Royal United Hospitals Bath
NHS Foundation Trust

Annual Report and Accounts

2019/20

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Contents

Message from the Chair and Chief Executive

At the time of writing, our efforts are largely concentrated on the challenges of COVID-19 - a health crisis like nobody had ever seen before. Across the globe health services faced unprecedented challenges and incredible pressures. The work covered in this report largely predates the pandemic, but we hope, shows that a hospital which is grounded in the pursuit of high standards of patient care, and excellent working conditions, is well set to weather such storms.

Coronavirus required us to work in ways we had never had to before; reconfiguring wards to ensure we had capacity for the predicted surge in COVID-19 cases, establishing additional intensive care beds and setting up the new Respiratory Assessment Unit, which was of significant benefit during the pandemic and will provide longer term support for the hospital in other ways.

Across the Trust our staff came together as one to tackle the pandemic head-on. From cleaners, porters and kitchen staff to doctors and nurses, our frontline workers continued working selflessly to provide the very best care and support to our patients. Many staff also volunteered to be redeployed to other roles across the hospital, ensuring we had staff where we needed them most.

While it was necessary for us to temporarily postpone some elective surgeries, we continued to provide urgent and emergency care for patients and established virtual clinics with many of our outpatients, one of several successful new ways of working that we will continue to use going forward. We do recognise that the hospital's focus on managing the pandemic has meant that large numbers of our patients have had planned operations postponed, and that other patients, some of whom may have potentially life limiting conditions, have been unable or unwilling to come into the hospital during this time. In collaboration with the two main independent sector hospitals in Bath – the Circle Bath Hospital and the BMI Bath Clinic, we have been able to maintain some of our elective and non-elective services, and as the numbers of COVID-19 patients in the hospital continue to reduce, we are urgently turning our attention to re-commencing as many of our services as we possibly and safely can.

The professionalism, dedication, skill and ability of our staff to stay calm in the face of such pressure is truly inspirational.

While we, and the South West as a whole, did not see the same scale of peak in number of cases as our colleagues at hospitals in London and Birmingham, we did sadly have coronavirus patients die while at the Royal United Hospitals NHS Foundation Trust. Each death is a tragedy that impacts on friends, family and the wider community, and our thoughts go out to all concerned.

We were uplifted by the local community, be it lining the streets every Thursday evening to clap for key workers, or donating gifts or money to the hospital through The Forever Friends Appeal, the hospital's charity. We continue to be grateful for the many signs of the affection and regard the hospital is held in by our local communities.

Work on COVID-19 was greatly strengthened by the working relationships we enjoy with colleagues in the Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (BSW). We set up processes for sharing scarce supplies, shared clinical understandings and innovative practice and made sure that all our patients would be cared for in the most suitable locations for their particular needs. The crisis accelerated these developments on the ground and BSW is now a vibrant force developing exciting plans for the future in how we care for all our patients. Trust staff also played a major role in the rapid development of the NHS Nightingale Hospital Bristol during April 2020. The hospital, situated on the Frenchay campus of the University of the West of England was designed to provide up to 300 additional intensive care beds for the whole of the newly created Severn critical care network which includes the RUH.

Elsewhere, we have continued to move forward with major capital projects that have been transforming the hospital site and making the RUH fit for the future. In October 2019, HRH The Duchess of Cornwall officially opened the new “RNHRD and Brownsword Therapies Centre”. The Centre brings together therapies and pain services located at the RUH with many of the services previously located at the RNHRD's Mineral Water Hospital site, known to many as the 'Min’. Bringing staff and services together on one site has been many years in the planning, and we worked closely with patients and staff to design the best new home for services relocating from the Min.

We are always working to improve the services we provide to our patients. Over the last 12 months we launched a new follow-up clinic for our Critical Care patients, which monitors not only their physical, but also their mental health once they have left the RUH. This recognises the impact of the trauma of critical care on people whose recovery needs to be multi-faceted. We also opened a new Trauma Assessment Unit alongside our Emergency Department, ensuring that patients with complex injuries and conditions who need specialist orthopaedic treatment can get speedier care.

