**Did we achieve in 13/14?**	**2015/16 National total [2]**
Patients attending the Emergency department waiting a maximum of four hours before a decision is made to treat, admit or discharge - All Types - Including the Urgent Care Centre [1]	95.0%	86.9%	✗	91.4%	✗	N/A	N/A	93.3%
Patients attending the Emergency department waiting a maximum of four hours before a decision is made to treat, admit or discharge - Type 1 - Emergency Department only	95.0%	84.7%	✗	90.5%	✗	93.7%	✗	90.0%

1. In 2014/15 the Urgent Care Centre opened alongside our Emergency Department. Since the beginning of 2015/16 we now report 'all types' (including Urgent Care Centre) performance as standard.

2. 2015/16 national data for the full year is not available yet, so national totals are to the end of Q3 only.

We have experienced significant non-elective pressures during 2015/16, with performance being affected by high demand for services. Increases in attendances within the Emergency Department and pressures with bed availability have contributed to difficulties either admitting or discharging patients within the four hour timeframe.

We have implemented three key workstreams during the year to try and improve patient flow, a key contributor to these pressures. The Front Door workstream has focused on actions to increase ambulatory care pathways, avoiding admission, and the Specialities workstream to improve pull from the front door into speciality areas, increasingly flow and reducing overall length of stay. Finally a Discharge Project which aims to improve processes both internally and externally through working with our community partners with the establishment of an integrated approach to discharge. In addition the RUH has supported 'Home for Christmas' and 'Home for Easter' campaigns, looking at supporting patients to be discharged prior to times where we know demand for services will be higher.

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. Our Accident and Emergency waiting time measures were audited in September 2015 as part of the Trust's Internal Audit Programme.

Measure	**Were we compliant in 2015/16?**	**Were we compliant in 2014/15?**
Access to healthcare for patients with learning disabilities	✓	✓

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.

Core indicators

Preventing people from dying prematurely

Summary Hospital Mortality Indicator (SHMI)

Measure		Latest Reporting Year	RUH Performance		National Average	National Best	National Worst
			Oct 14 - Sep 15	Jul 14 - Jun 15	Oct 14 - Sep 15		
Summary Hospital Level Mortality Indicator (SHMI)	Value	2015/16	0.97	0.97	1.00	0.65	1.18
	Banding	2015/16	2	2	2	3	1
	% of Patient Deaths with Palliative Care Coding	2015/16	21.5%	20.3%	26.6%	0.2%	53.5%

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 therefore this measure is not calculated by the Royal United Hospital.

SHMI is reported as a 12 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 helps to show whether mortality is within 'expected' range based on statistical methodology. There are three bandings applied, with a banding of two indicating that mortality is within expected range. The Trust has a banding of two, meaning that mortality levels are not significantly higher or lower than expected.

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

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 in section three 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

Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures (PROMs) assess the quality of care provided to patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

The four procedures are:

- hip replacements
- knee replacements
- groin hernia
- varicose veins

PROMs have been collected by all providers of NHS-funded care since April 2009.

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

Measure		Latest Reporting Year	RUH Performance		National Average	National Best	National Worst
			Apr 15 - Dec 15	Apr 14 - Mar 15	Apr 15 - Dec 15		
PROMS: Patient reported outcome measure	Groin Hernia - EQ VAS	2015/16	-	-0.79	-0.80	4.79	-6.61
	Groin Hernia - EQ-5D Index	2015/16	-	0.08	0.09	0.16	0.00
	Hip Replacement Primary EQ VAS	2015/16	-	11.97	12.04	18.95	4.06
	Hip Replacement Primary EQ-5D Index	2015/16	-	0.43	0.45	0.54	0.27
	Hip Replacement Primary Oxford Hip	2015/16	-	21.00	21.93	24.78	16.54
	Hip Replacement Revision EQ VAS	2015/16	-	6.63	5.36	-	-
	Hip Replacement Revision EQ-5D Index	2015/16	-	0.28	0.29	-	-
	Hip Replacement Revision Oxford Hip	2015/16	-	13.40	13.20	14.91	10.21
	Knee Replacement Primary EQ VAS	2015/16	-	5.96	5.51	12.18	-0.55
	Knee Replacement Primary EQ-5D Index	2015/16	-	0.31	0.33	0.40	0.22
	Knee Replacement Primary Oxford Knee	2015/16	-	17.66	12.17	20.29	12.44
	Knee Replacement Revision EQ VAS	2015/16	-	-	0.23	-	-
	Knee Replacement Revision EQ-5D	2015/16	-	-	0.27	-	-
	Knee Replacement Revision Oxford	2015/16	-	-	11.12	-	-
	Varicose Vein Aberdeen Varicose Vein	2015/16	-	-	-8.95	0.25	-19.13
	Varicose Vein EQ VAS	2015/16	-	-	-0.07	3.58	-5.62
	Varicose Vein EQ-5D Index	2015/16	-	-	0.10	0.15	0.04

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.

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

Historically the Trust scoring against this measure has been within expected range (above national average) for the majority of areas. Because of this, no specific improvement actions have been identified. However, the Trust intends to continue to improve against this measure in 2015/16.

There are three different measures included in PROMS, the EQ VAS, EQ-5D Index and Oxford hip and knee scores. The 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 Oxford Hip and Knee scores relate specifically to the patient's condition and therefore are a particular area of focus for the Trust when monitoring PROMS results.

The Trust will continue to review performance against PROMS measures when more recent data becomes available.

Readmissions

Measure		Latest Reporting Year	RUH Performance		National Average*	National Best*	National Worst*
			Apr 15 - Dec 15	Apr 14 - Mar 15	2011/2012		
Patient readmitted to a hospital within 28 days of being discharged	0-15 years old	2015/16	8.98%	8.88%	**8.15%**	0.00%	**13.58%**
	16 years or over	2015/16	7.50%	8.23%	**10.02%**	0.00%	**13.50%**

* Medium Acute Trusts

The Royal United Hospitals Bath NHS Foundation Trust 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 national average, best and worst figures for these measures are different to the time periods used for the RUH performance, and due to the amount of time between the two 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 intends to take or has taken the following actions to improve this performance, and so the quality of its services, by:

We are pleased to note that the adult re-admission rate has shown an improvement so far this year. 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.

Ensuring people have a positive experience of care

Responsiveness to the needs of patients

Measure		Latest Reporting Year	RUH Performance		National Average	National Best	National Worst
			2014/15	2013/14	2014/15		
Responsiveness to the Personal needs of Patients	Inpatient Overall score	2014/15	78.5%	76.6%	76.6%	87.4%	67.4%

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 patient responses to the National Inpatient Survey. The list of patients was 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 2015 National Inpatient Survey have not yet been released; therefore the latest available surveys have been included. These relate to the 2013 and 2014 inpatient surveys.

The overall score uses the results of a selection of questions from the Inpatient Survey looking at a range of elements of hospital care.

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

We are pleased that the inpatient overall score from the survey results in 2014 showed an improvement on the previous year and that our performance was above the national average. There were no questions where the Trust scored significantly lower in 2014 compared to 2013. Areas for improvement have been identified; these include cleanliness of wards, privacy and dignity of patients and patients being able to talk about their worries or fears. The Trust awaits the publication of the 2015 National Inpatient Survey to see if there have been improvements in these areas.

Staff survey

Measure	Latest Reporting Year	RUH Performance		National Average*	National Best*	National Worst*
		2015	2014	2015		
Staff who would recommend the trust to their family or friends	2015/16	75%	75%	69%	85%	46%

* Acute Trusts

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

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 remains in line with last year. Our Human Resource team have held listening events and are working with specific staff groups to ensure we continue to improve. During 2015/16 the Trust has launched new values which have been developed in conjunction with our staff and patients.

Treating and caring for people in a safe environment and protecting them from avoidable harm

Venous Thromboembolism (VTE)

Measure	Latest Reporting Year: 2015/16	RUH Performance		National Average	National Best	National Worst
		2015/16	2014/15	2015/16		
Patients admitted to hospital who were risk assessed for venous thromboembolism	Q1	96.88%	97.50%	96.00%	100.00%	86.10%
	Q2	97.55%	95.90%	95.80%	100.00%	75.00%
	Q3	98.50%	97.00%	95.40%	100.00%	61.50%
	Q4		97.18%			

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 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 quarterly totals. At the time of reporting only data to the end of quarter three of 2015/16 has been published.

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

The Trust scoring against this measure is in line with national averages.

Between July 2014 and July 2015 the Trust participated in a Safer Clinical Systems research project, funded by the Health Foundation which focussed on the management of VTE throughout the Trust. There were many interventions which included the implementation of an education programme, trust wide awareness campaign, and a review and procurement exercise of mechanical VTE prophylaxis devices which resulted in a £52,000 saving.

The biggest focus however, was ensuring VTE risk assessments were completed for elective surgical patients, and we improved our compliance for this from a baseline of 40% to 100%, resulting in an 80% reduction of hospital associated thrombosis following surgery.

This has sustained, and continues to be above 99% for this group of patients.

Clostridium difficile (C.difficile)

Measure		Latest Reporting Year	RUH Performance		National Average	National Best	National Wrst
			2015/16	2014/15	2014/15		
Rate of C.difficile infection	Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over	Reported	25.8	13.5	15.1	0.0	62.2
		Actual	13.8				

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

The performance shown for the current reporting period (April 2015 to March 2016) has been calculated internally by the Trust using the data submitted nationally, as published data was not available at the time of reporting. During 2015/16 we have reported 58 cases of Clostridium difficile; however 22 of these have since been found to be not attributable to the Trust and at the time of reporting 5 are still awaiting the outcome of review or appeal by the CCG's. Because of this the rates for both reported and actual (32) cases are shown above.

The Trust reports 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 14/15 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 eventually 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 2014/15. When calculated internally using the final validated figure, our rate per 100,000 bed days for the year 2014/15 was 12.6. This has been calculated in line with national definitions.

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

In 2015/16 the Trust invited a peer support review of how Clostridium difficile infections are managed and implementation of an action plan following the visit. Actions include the strengthening of antimicrobial stewardship, targeted training for clinical staff on the management of patients with C diff, improvements in environmental cleaning and adopting a whole health economy approach to improve clinical effectiveness. The Trust will continue to take this forward in the coming year.

Incidents

Measure		Latest Reporting Year	Trust Performance	RUH Performance	National Average*	National Best*	National Worst*
			Apr15-Mar16	Apr14-Mar15	Apr14-Mar15		
Patient Safety incidents and the percentage that resulted in severe harm or death	Number of Patient Safety Incidents	2015/16	7490	7507	8398	24804	1894
	Rate of Patient Safety Incidents (per 1000 bed days)		33.4	35.2	36.5	73.5	18.2
	Number Resulting in severe harm or death		43	20	41	4	193
	% resulting in severe harm or death		0.6%	0.3%	0.5%	0.0%	3.7%

* Acute Trusts (non-specialist)

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

The data shown for 2014/15 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 15 to March 16 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.

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

The Trust is pleased to note that we have maintained the level of incident reporting seen in 2014/15. It is important to support a culture of incident reporting to allow for learning to take place within the organisation. The Trust will continue to use the routine monitoring of data on incident themes and trends, to evidence quality improvement across the Trust.

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.

A clinician, who supports the achievement of quality indicator milestones and targets as well as the financial performance for their scheme, leads each CQUIN quality improvement programme. The following outlines the progress with the 2015/2016 CQUIN quality improvement schemes.

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.

A clinician, who supports the achievement of quality indicator milestones and targets as well as the financial performance for their scheme, leads each CQUIN quality improvement programme. The following shows the Trust's progress against the CQUIN quality improvement schemes for 2015/16.

National CQUIN schemes for 2015/16

Acute Kidney Injury

The Acute Kidney Injury (AKI) CQUIN has focused on AKI diagnosis and treatment in hospital and plans made to monitor a patient's kidney function after discharge by general practitioners.

An AKI patient safety improvement programme has been developed during the year. The first part of this has been to develop a group of action of best practice (known as the AKI bundle) and instigate an education and training programme across the hospital to support the roll out of the AKI bundle across the hospital. One hundred staff are being trained every month in line with the trajectory and data on AKI bundle compliance measured on pilot wards.

The second part of the programme related to the recording of AKI or discharge summaries, including medication review and any follow-up tests or renewals required from primary care; we are identifying patients with an AKI and putting actions in place to improve and monitor their treatment.

Sepsis

The sepsis safety programme that started in 2014 as a local CQUIN has been developed further this year in line with the national CQUIN for sepsis. As a result of this work we are now identifying patients earlier even more patients in the emergency department, MAU and SAU and ensuring that they receive the required treatment, including antibiotics within an hour of the patient arriving at the hospital. The percentage of patients benefiting has continued to increase in line with the challenging trajectories set. There is more detail on AKI and sepsis in Parts 1 and 2.

Dementia

A national scheme relating to dementia has been extended in 2015/16 to include delirium.

FAIRI – The Find, Assess, Investigate, Refer and Inform 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 FAIRI for 2015/16 was that 90% or more for each element was that 90% or more for each element was achieved by 31st March 2016. This target has been met or exceeded throughout the year.

A second element of the scheme has been the successful delivery of a quality improvement project to develop patient information on delirium. This has now been developed and tested and is being rolled out across the Older People's Unit, enabling the Trust to be compliant with the NICE standard.

A third element has related to an ongoing staff-training programme being developed and implemented. A dementia-training programme is now in place across the Trust and now forms part of the mandatory training programme for all staff.

Supporting carers of people with dementia has continued to be a key part of the dementia improvement programme; Carers surveys are undertaken on a monthly basis and themes discussed at the Dementia Strategy meeting to inform the ongoing improvement programme.

Improving recording of diagnosis in the Emergency Department

This national scheme has focused on ensuring coding for a patient's mental health, as well as physical health has been accurately recognised, recorded and coded. Data has been collected and audits undertaken to review the appropriateness and quality of actions taken in response to a patient's diagnosis.

Ambulatory/Urgent Care CQUIN

The CQUIN is made up of 2 parts.

1) To improve the clinical coding of Emergency Department attendance for patients with a mental health diagnosis.

2) To reduce the proportion of Avoidable Emergency Admissions to hospital by increasing the number of adults presenting at the Emergency Department and referred through the ambulatory care pathway. To work with Community Providers and Primary Care to increase the proportion of adult patients managed via ambulatory care pathways to reduce ED attendance and or admission from the Emergency Department.

Local goals agreed with Commissioners

Falls Prevention

The Falls Prevention scheme aimed to reduce the risk of falls whilst in hospital. This has included increasing the percentage of patients having a falls risk assessment within the first few hours of admission and increasing the percentage of patients who are reassessed within 48 hours, and repeatedly in line with the Trust standard timeframes. A third element of the schemes has been a Falls improvement project. A falls workplan is in place and has been progressed during 2015/16 to spread and embed best practice across the Trust to reduce falls and repeat falls.

We anticipate all elements of the scheme being achieved by 31st March 2016.

The Trust has also contributed to a National Falls audit. The results identified a number of areas of good practice and compliance. Low compliance and areas below the national percentage have been analysed and results discussed at the Falls steering group and actions incorporated into the Falls workplan.

Improving the Patient Experience of Discharge

The aim of this scheme was to improve patient involvement in, and information on discharge. This quality improvement initiative focused on improving patient experience and the effectiveness of discharge from the Trust. A discharge passport system has been developed supported by a number of patient and carer engagement events, held in partnership with Healthwatch.

All CQUIN milestones have been met and a passport has been developed and is now in use on the pilot wards. A Discharge programme board has been established to oversee improvement work relating to discharge. Further detail can be found on page 92.

Maternity CQUIN schemes

Breastfeeding

The breastfeeding scheme has focused on supporting women with their feeding choice, including both the initiation of breastfeeding and subsequent support for women with their choice of feeding at discharge. A target of 83% of women initiating breastfeeding has been maintained throughout 2015/16. An action plan has been developed to support this improvement programme. A second element of the plan has been the provision of information pertaining to safe feeding practice at discharge if they choose to bottle-feed.

Raising awareness of stillbirth

The stillbirth quality improvement initiative has focused on improving the information provided routinely to women on the risk of stillbirth and a subsequent risk assessment. Staff training has been in place to increase the number of women with whom “count the kicks” and reduced fetal movement is routinely discussed between 25-38 weeks gestation. The second element has focused on increasing the number of women who have a stillbirth risk assessment completed between 25-38 weeks. These two initiatives

are now incorporated in the Trust antenatal guidelines. A quarterly review and report on themes, lessons learned and actions from all stillbirths is also now in place. This work is supporting the ongoing workplan for stillbirth prevention.

Specialised Commissioning

Three CQUIN schemes relating to specialised commissioned services have been in place during 2015/16. There are:

1) **Term baby admission to the Neonatal Intensive Care Unit** – this scheme is aimed at reducing the separation of mothers and babies and reducing demand on neonatal services by improving learning from avoidable term admissions (≥37wk gestation) into neonatal units.

2) **Human Immunodeficiency Virus (HIV) reducing unnecessary CD4 monitoring** – evidence now indicates that for patients who are stable on treatment the CD4 count has little or no impact on their treatment plans. CD4 count is a measure of immune function but can fluctuate depending on their medication and general health.

3) **Oncotype DX** –this CQUIN promotes a more consistent uptake of the NICE recommendations for patients with early breast cancer. Oncotype DX is recommended to help make decisions about chemotherapy after surgery.

It is expected that all the specialised commissioning schemes will have been met by 31st March 2016.

Duty of Candour

In November 2014, it became a legal requirement for all NHS Trusts to implement the Duty of Candour. This was an important step towards ensuring an open, honest and transparent culture that was lacking at Mid Staffordshire NHS Foundation Trust.

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It sets out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. It is important that lessons are learned and improvements made when things go wrong and that the culture of the organisation encourages openness and transparency. The Care Quality Commission (CQC) inspection will check that the Trust has robust systems in place to meet the duty of candour regulation.

To ensure compliance with the Duty of Candour, the Trust has produced a Duty of Candour policy to guide staff. We are working with the Divisional Governance Leads to implement this system, which at present is being updated in response to feedback provided by staff. As clinicians become more familiar with the Regulation we are asking that they become Duty of Candour Champions to assist with the dissemination of knowledge.

Duty of Candour has also been incorporated into our incident reporting system, Datix. Moderate, Severe and Catastrophic patient safety incidents automatically trigger Duty of Candour 'fields' which have to be completed by the incident reporter and informs other staff, what actions they need to undertake. Failing to complete the actions in a timely manner will result in reminder emails being populated.

Every month, we randomly select 10 incidents deemed to have triggered Duty of Candour and assess each incident against the requirements of the regulation to ensure we have followed the correct procedure. These reviews over the year have shown that staff now have a greater understanding and appreciation of the requirements under Duty of Candour.

On a quarterly basis, a review of those incidents for which the reporter has indicated that Duty is not applicable, is performed. If it is discovered that Duty of Candour should have been implemented, the Duty of Candour action chain is initiated and the reporter of the incident contacted to explain why the previous decision has been overturned.

Care Quality Commission (CQC) rating

The Care Quality Commission (CQC) undertook a planned inspection of the Trust between 15th and 18th March 2016. An unannounced visit was also undertaken on 29th March 2016. The Trust is awaiting the report of the inspection findings and therefore at the time of writing this report, the Trust does not have a CQC rating for its services.

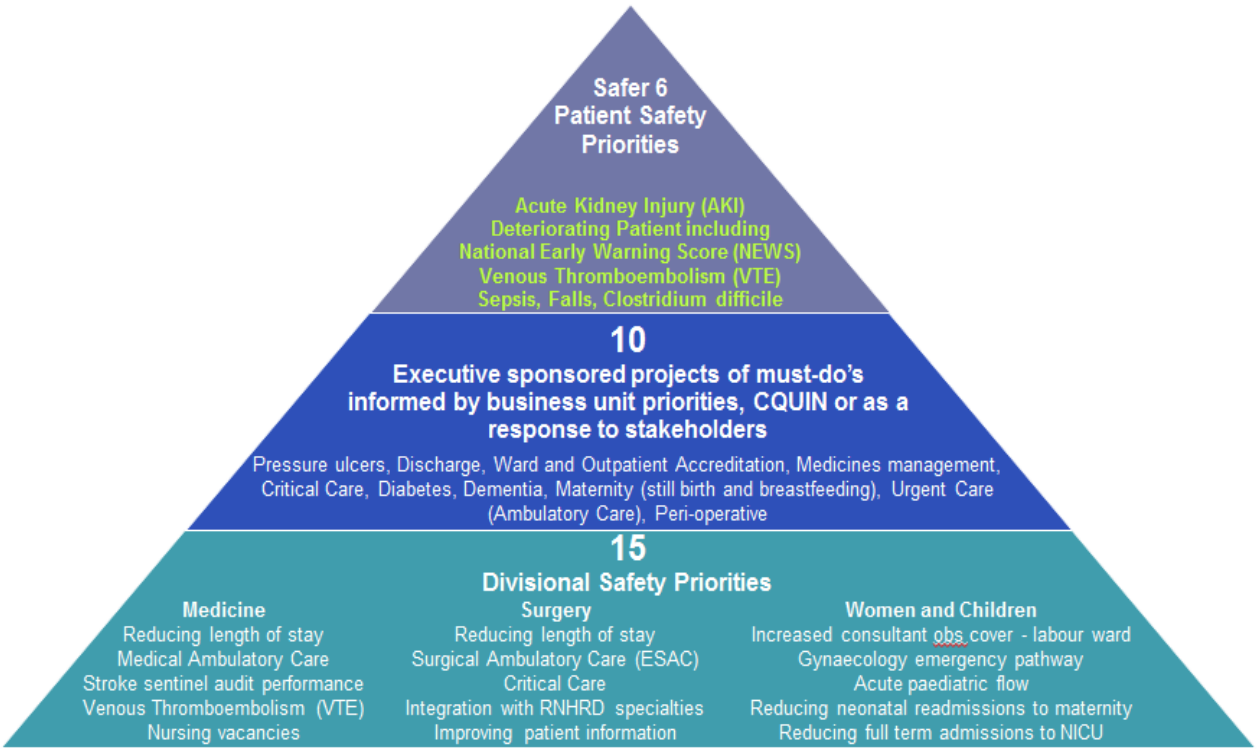
Until May 2015, the CQC published the Intelligent Monitoring Report for each acute NHS trust on a quarterly basis. This was used by the CQC to monitor the quality of care provided by acute trusts and to target inspections more effectively. NHS acute trusts were grouped into six risk bands based on the risk that people may not be receiving safe, effective, high quality care. Band 1 represented the highest risk with band 6 the lowest. The report was made up of indicators that look at a range of information including patient experience, staff surveys and statistical measures of performance. The final Intelligent Monitoring Report, published in May 2015, placed the RUH in the lowest risk banding, band 6.

Our Commitment to the national Sign up to Safety campaign

The RUH was selected as one of 12 Trusts nationally to lead the Sign up to Safety campaign. This strategy supports the Trust to actively lead and participate in these programmes and to embrace and embed an open, compassionate and transparent culture and reduce incidents of avoidable harm to patients. **The Sign up to Safety** priorities identified in 2014/2015 in line with national and local priorities were:

- Sepsis
- Venous Thrombosis Embolism
- Pressure ulcers reduction
- Falls prevention
- Deteriorating patients
- Acute Kidney Injury (AKI) – from 2015

The Trust has established a culture of improving patient safety taking the leading role in supporting local collaborative learning, so that improvements are made for patients. The RUH is the host and partnership leader of the West of England Academic Health Science Network (WEAHSN) Patient Safety Collaborative programme. Current priority areas include the deteriorating patient, Sepsis, Emergency Laparotomy, Medicines management and a focus on human factors. In 2015/16, in order to maximise resources and streamline improvement projects the Trust agreed the Safer 6 priorities aligning them to the Sign up to Safety and WEAHSN priorities. They are identified below in our **'Safer 6 Safety Priority triangle':**



Each of the Safer 6 Patient Safety priorities have an established work stream lead and work plan with agreed process and outcome measures. These are reported to the Patient Safety Steering Group chaired by the Director of Nursing and reported to the Board of Directors.

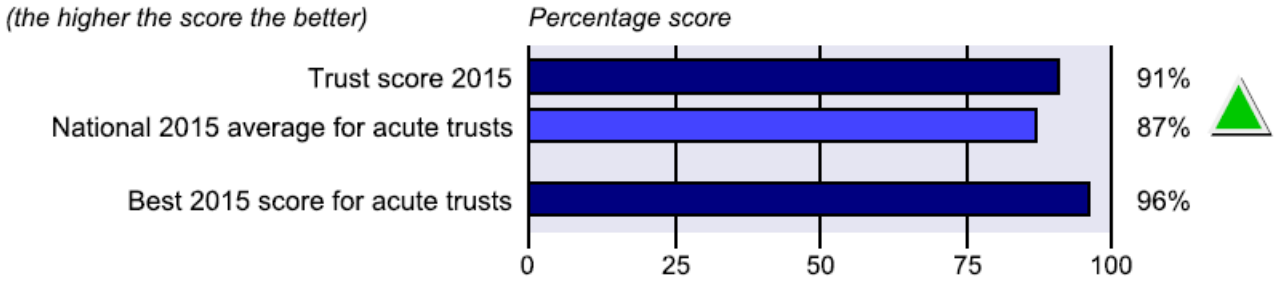
NHS staff survey results

This year, NHS England has requested that we include our most recent staff survey results for 2 questions. 2302 staff at Royal United Hospitals Bath NHS Foundation Trust took part in this survey. This is a response rate of 48% which is above average for acute trusts in England.

The Trust was asked to report against the following 2 questions:

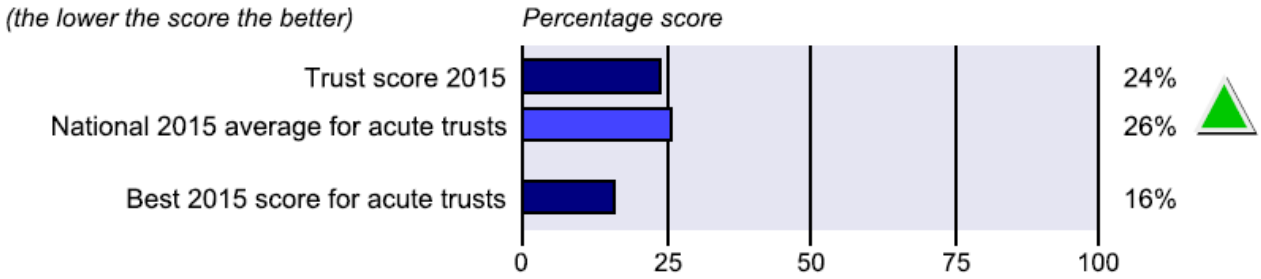
KF21 (percentage of staff believing that the organisation provides equal opportunities for career progression or promotion)

KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months) for the Workforce Race Equality Standard.

KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



We are pleased to note that the Trust scores better than the national average for both questions.

Part 7 - Statements from Stakeholders

18th May 2016

Quality Accounts 2015/16 for the Royal United Hospitals Bath NHS Foundation Trust (RUH)

NHS Bath and North East Somerset Clinical Commissioning Group (BaNES CCG) is pleased to have had the opportunity to review the Quality Accounts 2015/16 for the Royal United Hospitals Bath NHS Foundation Trust (RUH).

In a joint vision to maintain and continually improve the quality of services, the RUH, encompassing RNHRD, has worked collaboratively with commissioners to sustain and progress a comprehensive quality framework that includes nationally mandated quality indicators alongside locally agreed quality improvement targets. There are robust arrangements in place with the RUH to agree, monitor and review the quality of services, covering the key domains of safety, effectiveness and experience of care. In preparing this statement, key intelligence regarding quality, safety and patient experience has been reviewed to test the accuracy of the information reported in the account. It is the CCG's view that the account accurately reflects the achievements made by the RUH in 2015/2016.

It is important to acknowledge that, the RUH as with many other acute Trusts in England and Wales, have experienced on-going challenges again this year with pressures on the urgent and emergency care system. The RUH has taken positive steps to ensure that patient safety and experience of care is maintained and the CCG acknowledges the important contribution of all Trust staff in achieving this.

The National NHS Contract and Commissioning for Quality and Innovation (CQUIN) Scheme provides us with additional processes and evidence that quality improvements are made. The RUH signed up to a number of national and locally agreed improvement schemes in 2015-2016 and made excellent overall progress with each of the schemes. Of particular note is the progress made delivering the important national CQUIN on screening all patients at risk of severe sepsis and improving delivery of antibiotics within an hour for patients with severe sepsis. Good progress was made also with the local CQUINs and in particular the implementation of measures to reduce the occurrence of Acute Kidney Injury (AKI) with support given by the RUH in raising awareness among their healthcare partners including GPs. This will have an important and positive impact on patient care within B&NES and beyond. In addition to the above, the Trust has also made good progress implementing their other chosen quality priorities for 2015-2016. The CCG can confirm that there have been significant reductions in medication errors and hypoglycaemic rates for diabetic patients as a result of these quality improvement programmes that will now be sustained and embedded. We can also confirm that work has been undertaken within the RUH to improve the quality of investigation reports into serious incidents and that significant improvements have been made to safeguarding processes.

The RUH had previously shared with the CCG its proposed priorities for 2016/2017 which include further reduction in the incidence of Acute Kidney Injury (AKI), improving

the outcomes for stroke patients, further improving the experience of patients and carers at discharge and improving outpatient communication. These priorities were endorsed and are supported by the CCG. We recognise there are still improvements to be made with effective discharge arrangements and look forward to working closely with the Trust on this. We will also work closely with the Trust in 2016/2017 to progress the vision set out in Better Births (the Maternity 5 Year Forward View).

In conclusion, the RUH has made good progress over the last year with evidence of improvements in key quality and safety measures. The CCG recognises the RUH's commitment to working closely with commissioners and the public to ensure the on-going safe delivery of safe, high quality services and we look forward to continuing this positive collaborative relationship in the forthcoming year.

Yours sincerely

Tracey Cox
Chief Officer
c.c. Dawn Clarke

NHS
Wiltshire
Clinical Commissioning Group

"Wiltshire Clinical Commissioning Group (CCG) has reviewed the Royal United Hospital (RUH) Quality Accounts for 2015/2016. 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 the identification and treatment of Acute Kidney Injury, which was supported by a CQUIN in 2015/16. As a continued priority for the Trust into 16/17, the CCG is supportive of the Trust in its' ambition to embed quality improvement in AKI and to ensure this work is rolled out trust-wide.

The CCG endorses the values that the Trust has launched this year (Everyone Matters, Working together and Making a Difference) and anticipates that they will continue to be demonstrated consistently and reflected in patient and staff feedback. Similarly, the CCG is keen to see the resulting outcomes from the introduction of the Trust's standardised improvement methodology to support their Quality Strategy.

The CCG recognises the ongoing work by the Trust to monitor and improve patient experience. Patient feedback has identified some key areas of improvement over the year and others for further action; this is inclusive of Maternity services. The CCG will work with the Trust in 16/17 to progress the vision set out in Better Births (the Maternity 5 Year Forward View).

The Trust has identified priorities for 2016/2017which align with system-wide key areas of focus. Building on the accomplishments of 2015/16, the CCG anticipates that considerable achievements can be made in Sepsis and Acute Kidney Injury. The CCG also looks forward to working collaboratively with the Trust and other partners on Stroke care as part of the CCG's drive to improve patient outcomes and experience in this area.

The CCG confirms that we believe the accounts are accurate in regard to the service provided to Wiltshire patients and will support the Trust in 2016/17 to embed learning and achieve the identified Quality Priorities. The CCG would be keen to see the RUH further develop its Quality Account into 2016/2017 to include more information on the following:-

- Collaborative working with community health providers and primary care.
- Work to ensure patient safety during periods of high demand and challenge
- Having the right staff with the right skills in the right place.
- Clear and focused actions in response to patient feedback
- Linking improvement work to the NHS Outcomes Framework.

Yours sincerely

Deborah Fielding
Accountable officer, Wiltshire CCG

Quality Account Response 2015-6

We welcome initiatives by the RUH to ensure that discharge is timely and well managed with:

- the development of a discharge 'passport'; and
- further aspirations to improve for 2016-17.

The report acknowledges increasing pressures on urgent care: with longer waiting times in A&E, which are partly due to increased patient numbers.

Members appreciate that the trust has shared information and kept stakeholders abreast of the situation.

The Select Committee would have liked to have had sight of further information regarding Legionella, following the death of a man from Legionella in 2015 and the temporary closure of the Paulton Birth Centre in March 2016 so as to better inform the Quality Accounts for the RUH.

Following the rise in infections (MRSA and C. Diff), we trust the peer review and action plan helps tackle such issues.

The committee notes the recent CQC inspection of the RUH, and looks forward to receiving the feedback report too.

Given the proximity of acute hospitals in neighbouring districts (such as Bristol); members would like to see increased engagement by the RUH in delivering its services to the B&NES district that it serves most locally.

Bath & North East Somerset Council
Health & Wellbeing Select Committee

Healthwatch Wiltshire response to The Royal United Hospital NHS Foundation Trust's Quality Statement 2015/16

Healthwatch Wiltshire welcomes the opportunity to comment on The Royal United Hospital NHS Foundation Trust's quality account for 2015/16. Healthwatch Wiltshire was established to promote the voice of patients and the wider public with respect to health and social care services. Over the past year we have continued to work with the Trust to ensure that patients and the wider community are appropriately involved in providing feedback and that this feedback is taken seriously by the Trust.

We are pleased to see that The Trust has acknowledged the issues identified by local Healthwatch (Wiltshire and Bath and North East Somerset) concerning the patient, relatives and unpaid-carer's experience of discharge. We welcome the work that has been carried out by the Trust to improve the experience of discharge and that it remains a priority over the coming year. We will continue feedback to the Trust experiences of discharge in 2016/17 as this is one of Healthwatch Wiltshire's priorities.

As a result of patient feedback, the Trust has made outpatient communication a priority for the coming year. It is pleasing to see that the patient voice has influenced the Trust's priorities and that steps are being taken to improve the experience of those who use outpatient services.

It is concerning to see that some targets for infections, pressure ulcers and falls were not met this year. However, we recognise that the Trust has put in place measures to counteract deterioration and with the aim of reducing the number of further cases in all of these areas over the coming year.

We note that although National patient surveys have produced some positive results, response rates are low particularly for children and day case patients. In addition, The Care Quality Commission's maternity survey revealed that the Trust scored worse than the national average in four categories pertaining to antenatal and postnatal care. We would like to see action to address these issues over the coming year.

We are disappointed to see that improvements have not been made in performance on the Friends and Family Test. In particular, response rates are lower than the national average for A&E and inpatients. Whilst recognising that response rates for the test are problematic nationally, we would like to see significant improvements if the tests are to give meaningful results.

The Trust did not meet its targets for four-hour waiting times in A&E. However, we acknowledge the pressures that the Trust have faced and welcome the initiatives that have been put in place to improve the situation going forward.

We welcome the wider work being carried out by the Trust, to increase awareness amongst the public and professionals in areas such as sepsis and acute kidney injury. We note also their commitment to integrated working that aims to improve the patients' experience of discharge.

Healthwatch Wiltshire looks forward to working with the Trust over the coming year to ensure that the experiences of patients, their families and unpaid carers are heard and taken seriously.

Healthwatch B&NES thanks the Royal United Hospitals Bath NHS Foundation Trust (RUH) for sharing its Quality Account 2015 – 16 for comment.

Healthwatch B&NES notes with interest the comments made regarding Clostridium difficile and the proactive action that is being taken to address this and the three MRSA cases that were experienced during the year.

Programme Rapid Spread continues to work, however Healthwatch notes an increase in device-related Grade 2 pressure ulcers and encourages the RUH to remain vigilant with this theme.

Healthwatch B&NES offers congratulations on cancer access targets, but would like reassurance that the staffing issues that affected the two week wait on breast symptoms are now resolved. Healthwatch B&NES notes the work that has been carried out to address this issue.

Healthwatch B&NES was pleased to read of the open dialogue between the Trust and its commissioners regarding the Referral To Treatment target and anticipated winter pressure during quarter four. It is positive to see service provider and commissioner maintaining close monitoring of this and responding accordingly in real time.

Healthwatch B&NES is concerned about the reduction in Friends and Family Test (FFT) responses for inpatients and patients at the Accident and Emergency department. Healthwatch B&NES appreciates that the RUH is working with matrons and ward managers, but it would be grateful to know further details regarding the action plan for improvement.

Healthwatch B&NES notes that the Accident and Emergency four hour waiting times are not being met and the three key work streams that are being implemented to resolve this issue. Healthwatch looks forward to seeing the impact of these work streams next year.

Healthwatch B&NES commends the RUH on its discharge project, highlighting the scale of activity and level of commitment that has been shown to improve patient experience. Healthwatch B&NES has appreciated the opportunity to comment on the passport as it has been developed and looks forward to hearing results from the ward pilot. Healthwatch B&NES is reassured to see that it is a continued priority for 2016-17, however notes that next year's plan does not mention further work/action with the discharge passport itself.

Healthwatch B&NES notes that there have been several mentions of hospital cleanliness throughout the Quality Account. Healthwatch B&NES has also heard about this through the feedback that it receives, and would like reassurance that this is something that the Trust is addressing.

The current financial climate is proving particularly challenging for acute trusts, however it is clear from this year's Quality Account that the RUH is continuing to provide high quality care and treatment for its patients and their families, in addition to pursuing improvement in its practice through several Commissioning for Quality and Innovation (CQUIN) targets.

Part 8 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 2015/16 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 2015 to 31 March 2016
- Feedback from Bath and North East Somerset Clinical Commissioning Group dated 18th May 2016
- Feedback from Wiltshire Clinical Commissioning Group dated 20th May 2016
- Feedback from Bath and North East Somerset Council Health and Wellbeing Select Committee dated 10th May 2016
- Feedback from Healthwatch BANES dated 16th May 2016
- Feedback from Healthwatch Wiltshire dated 10th May 2016
- The National Patient Surveys dated 2014 and 2015
- The National Staff Survey 2015
- External Audit report from Grant Thornton dated 16th May 2016
- CQC Intelligent Monitoring Report dated May 2015

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

25th May 2016

Independent Practitioner's Limited Assurance Report to the Council of Governors of Royal United Hospitals Bath NHS Foundation Trust on the Quality Report

We have been engaged by the Council 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 2016 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in Annex 2 to Chapter 7 of the 'NHS Foundation Trust Annual Reporting Manual 2015/16' (the 'Criteria').

Scope and subject matter
The indicators for the year ended 31 March 2016 subject to the limited assurance engagement consist of those national priority indicators as mandated by Monitor:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the Council of Governors and Practitioner
The Council of Governors are responsible for the content and the preparation of the Quality Report covering the relevant indicators and in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2015/16' issued by Monitor and 'Detailed guidance for external assurance on quality reports 2015/16.

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
- 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 2015/16; 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 2015/16' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2015/16'.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual 2015/16, 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 2015 to 25 May 2016
- Papers relating to quality reported to the Board over the period 1 April 2015 to 25 May 2016
- Feedback from Commissioners dated 18/05/2016;
- Feedback from Governors dated 24/05/2016;
- Feedback from local Healthwatch organisations dated 20/05/2016;
- Feedback from Overview and Scrutiny Committee dated 20/05/2016
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The 2015 national patient survey;
- Care Quality Commission Intelligent Monitoring Report dated May 2015;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2016; and
- Quarterly complaints, PALS and inquest reports for 2015/16.

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.

The firm applies International Standard on Quality Control 1 and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Ethics for Professional Accountants issued by the International Ethics Standards Board for Accountants, which is founded on the fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Royal United Hospitals Bath NHS Foundation Trust as a body, to assist the Council 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 2016, to enable the Council 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 Council 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 indicators back to supporting documentation
- comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual 2015/16' to the categories reported in the Quality Report; and
- reading the documents.