We continue to invest in our staff and our future, progressing our Improving Together programme across all levels of the organisation. Improving Together is a long-term approach to quality improvement and frontline empowerment and problem-solving that will help deliver our vision – ‘To provide the highest quality of care, delivered by an outstanding team who all live by our values’. Hundreds of staff have already taken part in training and coaching, learning the sustainable skills and mind-set to help deliver our True North goals - quality improvement, patient and staff experience, partnership working and sustainability.

Our exceptional staff continue to do us proud, with their skills and expertise being recognised and celebrated locally and nationally. Examples included our Dyson Centre for Neonatal Care being awarded UNICEF’s prestigious Baby Friendly accreditation, in recognition of its work to protect, promote and support breastfeeding, while strengthening mother-baby and family relationships. Meanwhile our Library Services team received national acclaim for its project to provide our

dementia patients with audiobooks, plays and radio shows during their stay at the RUH.

Cardiac physiologist Helen Hodgson was awarded a prestigious 12-month NHS fellowship for female healthcare scientists, our Dementia Coordinator team was a finalist in the national Dementia Care Awards 2019, while the Optometry team was shortlisted in the Association of Optometrists Awards 2020. We were also delighted to be named as one of the top two Trusts in the country for our care of older people who have broken a hip. We also won two national awards for sustainability - for staff engagement and for sustainable infrastructure (the Spiritual Care Centre).

At the RUH we pride ourselves on being an outstanding place to work where staff can flourish. We aspire to create an open, non-judgemental and inclusive environment, as was clearly illustrated with the launch of our rainbow badges for staff. The NHS rainbow badge project is a way of demonstrating that the RUH is an inclusive environment for lesbian, gay, bisexual and transgender people. It is a way of signalling that people can feel confident in discussing LGBT+ issues with staff, and will be signposted to the appropriate support if needed.

We maintain our reputation for participating in national and worldwide research, helping to make vital contributions to public health and medical progress. Researchers at the RNHRD are leading on an international study into treatment for rheumatology and we have partnered with the University of Bristol to launch a UK-wide trial to test whether a commonly prescribed dementia drug could prevent debilitating falls for people with Parkinson's disease.

We are, as ever, hugely appreciative of everyone across the local community who supports the Trust – our Board of Executive and Non-Executive Directors, our Council of Governors, our 17,000 members, the Forever Friends Appeal and Friends of the RUH and their generous supporters. They all play a vital role in the organisation's continued success. We are also fortunate to be supported by a wide range of individuals, local businesses and charitable groups such as the Bath Cancer Unit Support Group, Time is Precious and many more.

The past year has been particularly financially challenging for the RUH, and there has been a significant deterioration from the position in 2018/19. This was partly driven by increasing cost pressures related to staffing, where high numbers of nursing vacancies were covered by agency staff, and also due to our falling short in the delivery of the level of efficiencies required to achieve the financial plan. It must be stressed that we needed to invest in this extra staffing to ensure that we kept our patients safe.

We are, nevertheless looking forward positively to the year ahead. That we can do so with confidence is in large part due to the work for the past 13 years of our outgoing CEO, James Scott. He transformed a hospital which struggled both in terms of its services and its finances into one which could be proud of its work and which returned a financial surplus for 12 of those years. He was an unwavering

champion for patients and an energetic supporter of staff development. The people who use the RUH and those who work here have a great deal to thank him for. But we, as he always did, now express our thanks to our quite incredible staff and for the wonderful support we continue to receive from the local community.

Performance report

Overview of performance

This overview provides a summary of the statutory background and principal activities of the RUH and how the Trust performed against its key targets and objectives from both a financial and operational perspective during 2019/20. Information about the Trust's future objectives and key risks to the achievement of these objectives are also outlined below.