The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement and consequently, the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

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 thereof, 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 2015/16'.

The scope of our limited 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.

Our audit work on the financial statements of Royal United Hospitals Bath NHS Foundation Trust. is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Royal United Hospitals Bath NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Royal United Hospitals Bath NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Royal United Hospitals Bath NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Royal United Hospitals Bath NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the work described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the Criteria;
- 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 2015/16'; 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 2015/16' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2015/16'.

Grant Thornton UK LLP.

Grant Thornton UK LLP
Chartered Accountants
Hartwell House
55-61 Victoria Street
Bristol
BS1 6FT

26 May 2016

Sustainability report

Sustainability vision and targets

Sustainable Development is an important objective for society and also represents an opportunity to reduce costs at the Trust. For example, expenditure on energy, waste and water was £2.9m 2015/16. The Trust's 'Sustainable Development Management Plan' (SDMP) addresses the themes set by the NHS Sustainable Development Unit[1]. This guidance suggests setting 'outcome' / 'performance' targets for: energy and carbon management, water, and waste. We also have plans in place to manage 'process' / 'input' measures for: procurement and food, low carbon travel, transport and access, designing the built environment; staff engagement; collaborations through partnerships and networks, governance, and finance. A section on Adaptation has also been added to the plan for completeness.

Our ***Sustainability Vision*** is to act as a national pilot site, driving positive change within the NHS by:

- Exceeding government sustainability targets
- Dramatically improving efficiency and reducing costs
- Delivering excellent staff and patient comfort through better control of the built environment.

Our ***2020 Sustainability Performance Targets***[2] have been set with reference to government legislation and are summarised below:

Energy & carbon management:

COST: £1.9m in 2015/16

TARGET: 22% reduction in CO_{2e} emissions against a 2015/16 baseline

SAVING: £428k per annum in 2015/16 prices

Water:

COST: £557k in 2015/16

TARGET: 14% reduction in consumption against a 2015/16 baseline

SAVING: £80k per annum in 2015/16 prices

Waste:

COST: £418k in 2015/16

SAVING: 11% saving against 2015/16 expenditure:

- reduce & reuse £15k worth of waste each year

- save £30k per year from better segregation of residual waste.

SAVING: £45k per annum in 2015/16 prices

This work on target setting has been presented to the *'Health Estates and Facilities Management Association'* as an example of best practice.

[1] 'Technical Briefing 9: Measuring Sustainable Development'; published by the Association of Public Health Observatories (APHO)
[2] Note: No cost inflation or projected utility cost increases have been added to costings at this stage.

Sustainability successes to date

A reference point with regards to the sustainability leadership demonstrated by the Trust is that in February 2016 the Carter Report on *'Operational productivity and performance in [the] NHS'* suggested that Trusts should implement 'LED lighting', utilise 'Combined Heat and Power' (CHP), and set up 'Smart Energy Management Systems'. We have already implemented the first two recommendations and are part way through the third. Examples of successes to date are:

- We won the 2012 **'Energy Efficiency Award'** from the **Health Service Journal**
- We installed a **Combined Heat and Power (CHP)** engine within the boiler house in 2012, this saves the Trust an estimated £415,000 per annum
- We also retrofitted the majority of the hospital's **lighting with LED** units in 2013. This has greatly improved the ambience of our buildings, saving an estimated £210,000-£250,000 per annum
- The **Environment Champions Toolkit** supports staff engagement, helping them reduce their environmental impact, providing user feedback and reducing costs
- We have worked with the BaNES Council team to promote **sustainable transport**, inviting them to engage with our staff via their transport road shows
- We invited City Car Club to locate **2 new hybrid cars** on site for business and personal use, assisting greatly with travel to our expanding community services
- The salary sacrifice **Cycle Scheme** processed 50 bicycles in 2015/16, saving staff an average of £247 each and the RUH £5,860 in National Insurance costs
- We have adopted the **'Next Bikes' scheme**, siting a station outside our main entrance that allows for better cycling connectivity with town and the train station
- There has been increased usage of our **Park & Ride scheme** from Odd Down, which is subsidised by the RUH
- Investments were made to enable **waste segregation** during transport on site and a **new waste manual** has been launched which will support staff in reducing the waste they produce.
- **Improved heating controls** have been installed in the on-site accommodation blocks, the West ward area, Bath and Wessex House, the Oasis Centre, Malvern House, and Theatres 9A and 9B
- **Demand side response** has been in place at the Trust since 2012, saving the Trust an estimated £80,000 per annum by using standby electricity generation capacity to help balance the National Grid.

2015/16 performance

2015/16 has been a successful year of consolidation, planning and pilot projects. This progress built on the Trust's investment during 2014/15 in the recruitment of a Compliance and Sustainability Manager and a Compliance and Sustainability Project Leader. The targets given above have been developed to meet the pledge given in the 2014/15 annual report to update our past sustainability objective of *'improving the efficiency of our estate through improved utilisation, functionality and sustainability of our buildings'* with numerical performance targets. In developing these targets and convincing people of their viability, pilot projects in condensate return for the boiler house, building management systems and leak reductions for water have been undertaken.

Sustainability procurement successes

Reviews of sustainability related supply contracts and funding applications have saved the Trust money in a number of ways. For example, we have: gained income from renewables generation capacity, reviewed / cancelled a number of contracts, sold surplus equipment, and audited historic invoices. On a per annum basis, during 2015/16, the following opportunities have been identified and acted upon:

- Avoided costs[3] of £39k
- Savings / rebates[4] of £135k
- Revenue / income generated of £13k

Energy and CO_2 performance

		2013/14	2014/15	2015/16
Non-financial indicators (tonnes CO_2e)	**Total gross emissions**	**12,953**	**12,873**	**12,611**
	Electricity *	4,060	2,339	1,151
	Natural gas	8,634	10,271	11,279
	Fuel Oil	56	65	76
	Waste	203	197	105
Related site energy consumption (millions kWh)	**Total**	**55.3**	**59.8**	**63.3**
	Electricity *	8.4	4.3	2.1
	Natural gas	46.9	55.5	61.2
Financial indicator (£k)	**Total**	**2,671**	**2,539**	**2,347**
	Electricity	806	480	360
	Natural gas	1,544	1,676	1,558
	Fuel oil	57	20	12
	Waste	264	363	418

* Note: Electricity consumed refers to the nett consumption of electricity from the National Grid and is calculated as electricity imports – exports. In order to avoid double counting, electricity generated onsite is not included in this figure, as it is supplied from the CHP engine which is ultimately powered from the gas consumption reported above.

During 2015/16, CO_{2e} emissions at the RUH fell by 2%, meaning that to date, against the 2013 baseline year for our 2020 target we have achieved an 8% reduction in emissions. This leaves a 22% saving to be achieved between now and 2020, which represents a further saving of £428k per annum at 2015/16 prices.

In the figures below, electricity consumption has reduced significantly. This can be explained by recent efforts to improve utilisation of 'Combined Heat and Power' (CHP) engine. Availability of the engine was 75% over 2014/15. For 2015/16 a project to increase availability brought the average to 91%, as measured through to the end of September 2015. Unfortunately, a failure of the engine in October 2015, which led to its replacement by our maintenance contractor's expense, meant that the average availability during 2015/16 was 76%. This was still up 1% on the previous year. Although the full benefits of the efforts to improve availability this year were not recognised, without them, availability during 2015/16 would have been 68%. It is also the case that the improvements made will carry through to 2015/16, and we should see dramatic improvements in CHP availability this year. The other priority this year is to invest in improvements in the 'Building Management System' (BMS) which will give better control over the heating system at the hospital and significantly reduce energy costs at the same time as making the hospital environment much more comfortable for staff and patients.

[3] Costs we avoided adding to a budget
[4] Costs saved from an existing budget

Water performance

		2013/14	2014/15	2015/16
Non-financial indicators	Water Consumption ('000m3)	213	227	223
Financial Indicator (£k)	Water Supply Costs	367	404	352
	Sewerage Costs	182	197	206
	Total cost:	548	601	557

We announced the launch of a 'leak busting' campaign in the 2014/15 annual report. This was in response to annual increases in water consumption of 18% in 2013/14 and 7% in 2014/15. 2015/16 has seen this trend reversed and we have achieved a 1% reduction in water consumption. Plans have also been developed which target significant savings in the coming years, with a target to achieve a 14% reduction in consumption by 2020, worth £80k at 2015/16 prices.

Waste performance

		2013/14	2014/15	2015/16
Non-financial indicators (tonnes)	**Total Waste**	**1,417**	**1,424**	**1,660**
	Incinerated Clinical Waste	164	171	172
	Alternative Treatment Clinical Waste	264	271	345
	Recycled	276	303	518
	Landfill	712	680	625
Financial indicator (£k)	**Total Waste Disposal Cost**	**264**	**363**	**418**
	Incinerated	Historic data not available for like to like comparison	72	70
	Alternative Treatment		113	140
	Recycled		38	81
	Landfill		140	126

The waste team has seen significant change over the past two years and a lot of work has gone into improving the systems and data collection. Many of the increases in the figures reported are due to an improved scope of reporting. Work during 2015/16 focused upon improving the compliance and safety of the waste management systems and in developing the reduction target provided in the previous section, this forms the basis of plans for the coming year.

These efforts during 2015/16 have seen internal recognition, with the Environment Portering Team winning 'Team of the Month' in November 2015 and later being awarded the overall 2015 'Team of the

Year' prize at the Trust's Annual Awards. This was the first time a non-clinical team has ever won the award and recognised excellent work which included the introduction of a new waste manual to standardise the safe handling of waste, regular audits which have improved waste management, training at induction to ensure new staff understand how waste must be segregated and managed, and engaging with staff across the hospital to ensure we understand our responsibilities in managing waste. The Trust has also been shortlisted in the National NHS Sustainability Awards in three categories: Innovation, Water and Waste. This was for the work with the Environment Champions scheme which enables staff at the Trust to get involved in improving our sustainability performance.

Plans for 2016/17 focus upon embedding the new Sustainable Development Plan and undertaking the first projects towards achieving the new targets.

Independent auditor's report to the Council of Governors of Royal United Hospitals Bath NHS Foundation Trust

Our opinion on the financial statements is unmodified

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

- give a true and fair view of the state of the financial position of the group's and the Trust's affairs as at 31 March 2016 and of the group's and Trust's expenditure and income for the year then ended; and
- have been prepared properly in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in 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 Council of Governors of the 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 Council 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 Council 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 for the year ended 31 March 2016 which comprise the group and Trust statement of comprehensive income, the group and Trust statement of financial position, , the group and Trust statement of changes in taxpayers' equity, the group and Trust statement of cash flows and the related notes.

The financial reporting framework that has been applied in their preparation is applicable law and IFRSs as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the NHS Foundation Trust Annual Reporting Manual (ARM) and the Directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006 issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

Overview of our audit approach

- Overall group materiality: £5,739,000, which represents 2% of the group's gross revenue expenditure adjusted for the exceptional item of the impairment of land of £23,552,000;
- We performed a full scope audit of Royal United Hospitals Bath NHS Foundation Trust and targeted audit procedures at Royal United Hospital Charitable Fund;
- Key audit risks were identified as:
    - Occurrence and Valuation of healthcare income and the existence of associated receivable balances
    - Occurrence of non-healthcare income
    - Completeness of operating expenditure

Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that, in our judgement, had the greatest effect on our audit:

Audit risk	How we responded to the risk
Occurrence and valuation of healthcare income and the existence of associated receivable balances Over 90% of the group's income is from contracts with NHS commissioners and is recognised when the service has been performed. The group invoices its commissioners throughout the year for services provided, and at the year-end accrues for activity not yet invoiced. Invoices for the final quarter of the year are not finalised and agreed until after the year-end and after the deadline for the production of the financial statements. This can involve further negotiation of contractual adjustments with commissioners. There is therefore a risk that the income from commissioners recognised in the financial statements and amounts due at year end, may be overstated. Given the scale of this income stream to the group we considered this to be an area of heightened risk of material misstatement in the financial statements. We therefore identified occurrence of healthcare income and the existence of the associated receivable balances as significant risks requiring special audit consideration. and valuation of healthcare income as a risk which requires particular audit attention.	Our audit work included, but was not restricted to: • Evaluating the group's accounting policy for revenue recognition of healthcare income for appropriateness and consistency with the prior period; • Gaining an understanding of the group's system for accounting for healthcare income and evaluating the design of the associated controls; • Using a summary of expenditure with the Trust accounted for by other NHS bodies provided by the Department of Health to identify any significant differences in and associated receivable balances with contracting bodies; • Inspecting a sample of income contracts, agreeing the income recorded in the financial statements to signed contracts; • Testing of a sample of contract variations to subsequent payments or receipts and relevant correspondence from the other party; and • Reviewing significant accounting estimates through assessing the competence of internal experts involved in the process and gaining an understanding of group wide controls. The group's accounting policy on healthcare income, including its recognition, is shown in note 1.2 to the financial statements and related disclosures are included in note 3. The group's accounting policy on healthcare receivables is shown in note 1.2 to the financial statements and related disclosures are included in note 3.
Occurrence of non-healthcare income Approximately 10% of the group's income is from non-healthcare sources. Income is recognised when the service has been performed. At the year-end income is accrued for services that have been performed but for which an invoice has not been issued. This will involve an element of estimation and contractual adjustment. We, therefore, identified the occurrence of non-healthcare income as a significant risk requiring special audit consideration	Our audit work included, but was not restricted to • Evaluating the group's accounting policy for revenue recognition of non-healthcare income for appropriateness and consistency with the prior year; • Gaining an understanding of the group's system for accounting for non-healthcare income and evaluating the design of the associated controls; • Agreeing, on a sample basis, amounts recognised in income in the financial statements to invoices; and • Agreeing, on a sample basis, accrued income and other revenue transactions to supporting documentation. The group's accounting policy on non-healthcare , including its recognition, is shown in note 1.2 to the financial statements and related disclosures are included in note 3.