Statement from the Chief Executive

2019/20 has been another challenging but successful year for our organisation. Across the wider NHS we have continued to see increasing operational and financial pressure on all hospitals. The RUH has continued to address these challenges and is committed to maintaining high quality services which are productive and efficient. Like many acute trusts, managing increases in emergency demand continued to represent the Trust's main operational and financial challenge in 2019/20, including meeting the four-hour emergency access target. These operational challenges generated cost pressures relating to pay, with vacancies backfilled by agency staff, and led to the non-delivery of the savings needed to meet the financial plan. Despite these challenges the RUH has delivered an adjusted surplus of £0.05m as set out in the Financial Performance section, however the Group reported a deficit of £7.7m. This position includes £8.84m of incentive funding received from NHS England/Improvement.

During the course of the year, the Trust worked well with partners across the local health economy to prepare for the UK's exit from the European Union, ensuring that there were no shortages in medication or other essential supplies during that period. Successful steps were also taken to ensure that members of staff from EU countries continued to receive both practical and emotional support.

The emergence of the COVID-19 pandemic in the fourth quarter of the year led to an almost complete suspension of all elective work, and may have also contributed to a fall in the number of patients accessing the Trust's emergency department. The full impact of these developments on the Trust will be further assessed during 2020/21.

Further information on the operational and financial performance of the Trust over the 2019/20 financial year is outlined in the following report.

About the Trust

Statutory background

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

Purpose and activities

The Royal United Hospitals Bath NHS Foundation Trust serves a population of approximately 500,000 residents across Bath and North East Somerset, West Wiltshire, Somerset and South Gloucestershire. In addition to our core local population, we also treat people visiting our area, including tourists, students and overseas visitors.

Our dedicated workforce of clinical and non-clinical staff deliver a range of high quality services from our main acute hospital site in Combe Park to the north-west of the centre of Bath. The Mineral Water Hospital in central Bath previously housed the RNHRD, but the Trust moved out of that facility in January 2020. Maternity services continue to be provided from a number of community birth centres and the Trust runs outpatient centres across the region.

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

Our core business is provision of NHS services under contracts to Bath and North East Somerset, Swindon and Wiltshire (BSW) and South Gloucestershire clinical commissioning groups (CCG) as well as NHS England specialised service commissioners. It is worth noting that the BSW CCG came into existence on 1 April 2020 following a merger of the previous BaNES, Swindon and Wiltshire CCGs.

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

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

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

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

In common with other areas, our population is evolving:

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

Patients are at the heart of all we do, and we aspire to be responsive and compassionate at all times. We place great importance on gathering feedback from patients and carers, and involving them in decisions and developments. This is embedded in the Trust through our Patient Experience Strategy supported by an Engagement Toolkit and a range of initiatives and practices, such as our complaints service, consultations and events, social media and other communications, and our volunteers, membership and governors.

We aim to provide the highest quality of services in response to the needs of our patients and the communities we serve. Our Trust Strategy was refreshed in 2017/18 following engagement with over 600 staff, patients and key stakeholders. It sets out our overall goals to achieve high quality care and patient experience, putting patients at the heart of all we do. It is built around five key strategic goals and also reflects our core trust values. Our programme of whole organisation development "Improving Together" is designed to support its delivery.

Supporting and developing our workforce has been a key focus of this strategy, and our innovative quality improvement programme, Improving Together, which was also

launched in 2018, seeks to galvanise all of our staff to take responsibility for suggesting and implementing improvements in their areas, regardless of their seniority or professional background. As part of this approach, four focus areas were identified as "breakthrough objectives", relating to our strategic goals, for focused improvement activity by our frontline teams. These are areas that we identified as requiring significant changes to the way that we operate. The breakthrough objectives for 2019/20 were:

- Reducing incidents recorded as causing significant harm by at least 20% Trust-wide
- Improving effective team working throughout the Trust
- Improving cost management throughout the Trust to deliver all services safely within budget
- Improving flow and ensuring no unnecessary hospital stays/delays to improve delivery of access standards and patient outcomes

Risks and issues

The following Trust-wide risks remain key to the delivery of our organisational objectives:

a. Workforce supply

National shortages of key staffing groups have and continue to impact on the Trust's ability to recruit to some groups, in particular nursing staff and certain specialists.