Audit risk	How we responded to the risk
Completeness of operating expenditure Other operating costs account for 43% of the group's total expenditure. Management uses judgement to estimate accruals for un-invoiced amounts at year-end. We therefore identified completeness of expenditure on operating expenses as a risk requiring particular audit attention.	Our audit work included, but was not restricted to: • Gaining an understanding of the systems used to recognise operating expenditure and year-end accruals and evaluating the design of the associated controls; • Gaining an understanding of the accruals processes for unprocessed invoices and expenditure incurred but not yet invoiced (GRNI) at the year end and testing a sample of these items to ensure expenditure has been correctly recorded in the appropriate period; • considering the completeness of reported accruals and provision by review of Trust Board and Committee minutes and papers for events subsequent to the year end and our correspondence with the group's solicitors; and • Testing, on a sample basis, post year end payments made in April to confirm the completeness of year-end payables and accruals. The group's accounting policy on expenditure is shown in note 1.4 to the financial statements and related disclosures are included in note 5.1.

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 economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

We determined materiality for the audit of the group financial statements as a whole to be £5,739,000, which is 2% of the group's gross revenue expenditure adjusted for the exceptional item of the impairment of land of £23,552,000. This benchmark is considered the most appropriate because we consider users of the group's financial statements to be most interested in how it has expended its revenue and other funding.

Materiality for the current year is higher than the level that we determined for the period ended 31 March 2015. This reflects a full year of transactions for this financial year following the change to Foundation Trust status by the Trust in November 2014, part way through the previous financial year.

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 cash, disclosure of senior manager salaries and allowances in the Remuneration Report.

We determined the threshold at which we would communicate misstatements to the Audit Committee to be £250,000. In addition we communicated misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

Overview of the scope of our audit

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 and Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Chief Executive as Accounting Officer; 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 incorrect based on, or 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.

We conducted our audit in accordance with 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 of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code) and those standards 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 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, and in particular included:

- evaluation by the group audit team of the identified component to assess the significance of that component and to determine the planned audit response based on a measure of materiality;
- an interim visit to evaluate the group's internal control environment including its IT systems and controls over key financial systems;
- we carried out targeted audit procedures on the financial statements of the Royal United Hospital Charitable Fund focusing on investments and cash balances.

Overview of the scope of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016 and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Other reporting required by regulations

Our opinion on other matters required by the Code is unmodified

In our opinion:

- the part of the Remuneration Report and Staff Report subject to audit have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the NHS Foundation Trust Annual Reporting Manual; and
- the other information published together with the audited financial statements in the annual report is consistent with the audited financial statements.

Matters on which we are required to report by exception

Under the ISAs (UK and Ireland), we are 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.

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

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust ARM or is misleading or inconsistent with the information of which we are aware from our audit; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of the above matters.

Responsibilities for the financial statements and the audit

What the Chief Executive, as Accounting Officer, is responsible for:
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. The Accountable Officer is also responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

What we are responsible for:
Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and ISAs (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

We are also required under Section 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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 Code of Audit Practice.

Signature

Barrie Morris
Director
for and on behalf of Grant Thornton UK LLP
Hartwell House, 55-61 Victoria Street. Bristol, BS1 6FT

Date 26 May 2016

Royal United Hospitals Bath NHS
NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation Trust

Annual accounts for the year ended 31 March 2016

Foreword to the accounts

Royal United Hospitals Bath NHS Foundation Trust

These accounts, for the year ended 31 March 2016, 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 **25 May 2016**

Consolidated Statement of Comprehensive Income

	Note	Group 2015/16 £000	2014/15 £000
Operating income from patient care activities	3	270,473	106,783
Other operating income	4	22,463	9,265
Total operating income from continuing operations		**292,936**	**116,048**
Operating expenses	5, 7	(310,515)	(119,624)
Operating surplus/(deficit) from continuing operations		**(17,579)**	**(3,576)**
Finance income	10	179	20
Finance expenses	11	(244)	(55)
PDC dividends payable		(5,042)	(2,376)
Net finance costs		**(5,107)**	**(2,411)**
Share of profit of profit / (loss)		-	-
Gains/ (losses) arising from transfers by absorption		-	7,034
Surplus/(deficit) for the year from continuing operations		**(22,686)**	**1,047**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations		**-**	**-**
Surplus/(deficit) for the year		**(22,686)**	**1,047**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(5,101)	(2,947)
Revaluations	18	7,280	3,676
Other reserve movements		-	(330)
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on available-for-sale financial investments	19	(192)	251
Total comprehensive income/(expense) for the period		**(20,699)**	**1,697**
Surplus / (deficit) for the period attributable to:			
the Foundation Trust		(22,686)	1,047
Total comprehensive income / (expense) for the period attributable to:			
the Foundation Trust		(20,699)	1,697

Statements of Financial Position

		Group		Trust	
		31 March 2016	31 March 2015	31 March 2016	31 March 2015
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	13, 14	1,634	1,194	1,634	1,194
Property, plant and equipment	15, 16	170,723	182,791	170,723	182,791
Other investments	19	6,405	6,516	-	-
Trade and other receivables	23	1,254	1,346	1,254	1,346
Total non-current assets		**180,016**	**191,847**	**173,611**	**185,331**
Current assets					
Inventories	22	4,481	4,874	4,481	4,874
Trade and other receivables	23	17,653	17,725	18,813	17,953
Non-current assets for sale	24	398	-	398	-
Cash and cash equivalents	25	14,173	10,679	12,177	9,610
Total current assets		**36,705**	**33,278**	**35,869**	**32,437**
Current liabilities					
Trade and other payables	26	(22,495)	(20,973)	(22,489)	(20,937)
Other liabilities	27	(1,648)	(1,527)	(1,648)	(1,527)
Borrowings	28	(2,824)	(1,079)	(2,824)	(1,079)
Provisions	30	(1,468)	(979)	(1,468)	(979)
Total current liabilities		**(28,435)**	**(24,558)**	**(28,429)**	**(24,522)**
Total assets less current liabilities		**188,286**	**200,567**	**181,051**	**193,246**
Non-current liabilities					
Borrowings	28	(16,235)	(9,315)	(16,235)	(9,315)
Provisions	30	(1,030)	(1,393)	(1,030)	(1,393)
Total non-current liabilities		**(17,265)**	**(10,708)**	**(17,265)**	**(10,708)**
Total assets employed		**171,021**	**189,859**	**163,786**	**182,538**
Financed by					
Public dividend capital		150,370	148,855	150,370	148,855
Revaluation reserve		44,287	46,979	44,287	46,979
Income and expenditure reserve		(30,871)	(13,296)	(30,871)	(13,296)
Charitable fund reserves	20	7,235	7,321	-	-
Total taxpayers' and others' equity		**171,021**	**189,859**	**163,786**	**182,538**

The notes on pages 1 to 39 form part of these accounts.

Name James Scott
Position Chief Executive
Date **25 May 2016**

Statement of Changes in Equity for the year ended 31 March 2016

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 April 2015 - brought forward	**148,855**	**46,979**	**(13,296)**	**7,321**	**189,859**
Surplus/(deficit) for the year	-	-	(23,958)	1,272	**(22,686)**
Other transfers between reserves	-	(4,871)	4,871	-	**-**
Impairments	-	(5,101)	-	-	**(5,101)**
Revaluations	-	7,280	-	-	**7,280**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	(192)	**(192)**
Public dividend capital received	2,861	-	-	-	**2,861**
Public dividend capital repaid	(1,000)	-	-	-	**(1,000)**
Public dividend capital written off	(346)	-	346	-	**-**
Other reserve movements	-	-	1,166	(1,166)	**-**
Taxpayers' and others' equity at 31 March 2016	**150,370**	**44,287**	**(30,871)**	**7,235**	**171,021**

Statement of Changes in Equity for the year ended 31 March 2015

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	NHS charitable funds reserves £000	Total £000
At start of period for new FTs	**139,806**	**45,825**	**(6,368)**	**6,899**	**186,162**
Surplus/(deficit) for the year	-	-	648	399	**1,047**
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**	**(13,296)**	**7,321**	**189,859**

Statement of Changes in Equity for the year ended 31 March 2016

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**148,855**	**46,979**	**(13,296)**	**182,538**
Surplus/(deficit) for the year	-	-	(22,792)	**(22,792)**
Other transfers between reserves	-	(4,871)	4,871	**-**
Impairments	-	(5,101)	-	**(5,101)**
Revaluations	-	7,280	-	**7,280**
Public dividend capital received	2,861	-	-	**2,861**
Public dividend capital repaid	(1,000)	-	-	**(1,000)**
Public dividend capital written off	(346)	-	346	**-**
Taxpayers' and others' equity at 31 March 2016	**150,370**	**44,287**	**(30,871)**	**163,786**

Statement of Changes in Equity for the year 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	-	-	648	**648**
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**	**(13,296)**	**182,538**

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 2015/16 £000	Group 2014/15 £000	Trust 2015/16 £000	Trust 2014/15 £000
Cash flows from operating activities					
Operating surplus/(deficit)		(17,579)	(3,576)	(17,556)	(3,744)
Non-cash income and expense:					
Depreciation and amortisation	5.1	9,503	3,500	9,503	3,500
Impairments and reversals of impairments	6	23,552	5,484	23,552	5,484
(Gain)/loss on disposal of non-current assets	5.1	60	37	60	37
Income recognised in respect of capital donations	4	(27)	(112)	(27)	(112)
(Increase)/decrease in receivables and other assets		676	(857)	(257)	(709)
(Increase)/decrease in inventories		393	(421)	393	(421)
Increase/(decrease) in payables and other liabilities		46	1,312	47	1,312
Increase/(decrease) in provisions		115	(112)	115	(112)
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		(36)	(168)	-	
Other movements in operating cash flows		-	-	(54)	-
Net cash generated from/(used in) operating activities		**16,703**	**5,087**	**15,776**	**5,235**
Cash flows from investing activities					
Interest received		51	17	51	17
Purchase of intangible assets		(822)	(516)	(822)	(516)
Purchase of property, plant, equipment and investment property		(17,110)	(6,584)	(17,110)	(6,584)
Receipt of cash donations to purchase capital assets		27	62	27	62
Net cash generated from/(used in) investing activities		**(17,854)**	**(7,021)**	**(17,854)**	**(7,021)**
Cash flows from financing activities					
Public dividend capital received		2,861	2,000	2,861	2,000
Public dividend capital repaid		(1,000)	-	(1,000)	-
Movement on loans from the Department of Health		8,753	2,795	8,753	2,795
Capital element of finance lease rental payments		(87)	(62)	(87)	(62)
Interest paid on finance lease liabilities		(6)	(2)	(6)	(2)
Other capital receipts		-	3	-	3
Other interest paid		(164)	(50)	(164)	(50)
PDC dividend paid		(5,712)	(2,667)	(5,712)	(2,667)
Cash flows from (used in) other financing activities		-	-	-	-
Net cash generated from/(used in) financing activities		**4,645**	**2,017**	**4,645**	**2,017**
Increase/(decrease) in cash and cash equivalents		**3,494**	**83**	**2,567**	**231**
Cash and cash equivalents at 1 April		**10,679**	**-**	**9,610**	**-**
Cash and cash equivalents at start of period for new FTs		**-**	**9,564**	**-**	**8,527**
Cash and cash equivalents transferred under absorption accounting		-	1,032	-	852
Cash and cash equivalents at 31 March	25	**14,173**	**10,679**	**12,177**	**9,610**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. 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 the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015/16 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 second accounting period as an authorised NHS Foundation Trust, as such the stated comparatives for the period are for the five months from the 1st November 2014 to the 31st March 2015. The comparatives for the Statement of Financial Position and the corresponding notes are as at 31st March 2015.

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. Although the Group is reporing a deficit of £22.686m this is driven by a one-off technical adjustment to the value of land and does not adversely affect the Trusts performance going forward. The Trust has adequate plans and resources to continue in operational existence for the foreseeable future. For this reason the Trust continues to adopt the going concern basis in preparing the Accounts

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) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

• Recognise and measure them in accordance with the foundation trust's accounting policies and
• Eliminate intra-group transactions, balances, gains and losses.

The key accounting policy for the RUH Charitable Funds in is relation to it's investments. The Corporate Trustee have established a policy under which the funds are invested, ensuring that the money is not exposed to undue risk but provides returns sufficient to counter the effects of inflation. All investments are held at market value on the balance sheet.

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.

Employer's 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 valuation. 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. During March 2016 the Trust requested the services of an expert valuer to conduct a full site valuation of its land. Details of the revaluation and value of the property plant and equipment are shown in note 15.1. Under IFRS 13, the basis for valuing land is the depreciated replacement cost method (DRC), the guidance states that although the ultimate objective of the methodology is to produce a valuation of the actual property in its actual location, the initial stage of estimating the gross replacement cost has to reflect the cost of a site suitable for a modern equivalent facility.

Often this will be a site of a similar size and in a similar location to the actual site. However, if the actual site is clearly one that a prudent buyer would no longer consider appropriate because it would be commercially wasteful or would be an inappropriate use of resources, the modern equivalent site is assumed to have the appropriate characteristics. The fundamental principle is that the hypothetical buyer would purchase the least expensive site that would be suitable and appropriate for its proposed operations. In addition other factors need to be considered in addition to establishing the location of the modern equivalent site. The modern equivalent asset may not require a site as extensive as the actual site. In this respect land is no different to any other asset. If a smaller area is now sufficient to provide the same service, the modern equivalent site will be based on the reduced area required, even if the actual site is larger.

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 differs 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.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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.

Note 1.5 Property, plant and equipment (continued)

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 i.e.:

- 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 the plan 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 current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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, i.e., when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

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 assets are categorised as "fair value through income and expenditure" and loans and receivables

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.

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.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

For each receivable at the 31st March 2016, an assessment is made based on historic debt collection performance and the nature of the debt, to determine the risk of non-payment. Those with high risk are provided for as a bad debt provision

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 30.2 but is not recognised in the NHS foundation trust's accounts.

Note 1.11 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 31 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 31, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.12 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 1.13 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 1.14 Third party assets

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

Note 1.15 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 1.16 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 1.17 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2015/16.

Note 1.18 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 11 (amendment) - acquisition of an interest in a joint operation
Published May 2014
Not yet EU adopted, expected to be effective from 2016/17

IAS 16 (amendment) and IAS 38 (amendment) - depreciation and amortisation
Published May 2014
Not yet EU adopted, expected to be effective from 2016/17

IAS 16 (amendment) and IAS 41 (amendment) - bearer plants
Published June 2014
Not yet EU adopted, expected to be effective from 2016/17

IAS 27 (amendment) - equity method in separate financial statements
Published August 2014
Not yet EU adopted, expected to be effective from 2016/17

IFRS 10 (amendment) and IAS 28 (amendment) - sale or contribution of assets
Published September 2014
Not yet EU adopted, expected to be effective from 2016/17

IFRS 10 (amendment) and IAS 28 (amendment) - investment entities applying the consolidation exception
Published December 2014
Not yet EU adopted, expected to be effective from 2016/17

IAS 1 (amendment) - disclosure initiative
Published December 2014
Not yet EU adopted, expected to be effective from 2016/17

IFRS 15 Revenue from contracts with customers
Published May 2014
Not yet EU adopted, expected to be effective from 2017/18

Annual Improvements to IFRS: 2012-15 cycle
Published September 2014
Not yet EU adopted, expected to be effective from 2017/18

IFRS 9 Financial Instruments
Published July 2014
Not yet EU adopted, expected to be effective from 2018/19

Note 1.19 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 2016:

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 Board is the Chief Operating Decision Maker and considers the Trust's healthcare services, along with all the supporting services as one segment. The operations of the Charitable Funds are distinct and separate and, as such, are deemed a separate segment.

The Trust operates from two separate sites, however, the finances of the sites are aggregated into a single operating segment because they have similar economic characteristics, the nature of the services they provide are essentially the same, i.e. free NHS healthcare, the customers all come from the general population of the surrounding geographical area, and both operate under the same regulators.

	Trust	2015-16 Charitable Funds	Total Segments
Income	292,068	2,204	294,272
Costs	309,625	2,226	311,851
Net Operating (deficit)/surplus	(17,557)	(22)	(17,579)

	Trust	2014-15 Charitable Funds	Total
Income	115,425	851	116,276
Costs	119,169	683	119,852
Net Operating (deficit)/surplus	(3,744)	168	(3,576)

The net deficits/surpluses are based on operating revenue and expenditure, therefore exclude depreciation, amortisation, PDC dividend payments, and other financing interest.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	Group	
	2015/16	**2014/15**
	£000	**£000**
Acute services		
Elective income	40,018	14,694
Non elective income	96,885	38,164
Outpatient income	71,525	26,293
A & E income	9,332	3,215
Other NHS clinical income	44,931	21,437
Additional income for delivery of healthcare services*	1,000	-
Private patient income	809	259
Other clinical income	5,973	2,721
Total income from activities	**270,473**	**106,783**

Note 3.2 Income from patient care activities (by source)

	Group	
Income from patient care activities received from:	**2015/16**	**2014/15**
	£000	**£000**
CCGs and NHS England	262,035	103,533
Local authorities	1,114	461
Department of Health	-	9
Other NHS foundation trusts	1,494	904
NHS trusts	561	300
NHS other	276	-
Non-NHS: private patients	809	259
Non-NHS: overseas patients (chargeable to patient)	118	-
NHS injury scheme (was RTA)	454	341
Non NHS: other	2,612	976
Additional income for delivery of healthcare services*	1,000	-
Total income from activities	**270,473**	**106,783**
Of which:		
Related to continuing operations	270,473	106,783

*The £1m reported as "additional income for delivery of healthcare services" relates to funds received from the Department of Health to support the provision of healthcare services in 2015/16 as part of the national capital to revenue transfer.

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	Group	
	2015/16	2014/15
	£000	£000
Income recognised this year	118	-
Cash payments received in-year	4	-
Amounts added to provision for impairment of receivables	81	-
Amounts written off in-year	-	-

Note 4 Other operating income

	Group	
	2015/16	2014/15
	£000	£000
Research and development	640	251
Education and training	12,832	5,185
Receipt of capital grants and donations	27	-
Charitable and other contributions to expenditure	84	-
Non-patient care services to other bodies	1,142	510
Reversal of impairments	-	22
Rental revenue from operating leases	452	180
Income in respect of staff costs where accounted on gross basis	1,453	322
Incoming resources received by NHS charitable funds	2,119	851
Other income	3,714	1,944
Total other operating income	**22,463**	**9,265**
Of which:		
Related to continuing operations	22,463	9,265

Income generated from car parking accounts for £1.5m of "other income".

Note 5.1 Operating expenses

	Group	
	2015/16	**2014/15**
	£000	**£000**
Services from NHS foundation trusts	293	75
Services from NHS trusts	10	24
Services from CCGs and NHS England	36	-
Services from other NHS bodies	-	2
Purchase of healthcare from non NHS bodies	1,684	729
Employee expenses - executive directors	1,298	474
Remuneration of non-executive directors	130	64
Employee expenses - staff	176,856	72,676
Supplies and services - clinical	27,282	11,198
Supplies and services - general	5,471	2,049
Establishment	2,618	1,098
Research and development	1,839	149
Transport	795	437
Premises	8,997	3,354
Increase/(decrease) in provision for impairment of receivables	(18)	518
Increase/(decrease) in other provisions	-	(143)
Inventories written down	92	40
Drug costs	10,742	2,194
Inventories consumed	31,378	11,683
Rentals under operating leases	68	-
Depreciation on property, plant and equipment	9,121	3,361
Amortisation on intangible assets	382	139
Impairments	23,552	5,506
Audit fees payable to the external auditor		
audit services- statutory audit	57	56
other auditor remuneration (external auditor only)	12	12
Clinical negligence	4,533	1,408
Loss on disposal of non-current assets	60	37
Legal fees	188	137
Consultancy costs	584	270
Internal audit costs	59	38
Training, courses and conferences	967	903
Patient travel	46	-
Redundancy	291	-
Hospitality	128	52
Insurance	244	95
Losses, ex gratia & special payments	7	-
Other resources expended by NHS charitable funds	515	259
Other	198	730
Total	**310,515**	**119,624**
Of which:		
Related to continuing operations	310,515	119,624

Note 5.2 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £2m (2014/15: £2m).

Note 6 Impairment of assets

	Group	
	2015/16	**2014/15**
	£000	**£000**
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	65	-
Changes in market price	23,487	5,484
Total net impairments charged to operating surplus / deficit	**23,552**	**5,484**
Impairments charged to the revaluation reserve	5,101	2,947
Total net impairments	**28,653**	**8,431**

The most significant impairment in 2015-16 relates to the valuation of the Trust's land. During March 2016 the Trust requested the services of an expert valuer to conduct a full site valuation of its land. Details of the revaluation and value of the property plant and equipment are shown in note 15.1. Under IFRS 13, the basis for valuing land is the depreciated replacement cost method (DRC), the guidance states that although the ultimate objective of the methodology is to produce a valuation of the actual property in its actual location, the initial stage of estimating the gross replacement cost has to reflect the cost of a site suitable for a modern equivalent facility.

Often this will be a site of a similar size and in a similar location to the actual site. However, if the actual site is clearly one that a prudent buyer would no longer consider appropriate because it would be commercially wasteful or would be an inappropriate use of resources, the modern equivalent site is assumed to have the appropriate characteristics. The fundamental principle is that the hypothetical buyer would purchase the least expensive site that would be suitable and appropriate for its proposed operations. In addition other factors need to be considered in addition to establishing the location of the modern equivalent site. The modern equivalent asset may not require a site as extensive as the actual site. In this respect land is no different to any other asset. If a smaller area is now sufficient to provide the same service, the modern equivalent site will be based on the reduced area required, even if the actual site is larger.

The change in methodology resulted in a reduction of the Trusts the land's value by £22,865k.

Two departments within the main site, the Wolfson Centre and Waterhouse Ward, were refurbished and subsequently valued in year resulting in impairments of £468k and £154k respectively.

Note 7 Employee benefits

	Group			
			2015/16	2014/15
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	141,170	4,347	**145,517**	60,119
Social security costs	11,113	512	**11,625**	4,280
Employer's contributions to NHS pensions	17,173	570	**17,743**	6,849
Termination benefits	291	-	**291**	-
Agency/contract staff	-	5,665	**5,665**	1,932
NHS charitable funds staff	456	-	**456**	194
Total gross staff costs	**170,203**	**11,094**	**181,297**	**73,374**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**170,203**	**11,094**	**181,297**	**73,374**
Of which				
Costs capitalised as part of assets	1,032	-	**1,032**	123

Note 7.1 Retirements due to ill-health

During 2015/16 there were 5 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2015). The estimated additional pension liabilities of these ill-health retirements is £308k (£109k in 2014/15).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors' remuneration

The aggregate amounts payable to directors were:

	Group	
	2015/16	2014/15
	£000	£000
Salary	1090	358
Taxable benefits	0	0
Performance related bonuses	76	0
Employer's pension contributions	120	41
Total	**1,286**	**399**

Further details of directors' remuneration can be found in the remuneration report.

Note 8 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation.

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representative as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained.

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Those employees who are not eligible to join the NHS Pension scheme are enrolled into the National Employees Savings Trust (NEST) scheme. This is to comply with the Government's auto enrolment requirements. NEST is a defined contribution scheme with a phased employer contribution rate.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Note 9 Operating leases

Note 9.1 Royal United Hospitals Bath NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Royal United Hospitals Bath NHS Foundation Trust is the lessor.

The rent received relates to payment made by residents of the Trust's dwellings on the main hospital site. Rent is charged on a rolling monthly basis. The payments are due monthly and are paid in the current month.

	Group	
	2015/16	2014/15
	£000	£000
Operating lease revenue		
Contingent rent	452	180
Total	**452**	**180**

	31 March 2016	31 March 2015
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	452	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	**452**	**-**

Note 9.2 Royal United Hospitals Bath NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Royal United Hospitals Bath NHS Foundation Trust FT is the lessee.

	Group	
	2015/16	2014/15
	£000	£000
Operating lease expense		
Minimum lease payments	68	-
Total	**68**	**-**

	31 March 2016	31 March 2015
	£000	£000
Future minimum lease payments due:		
- not later than one year;	68	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	**68**	**-**

Note 10 Finance income

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

	Group	
	2015/16	**2014/15**
	£000	**£000**
Interest on bank accounts	51	17
Investment income on NHS charitable funds financial assets	128	3
Total	**179**	**20**

Note 11.1 Finance expenditure

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

	Group	
	2015/16	**2014/15**
	£000	**£000**
Interest expense:		
Loans from the Department of Health	226	42
Finance leases	7	2
Interest on late payment of commercial debt	-	-
Total	**233**	**44**

Note 11.2 The late payment of commercial debts (interest) Act 1998

	Group	
	2015/16	**2014/15**
	£000	**£000**
Amounts included within interest payable arising from claims made under this legislation	1	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 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 defict for the period was £22.792 million (2014/15: £0.549 million(surplus)). The trust's total comprehensive expense for the period was £20.612 million (2014/15: £1.278 million(income)).