Our staff are central to our strategy to provide quality services and care. We see an ongoing focus on staff engagement and wellbeing as a priority to individual choice to stay, and we continue to monitor levels of satisfaction and actively seek new ways to support our employees. During 2020/21 and going forward we will also continue to invest in recruitment and retention including the development of new roles, training, flexible working, accommodation and alternative sources of supply including overseas recruitment.

b. System sustainability

The national picture of financial challenge for public services is well publicised with ongoing growth in demand and expectations and strong inter-dependencies between systems e.g. NHS and Social care. Our local catchment population is older than the UK average with 2.9% more over 65s identified in 2017 and current forecasts estimate this gap will continue to widen with 1.8% higher growth in this population segment by 2022. The financial sustainability of the local health and care system remains under significant strain and we are working with our STP partners to identify solutions, including the development of local area-integrated care arrangements. The focus of work currently is around frail elderly

pathways, mental health conditions, prevention and review of any unwarranted variation against local and national benchmarks.

c. Performance

In the context of an aging population and financial challenge, the health system has struggled to enact transformational change which effectively matches capacity and demand. Performance against key national indicators, including A&E four hour waits, RTT and cancer access standards, within this context, has been and continues to be very challenging. Work continues with commissioners to identify and progress opportunities for more effective capacity/demand management as a system, alongside continuing to embed successes in review and redesign of key pathways e.g. discharges and admissions.

Steps are being taken to embed some of the changes to working practices that have come about in response to the COVID-19 outbreak, with a view to also supporting the achievement of lasting transformation on some of the longstanding challenges that the Trust has faced. These include an increase in the use of virtual outpatient appointments and concerted efforts to ensure that patients who do not or no longer require hospital treatment are cared for in more appropriate settings.

d. Recovery of patient services following the COVID-19 outbreak

Once the COVID-19 outbreak had been declared a global pandemic, in common with other trusts, and in line with government policy, the vast majority of other clinical services at the hospital, elective and non-elective, were suspended. Some services continued to be provided from the two local independent sector hospitals.

As the number of COVID-19 cases in the community continues to decrease, the Trust is taking steps to re-commence as many of its normal clinical services as possible, to start to address the growing waiting lists and to provide needed care for those with serious conditions. However, there is a recognition that this needs to be done carefully. Because of social distancing requirements, 107 hospital beds will not be re-opened initially. The nature of some parts of the hospital site also makes social distancing challenging, although various steps are being taken to alleviate these concerns. However, there are also questions about how confident patients and their carers will be to come onto the site at the present time.

<u>Going Concern</u>

The Trust continues to operate in a climate of financial uncertainty within the NHS in England and the unprecedented situation that has arisen from the COVID-19 outbreak. Whilst there are known risks over the coming five years, including a substantial capital programme, continuing operational pressures and financial

challenges, there is sufficient evidence in the view of the Board to support the view that the Trust will continue to operate as a going concern over the 12 months from the signing of the opinion.

The Trust is forecasting a breakeven position in 2020/21. The Trust is working on the principal of a breakeven position as part of the interim COVID arrangements. As advised by NHS England/Improvement (NHSE/I) the Trust has been guaranteed minimum level of income for the first four months of the financial year from commissioners in relation to COVID-19. Additional guidance was issued by NHSE/I in May 2020, stating that it was reasonable to assume that the funding would continue to flow for the remaining months of 2020/21 and into 2021/22. Therefore there is no material risk to the cash flow of the Trust.

The Board of Directors has carefully considered the principle of 'Going Concern' and the Directors have concluded that whilst there are uncertainties relating to the financial year 2020/21, the going concern basis remains appropriate. This is because the Board of Directors has a reasonable expectation that the Trust will have access to adequate resources to continue to deliver services for the foreseeable future.

The assessment accords with the statutory guidance contained in the NHS Foundation Trust Annual Reporting Manual and the Department of Health and Social Care Group Accounting Manual (GAM).