Note 13.1 Intangible assets - 2015/16

Group	Software licences	Licences & trademarks	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**1,590**	**1,089**	**2,679**
Additions	102	720	**822**
Disposals / derecognition	(232)	-	**(232)**
Gross cost at 31 March 2016	**1,460**	**1,809**	**3,269**
Amortisation at 1 April 2015 - brought forward	**1,060**	**425**	**1,485**
Provided during the year	169	213	**382**
Disposals / derecognition	(232)	-	**(232)**
Amortisation at 31 March 2016	**997**	**638**	**1,635**
Net book value at 31 March 2016	**463**	**1,171**	**1,634**
Net book value at 1 April 2015	**530**	**664**	**1,194**

Note 13.2 Intangible assets - 2014/15

Group	Software licences	Licences & trademarks	Total
	£000	£000	£000
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)**
Valuation/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**
Net book value at 1 November 2014	**485**	**310**	**795**

Note 14.1 Intangible assets - 2015/16

Trust	Software licences	Licences & trademarks	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**1,590**	**1,089**	**2,679**
Additions	**102**	**720**	**822**
Disposals / derecognition	**(232)**	**-**	**(232)**
Gross cost at 31 March 2016	**1,460**	**1,809**	**3,269**
Amortisation at 1 April 2015 - brought forward	**1,060**	**425**	**1,485**
Provided during the year	**169**	**213**	**382**
Disposals / derecognition	**(232)**	**-**	**(232)**
Amortisation at 31 March 2016	**997**	**638**	**1,635**
Net book value at 31 March 2016	**463**	**1,171**	**1,634**
Net book value at 1 April 2015	**530**	**664**	**1,194**

Note 14.2 Intangible assets - 2014/15

Trust	Software licences	Licences & trademarks	Total
	£000	£000	£000
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)**
Valuation/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**
Net book value at 1 November 2014	**485**	**310**	**795**

Note 15.1 Property, plant and equipment - 2015/16

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**37,866**	**126,897**	**2,906**	**2,392**	**44,643**	**77**	**6,324**	**575**	**221,680**
Additions	-	3,936	66	9,320	3,325	-	2,151	98	**18,896**
Impairments	(27,966)	(1,322)	-	(65)	-	-	-	-	**(29,353)**
Revaluations	-	7,983	196	-	-	-	-	-	**8,179**
Transfers to/ from assets held for sale	(12)	(386)	-	-	-	-	-	-	**(398)**
Disposals / derecognition	-	-	-	-	(1,544)	-	(881)	-	**(2,425)**
Valuation/gross cost at 31 March 2016	**9,888**	**137,108**	**3,168**	**11,647**	**46,424**	**77**	**7,594**	**673**	**216,579**
Accumulated depreciation at 1 April 2015 - brought forward	**-**	**9,300**	**95**	**-**	**25,686**	**70**	**3,553**	**185**	**38,889**
Provided during the year	-	4,945	98	-	3,003	5	1,015	55	**9,121**
Impairments	-	(700)	-	-	-	-	-	-	**(700)**
Revaluations	-	886	13	-	-	-	-	-	**899**
Disposals/ derecognition	-	-	-	-	(1,483)	-	(870)	-	**(2,353)**
Accumulated depreciation at 31 March 2016	**-**	**14,431**	**206**	**-**	**27,206**	**75**	**3,698**	**240**	**45,856**
Net book value at 31 March 2016	**9,888**	**122,677**	**2,962**	**11,647**	**19,218**	**2**	**3,896**	**433**	**170,723**
Net book value at 1 April 2015	**37,866**	**117,597**	**2,811**	**2,392**	**18,957**	**7**	**2,771**	**390**	**182,791**

Note 15.2 Property, plant and equipment - 2014/15

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 - purchased/ leased/ grants/ donations	-	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**
Net book value at 1 November 2014	**35,784**	**115,249**	**2,729**	**4,013**	**17,745**	**12**	**2,516**	**175**	**178,223**

Note 15.3 Property, plant and equipment financing - 2015/16

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 2016									
Owned	9,888	117,300	2,962	10,016	17,277	2	3,896	345	**161,686**
Finance leased	-	-	-	-	41	-	-	-	**41**
Donated	-	5,377	-	1,631	1,900	-	-	88	**8,996**
NBV total at 31 March 2016	**9,888**	**122,677**	**2,962**	**11,647**	**19,218**	**2**	**3,896**	**433**	**170,723**

Note 15.4 Property, plant and equipment financing - 2014/15

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 16.1 Property, plant and equipment - 2015/16

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**37,866**	**126,897**	**2,906**	**2,392**	**44,643**	**77**	**6,324**	**575**	**221,680**
Additions	-	3,936	66	9,320	3,325	-	2,151	98	**18,896**
Impairments	(27,966)	(1,322)	-	(65)	-	-	-	-	**(29,353)**
Revaluations	-	7,983	196	-	-	-	-	-	**8,179**
Transfers to/ from assets held for sale	(12)	(386)	-	-	-	-	-	-	**(398)**
Disposals / derecognition	-	-	-	-	(1,544)	-	(881)	-	**(2,425)**
Valuation/gross cost at 31 March 2016	**9,888**	**137,108**	**3,168**	**11,647**	**46,424**	**77**	**7,594**	**673**	**216,579**
Accumulated depreciation at 1 April 2015 - brought forward	**-**	**9,300**	**95**	**-**	**25,686**	**70**	**3,553**	**185**	**38,889**
Provided during the year	-	4,945	98	-	3,003	5	1,015	55	**9,121**
Impairments	-	(700)	-	-	-	-	-	-	**(700)**
Revaluations	-	886	13	-	-	-	-	-	**899**
Disposals/ derecognition	-	-	-	-	(1,483)	-	(870)	-	**(2,353)**
Accumulated depreciation at 31 March 2016	**-**	**14,431**	**206**	**-**	**27,206**	**75**	**3,698**	**240**	**45,856**
Net book value at 31 March 2016	**9,888**	**122,677**	**2,962**	**11,647**	**19,218**	**2**	**3,896**	**433**	**170,723**
Net book value at 1 April 2015	**37,866**	**117,597**	**2,811**	**2,392**	**18,957**	**7**	**2,771**	**390**	**182,791**

Note 16.2 Property, plant and equipment - 2014/15

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 - purchased/ leased/ grants/ donations	-	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**
Net book value at 1 November 2014	**35,784**	**115,249**	**2,729**	**4,013**	**17,745**	**12**	**2,516**	**175**	**178,223**

Note 16.3 Property, plant and equipment financing - 2015/16

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 2016									
Owned	9,888	117,300	2,962	10,016	17,277	2	3,896	345	**161,686**
Finance leased	-	-	-	-	41	-	-	-	**41**
Donated	-	5,377	-	1,631	1,900	-	-	88	**8,996**
NBV total at 31 March 2016	**9,888**	**122,677**	**2,962**	**11,647**	**19,218**	**2**	**3,896**	**433**	**170,723**

Note 16.4 Property, plant and equipment financing - 2014/15

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 17 Donations of property, plant and equipment

During the year to 31 March 2016 the Trust received donations from which assets were purchased to the value of £1.2m. These donations were mainly made as follows:
£1,181k: Royal United Hospitals Bath Charitable fund
£27k: Friends of the Royal United Hospital

The donations from the Royal United Hospitals Bath Charitable Fund were for the following:
£650k for the purchased of a CT Simulator
£400k contribution for the RUH Development project
£131k for the purchase of other 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 18 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.

Buildings were restated to current value by the use of indices at the 31st March 2016. 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.

During March 2016 the Trust requested the services of an expert valuer to conduct a full site valuation of its land. Details of the revaluation and value of the property plant and equipment are shown in note 15.1. Under IFRS 13, the basis for valuing land is the depreciated replacement cost method (DRC), the guidance states that although the ultimate objective of the methodology is to produce a valuation of the actual property in its actual location, the initial stage of estimating the gross replacement cost has to reflect the cost of a site suitable for a modern equivalent facility.

Often this will be a site of a similar size and in a similar location to the actual site. However, if the actual site is clearly one that a prudent buyer would no longer consider appropriate because it would be commercially wasteful or would be an inappropriate use of resources, the modern equivalent site is assumed to have the appropriate characteristics. The fundamental principle is that the hypothetical buyer would purchase the least expensive site that would be suitable and appropriate for its proposed operations. In addition other factors need to be considered in addition to establishing the location of the modern equivalent site. The modern equivalent asset may not require a site as extensive as the actual site. In this respect land is no different to any other asset. If a smaller area is now sufficient to provide the same service, the modern equivalent site will be based on the reduced area required, even if the actual site is larger.

This assessment was undertaken by an independent valuer, Cushman & Wakefield, on behalf of DTZ Ltd.

The application of this revised methodology resulted in an impairment of £22,865k to the value of the Trust's land.

During the year to 31 March 2016, two areas of the Trust's property underwent a major refurbishment. The Wolfson Centre was completed and valued at 1 October 2015, and the West Ward Block was completed and valued at 31 December 2015 and incurred impairments of £468k and £154k respectively. These areas were excluded from the indexation applied at the 31 March 2016 to the rest of the Trust's property.

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 impairments arise from other factors, all the impairment 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 impairment is actioned where applicable.

At the 31st March 2016 the application of indices applied to Trust assets (excluding those detailed above) resulted in increases to Trust assets of £7,280,000 which was taken to the revaluation reserve.

Note 19.1 Investments - 2015/16

Group	Other investments
	£000
Carrying value at 1 April 2015	**6,516**
Acquisitions in year	81
Movement in fair value	(192)
Carrying value at 31 March 2016	**6,405**

Note 19.2 Investments - 2014/15

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**

All investments held by the group are those of the RUH Charitable Funds

Note 20 Analysis of charitable fund reserves

The Royal United Hospital Charitable fund has been consolidated within this set of accounts

	31 March 2016 £000	31 March 2015 £000
Unrestricted funds:		
Unrestricted income funds	1,036	1,019
Restricted funds:		
Restricted income funds	6,199	6,302
	7,235	**7,321**

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 21 Disclosure of interests in other entities

The Royal United Hospitals Bath NHS Foundation Trust has no interests in any subsidiaries, joint arrangements, associates or unconsolidated structured entities.

Note 22 Inventories

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Drugs	1,900	2,308	1,900	2,308
Consumables	2,484	2,453	2,484	2,453
Energy	67	85	67	85
Other	30	28	30	28
Total inventories	**4,481**	**4,874**	**4,481**	**4,874**

Inventories recognised in expenses for the year were -£53,071k (2014/15: -£24,747k). Write-down of inventories recognised as expenses for the year were -£92k (2014/15: -£40k).

Note 23.1 Trade receivables and other receivables

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Current				
Trade receivables due from NHS bodies	8,976	12,531	8,976	12,531
Receivables due from NHS charities	-	-	1,161	-
Other receivables due from related parties	2,235	2,431	2,235	2,431
Provision for impaired receivables	(579)	(803)	(579)	(803)
Deposits and advances	7	22	7	22
Prepayments (non-PFI)	2,465	2,519	2,465	2,519
Accrued income	3,308	768	3,308	768
PDC dividend receivable	511	-	511	-
VAT receivable	681	211	681	211
Other receivables	48	46	48	46
Trade and other receivables held by NHS charitable funds	1	-	-	-
Total current trade and other receivables	**17,653**	**17,725**	**18,813**	**17,725**
Non-current				
Provision for impaired receivables	(258)	(248)	(258)	(248)
Accrued income	1,512	1,594	1,512	1,594
Total non-current trade and other receivables	**1,254**	**1,346**	**1,254**	**1,346**

Note 23.2 Provision for impairment of receivables

	Group		Trust	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
At 1 April as previously stated	**1,051**	**-**	**1,051**	**-**
Prior period adjustments	-	-	-	-
At 1 April - restated	**1,051**	**-**	**1,051**	**-**
At start of period for new FTs	**-**	**458**	**-**	**458**
Transfers by absorption	-	82	-	82
Increase in provision	456	566	456	566
Amounts utilised	(196)	(7)	(196)	(7)
Unused amounts reversed	(474)	(48)	(474)	(48)
At 31 March	**837**	**1,051**	**837**	**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 23.3 Analysis of impaired receivables

Group	**31 March 2016**		**31 March 2015**	
	Trade receivables	Other receivables	Trade receivables	Other receivables
Ageing of impaired receivables	**£000**	**£000**	**£000**	**£000**
0 - 30 days	25	8	747	-
30-60 Days	29	14	43	-
60-90 days	139	25	53	-
90- 180 days	80	31	69	-
Over 180 days	239	247	139	-
Total	**512**	**325**	**1,051**	**-**
Ageing of non-impaired receivables past their due date				
0 - 30 days	2,393	-	10,212	-
30-60 Days	568	-	1,384	-
60-90 days	846	-	1,100	-
90- 180 days	745	-	935	-
Over 180 days	579	-	508	-
Total	**5,131**	**-**	**14,139**	**-**

Trust	**31 March 2016**		**31 March 2015**	
	Trade receivables	Other receivables	Trade receivables	Other receivables
Ageing of impaired receivables	**£000**	**£000**	**£000**	**£000**
0 - 30 days	25	8	747	-
30-60 Days	29	14	43	-
60-90 days	139	25	53	-
90- 180 days	80	31	69	-
Over 180 days	239	247	139	-
Total	**512**	**325**	**1,051**	**-**
Ageing of non-impaired receivables past their due date				
0 - 30 days	2,393	-	10,212	-
30-60 Days	568	-	1,384	-
60-90 days	846	-	1,100	-
90- 180 days	745	-	935	-
Over 180 days	579	-	508	-
Total	**5,131**	**-**	**14,139**	**-**

Any receivable that is not due and has not been impaired are with customers with a good credit history with the Trust and full payment is anticipated.