Performance analysis

Overview of performance during 2019/20

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. The Trust manages performance against the NHS Single Oversight Framework which does not give a performance assessment in its own right; it aims to help providers attain and maintain Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework looks at providers across five themes: Quality of care (safe, effective, caring and responsive), Finance and use of resources, Operational performance, Strategic Change and Leadership and improvement capability (well-led).

The Trust's integrated balanced scorecard incorporates all the national indicators within NHSI's previous Single Oversight Framework across these five themes. With the transition in 2019/20 to the new NHS Oversight Framework, the Trust is looking forward to working with its partners within the BSW STP to provide a comprehensive assessment of performance across the whole local health economy. For the RUH specifically, the overall governance rating of 2 out of 4 (where 1 reflects providers

with maximum autonomy) awarded under the previous Single Oversight Framework during 2018/19 remains in place.

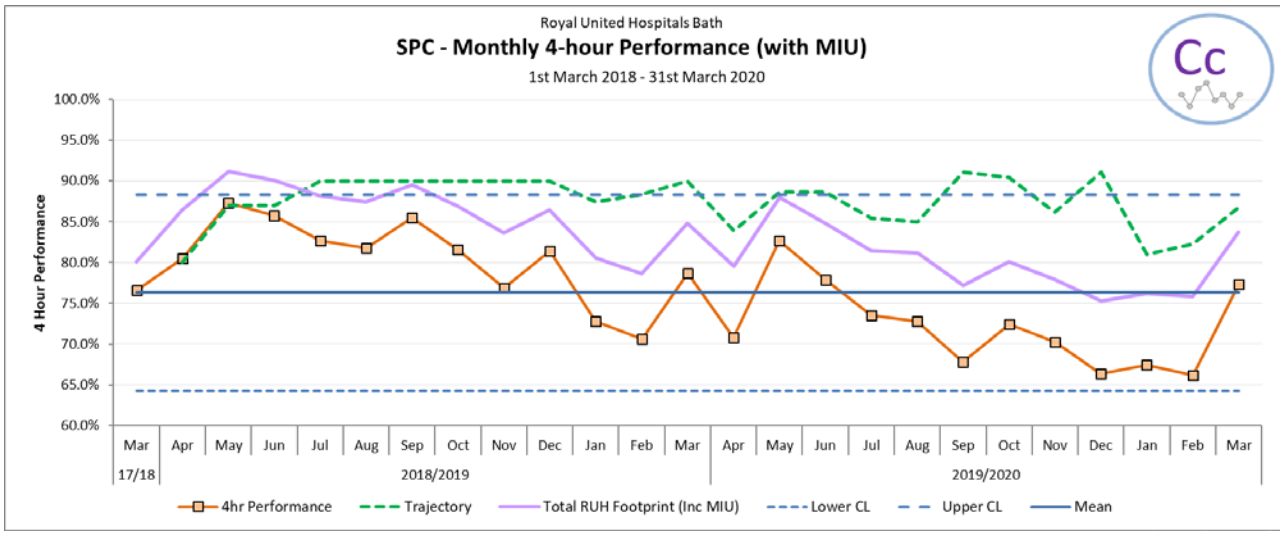
The Trust has a well embedded data quality assurance framework to ensure a high level of data integrity is maintained which is led by the Trust's Quality Board. Our reporting against national standards is robust and regularly audited as part of the Trust's Quality accounts.

Urgent and Emergency Care

The Trust continues to be monitored against the national access target of treating 95% of patients attending its Emergency Department within 4-hours of admission. In common with many other acute hospitals in the country, the RUH has found the delivery of this target extremely challenging.

During 2019/20, the RUH has focused on a number of key actions to support the flow of patients out of the Emergency Department and to increase the number of patients that go directly to an assessment unit. The Trust continues to work collaboratively with all partners within the local Health and Social Care system to ensure that all patients are seen, treated and cared for in the most appropriate setting for their needs.