Note 24.1 Non-current assets for sale and assets in disposal groups

Group	2015/16 Most recently held as: Intangible assets £000	Property, plant & equipment £000	Investments in associates & joint £000	Investment properties £000	NHS charitable fund assets £000	2015/16 Total £000	2014/15 Total £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Plus assets classified as available for sale in the year	-	398	-	-	-	**398**	**-**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**398**	**-**	**-**	**-**	**398**	**-**

Trust	2015/16 Most recently held as: Intangible assets £000	Property, plant & equipment £000	Investments in associates & joint £000	Investment properties £000	2015/16 Total £000	2014/15 Total £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**-**	**-**	**-**	**-**	**-**
Plus assets classified as available for sale in the year	-	398	-	-	**398**	**-**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**398**	**-**	**-**	**398**	**-**

During 2015/16 the land and buildings of Trim Street have been classified as held for sale in the accounts. On the 21st October 2015 the Board of Directors approved the sale of Trim Street . The assets have been held at carrying value as this is likely to be lower than the fair value (market value) less costs to sell. The land and building have a Net Book Value of £398k and have been made available to purchase on the open market.

Note 26.1 Trade and other payables

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Current				
Receipts in advance	-	-	-	-
NHS trade payables	459	808	459	808
Amounts due to other related parties	160	16	160	16
Other trade payables	4,270	3,424	4,270	3,424
Capital payables	2,941	1,155	2,941	1,155
Social security costs	-	-	-	-
VAT payable	139	-	139	-
Other taxes payable	3,372	3,339	3,372	3,339
Other payables	2,552	3,885	2,552	3,885
Accruals	8,596	8,151	8,596	8,151
PDC dividend payable	-	159	-	159
Trade and other payables held by NHS charitable funds	6	36	-	-
Total current trade and other payables	**22,495**	**20,973**	**22,489**	**20,937**

Note 24.2 Liabilities in disposal groups

The Foundation Trust has no liabilites in disposal groups

Note 25.1 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	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
At 1 April	**10,679**	**-**	**9,610**	**-**
At start of period for new FTs	**-**	**9,564**	**-**	**8,527**
Transfers by absorption	-	360	-	-
Net change in year	3,494	83	2,567	1,083
At 31 March	**14,173**	**10,007**	**12,177**	**9,610**
Broken down into:				
Cash at commercial banks and in hand	18	30	18	30
Cash with the Government Banking Service	14,155	10,649	12,159	9,580
Total cash and cash equivalents as in SoFP	**14,173**	**10,679**	**12,177**	**9,610**
Total cash and cash equivalents as in SoCF	**14,173**	**10,679**	**12,177**	**9,610**

Note 25.2 Third party assets held by the NHS foundation trust

Royal United Hospitals Bath NHS Foundation Trust does not hold any cash or cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties.

Note 27 Other liabilities

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Current				
Deferred goods and services income	1,648	1,527	1,648	1,527
Total other current liabilities	**1,648**	**1,527**	**1,648**	**1,527**

Note 28 Borrowings

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Current				
Loans from the Department of Health	2,767	990	2,767	990
Obligations under finance leases	57	89	57	89
Total current borrowings	**2,824**	**1,079**	**2,824**	**1,079**
Non-current				
Loans from the Department of Health	16,211	9,235	16,211	9,235
Obligations under finance leases	24	80	24	80
Total non-current borrowings	**16,235**	**9,315**	**16,235**	**9,315**

Note 29 Finance leases

Trust as a lessee

Obligations under finance leases where Royal United Hospitals Bath NHS Foundation Trust is the lessee.

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Gross lease liabilities	**81**	**173**	**81**	**173**
of which liabilities are due:				
- not later than one year;	57	89	57	89
- later than one year and not later than five years;	24	84	24	84
- later than five years.	-	-	-	-
Finance charges allocated to future periods	-	(4)	-	(4)
Net lease liabilities	**81**	**169**	**81**	**169**
of which payable:				
- not later than one year;	57	89	57	89
- later than one year and not later than five years;	24	80	24	80
- later than five years.	-	-	-	-

Note 30.1 Provisions for liabilities and charges analysis

Group	Pensions - other staff	Other legal claims	Agenda for change	Redundancy	Other	NHS charitable fund provisions	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2015	**841**	**85**	**1,148**	**-**	**298**	**-**	**2,372**
Arising during the year	136	77	132	52	476	-	**873**
Utilised during the year	(61)	(93)	(3)	-	(23)	-	**(180)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	**-**
Reversed unused	(16)	(36)	(466)	-	(60)	-	**(578)**
Unwinding of discount	11	-	-	-	-	-	**11**
At 31 March 2016	**911**	**33**	**811**	**52**	**691**	**-**	**2,498**
Expected timing of cash flows:							
- not later than one year;	76	33	616	52	691	-	**1,468**
- later than one year and not later than five years;	835	-	195	-	-	-	**1,030**
- later than five years.	-	-	-	-	-	-	**-**
Total	**911**	**33**	**811**	**52**	**691**	**-**	**2,498**

Trust	Pensions - other staff	Other legal claims	Agenda for change	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2015	**841**	**85**	**1,148**	**-**	**298**	**2,372**
Arising during the year	136	77	132	52	476	**873**
Utilised during the year	(61)	(93)	(3)	-	(23)	**(180)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	**-**
Reversed unused	(16)	(36)	(466)	-	(60)	**(578)**
Unwinding of discount	11	-	-	-	-	**11**
At 31 March 2016	**911**	**33**	**811**	**52**	**691**	**2,498**
Expected timing of cash flows:						
- not later than one year;	76	33	616	52	691	**1,468**
- later than one year and not later than five years;	835	-	195	-	-	**1,030**
- later than five years.	-	-	-	-	-	**-**
Total	**911**	**33**	**811**	**52**	**691**	**2,498**

Pensions - other Staff
Early retirement costs and injury benefit payments for staff other than directors, based on the information provided by NHS Pensions. It is certain that the amounts and timings of the cash flows are accurate for the life of the claimant.

Other Legal Claims
Litigation claims against the Trust that are being handled by NHS Litigation Authority. The provision is based on the information provided by NHS Litigation Authority

Agenda for Change
Provision for the amounts due to non medical staff for missed increment payments at the top and bottom of the band. The amounts are based on the individuals in question and so an accurate estimate of amounts owed. The timing is reliant on the staff claiming the funds.

Redundancy

A provision for the planned redundancies following the acquisition of the RNHRD. These are calculated amounts and are for people identified for redundancy therefore the cash flows are likely in the next 12 months.

Other
A range of provisions for various pay disputes and negotiations across the Trust including doctors pay banding, underpayments and on-call payments. These amounts are estimates based on known salaries and the likelihood of back pay. It is very likely that these will be resolved in the coming year

Note 30.2 Clinical negligence liabilities

At 31 March 2016, £43,907k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Royal United Hospitals Bath NHS Foundation Trust (31 March 2015: £25,546k).

Note 31 Contingent assets and liabilities

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Value of contingent liabilities				
NHS Litigation Authority legal claims	(31)	(19)	(31)	(19)
Gross value of contingent liabilities	**(31)**	**(19)**	**(31)**	**(19)**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**(31)**	**(19)**	**(31)**	**(19)**
Net value of contingent assets	**722**	**-**	**-**	**-**

Note 32 Contractual capital commitments

	Group		Trust	
	2016 £000	2015 £000	2016 £000	2015 £000
Property, plant and equipment	6,671	1,717	6,671	1,717
Intangible assets	69	-	69	-
Total	**6,740**	**1,717**	**6,740**	**1,717**

Note 33 Defined benefit pension schemes

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 payments

Note 34 Financial instruments

Note 34.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the 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 34.2 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 2016					
Trade and other receivables excluding non financial assets	18,906	-	-	-	**18,906**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	12,177	-	-	-	**12,177**
Financial assets held in NHS charitable funds	1,996	6,405	-	-	**8,401**
Total at 31 March 2016	**33,079**	**6,405**	**-**	**-**	**39,484**

Financial Assets held in the NHS Charitable fund: Fair Value Hierarchy	Level 1	Level 2	Level 3
	£000	£000	£000
Bonds	1,181	-	-
Equities	2,508	-	-
Alternative Assets	1,148	-	-
Cash	1,568	-	-
Total at 31 March 2016	**6,405**	**-**	**-**

The fair value hierarchy consists of the following three levels:

Level 1 quoted prices (unadjusted) in active markets for identical assets or liabilities.

Level 2 inputs other than quoted prices included within Level 1 that are observable for the asset or liability either directly or indirectly.

Level 3 inputs for the asset or liability that are not based on observable market data (unobservable inputs).

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					
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	1,069	6,516	-	-	**7,585**
Total at 31 March 2015	**29,978**	**6,516**	**-**	**-**	**36,494**

Trust	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 2016					
Trade and other receivables excluding non financial assets	18,906	-	-	-	**18,906**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	12,177	-	-	-	**12,177**
Total at 31 March 2016	**31,083**	**-**	**-**	**-**	**31,083**

Trust	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					
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**
Total at 31 March 2015	**28,909**	**-**	**-**	**-**	**28,909**

Note 34.3 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 2016			
Borrowings excluding finance lease and PFI liabilities	18,978	-	**18,978**
Obligations under finance leases	81	-	**81**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	22,495	-	**22,495**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Financial liabilities held in NHS charitable funds	-	-	**-**
Total at 31 March 2016	**41,554**	**-**	**41,554**

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**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	18,071	-	**18,071**
Other financial liabilities	1,527	-	**1,527**
Provisions under contract	2,372	-	**2,372**
Financial liabilities held in NHS charitable funds	36	-	**36**
Total at 31 March 2015	**32,400**	**-**	**32,400**

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2016			
Borrowings excluding finance lease and PFI liabilities	18,978	-	**18,978**
Obligations under finance leases	81	-	**81**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	22,495	-	**22,495**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2016	**41,554**	**-**	**41,554**

Trust	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**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	18,071	-	**18,071**
Other financial liabilities	1,527	-	**1,527**
Provisions under contract	2,372	-	**2,372**
Total at 31 March 2015	**32,364**	**-**	**32,364**

Note 34.4 Maturity of financial liabilities

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
In one year or less	25,319	21,603	-	-
In more than one year but not more than two years	2,768	2,383	-	-
In more than two years but not more than five years	8,400	3,960	-	-
In more than five years	5,067	4,454	-	-
Total	**41,554**	**32,400**	**-**	**-**

Note 34.5 Fair values of financial assets and liabilities at 31 March 2016

Financial Assets are carried at cost which is not considered to be significantly different to fair value.

Financial Liabilities are carried at cost which is not considered to be significantly different to fair value.

Note 35 Losses and special payments

Group and Trust	2015/16 Total number of cases Number	2015/16 Total value of cases £000	2014/15 Total number of cases Number	2014/15 Total value of cases £000
Losses				
Total losses	-	-	-	-
Special payments				
Ex-gratia payments	29	8	9	3
Total special payments	**29**	**8**	**9**	**3**
Total losses and special payments	**29**	**8**	**9**	**3**

Note 36 Prior period adjustments

An adjustment of £228k has been made to the opening balances for trade and other receivables, the I&E reserve, operating income, and surplus in relation to the adjustment required to the Trust figure on consolidating the RUH Charitable Funds.

Note 39 Related parties

During the year none of the Department of Health Ministers, Royal United Hospitals Bath NHS Foundation Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Royal United Hospitals Bath NHS Foundation Trust

The Department of Health is regarded as a related party. During the 12 month period to 31 March 2016, 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 12 months to 31st March 2016 £000	Expenditure 12 months to 31st March 2016 £000	Receivables at the 31st March 2016 £000	Payables at the 31st March 2016 £000
NHS Wiltshire CCG	87,814	379	1,442	36
NHS Bath and North East Somerset CCG	80,320	12	2,657	-
NHS Somerset CCG	29,471	-	485	-
NHS South Gloucestershire CCG	7,873	-	187	-
NHS Bristol CCG	1,875	-	192	-
NHS Gloucestershire CCG	888	-	42	-
NHS North Somerset CCG	694	-	13	-

NHS England Organisations	Income 12 months to 31st March 2016 £000	Expenditure 12 months to 31st March 2016 £000	Receivables at the 31st March 2016 £000	Payables at the 31st March 2016 £000
NHS England South West Local Office	558	-	13	-
NHS England - South West Commissioning Hub	40,135	-	1,622	-
NHS England South Central Local Office	5,320	-	1,426	-
NHS England - Wessex Commissioning Hub	4,651	-	1,356	-

NHS Trusts and Foundation Trusts	Income 12 months to 31st March 2016 £000	Expenditure 12 months to 31st March 2016 £000	Receivables at the 31st March 2016 £000	Payables at the 31st March 2016 £000
University Hospitals Bristol NHS Foundation Trust	1,540	711	173	92
North Bristol NHS Trust	726	724	91	209
Great Western Hospitals NHS Foundation Trust	694	2,261	185	382
Salisbury NHS foundation trust	447	82	177	-
Avon and Wiltshire mental health partnership NHS Trust	106	-	339	-
Somerset partnership NHS foundation Trust	165	353	2	-
Yeovil District hospital NHS foundation Trust	41	-	8	-
Gloucestershire Hospitals NHS Foundation Trust	5	1,712	1	144

Other Agencies	Income 12 months to 31st March 2016 £000	Expenditure 12 months to 31st March 2016 £000	Receivables at the 31st March 2016 £000	Payables at the 31st March 2016 £000
Health Education England	10,376	48	68	44
Department Of Health (excluding PDC)	1,668	13	9	44
Bath and North East Somerset Council	679	76	39	71
Wiltshire Unitary Authority	465	-	8	-
Welsh Assembly Government (incl all other Welsh Health Bodies)	274	52	-	-
Public Health England	-	2,052	-	1,537
NHS Litigation Authority	-	4,755	-	8
NHS Blood and Transplant (excluding Bio products Laboratory)	18	1,719	-	-

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.