The RUH's performance during 2019/20 is outlined below:

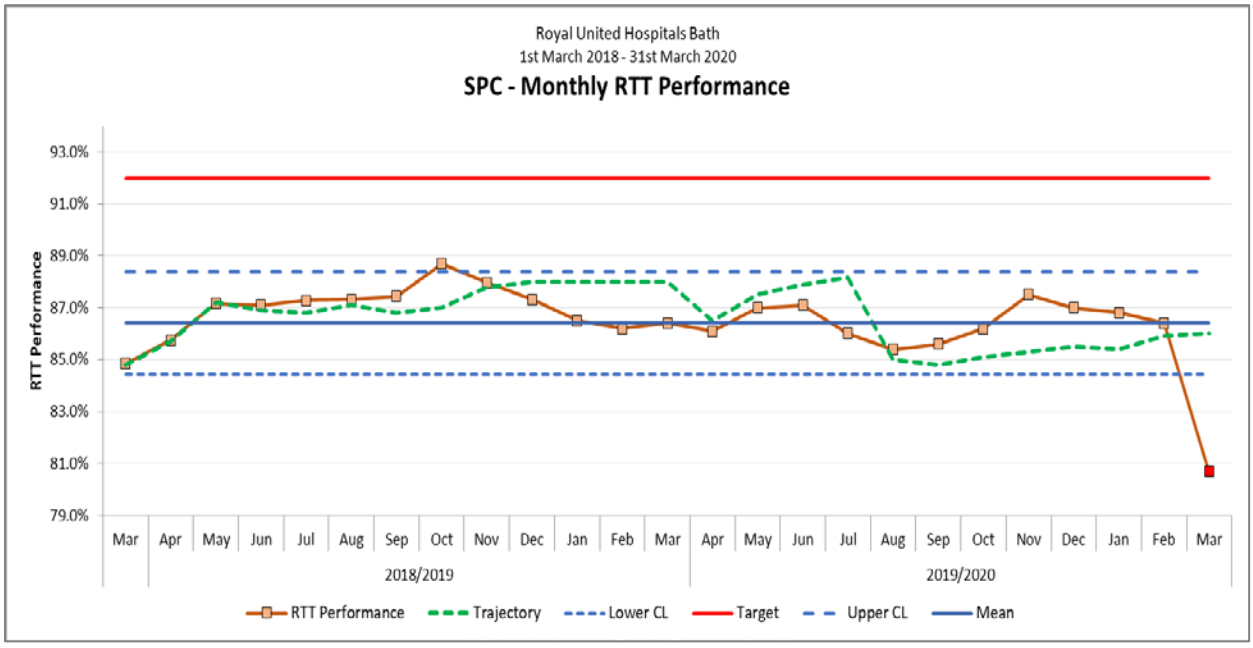


Performance improved significantly in March 2020 as a result of the COVID-19 pandemic due mainly to a dramatic reduction in the number of attendances to the Emergency Department. Patient feedback about the quality of the care that they receive in our Emergency Department and other access areas continues to be positive.

Moving into 2020/21, achieving the 4-hour performance standard, as well as other key clinical indicators, remains a high priority for the RUH albeit now with the added complexity of the COVID-19 outbreak.

18-week Referral to Treatment Time

During 2019/20 pressure has continued from the competing demands of emergency care and a sustained increase in elective demand, particularly for cancer activity. We worked closely with lead clinicians to ensure that patients are clinically prioritised to ensure those who need surgery are able to receive treatments. The Trust also worked with its local Clinical Commissioning Groups to understand and support the high demand for outpatient, elective and surgical treatment, including support from local independent providers. This supported the Trust to deliver RTT performance above the national position, albeit below target.



A different approach to planning elective activity during the winter has also helped effectively balance elective and emergency capacity during periods of expected high demand for emergency care which supported the continuation of elective Orthopaedic operating right up until the start of the COVID-19 pandemic response in March.

During Q4 RTT performance declined sharply as all routine operating was suspended in response to COVID-19 planning, including the use of Day theatres as expansion of the Intensive Care bed base.

The reduction in elective activity, together with the significant growth in referrals of patients with a suspected diagnosis of cancer resulting in clinically urgent patients being prioritised, has impacted on the Trust's ability to reduce the number of patients waiting for treatment below the March 2019 position.

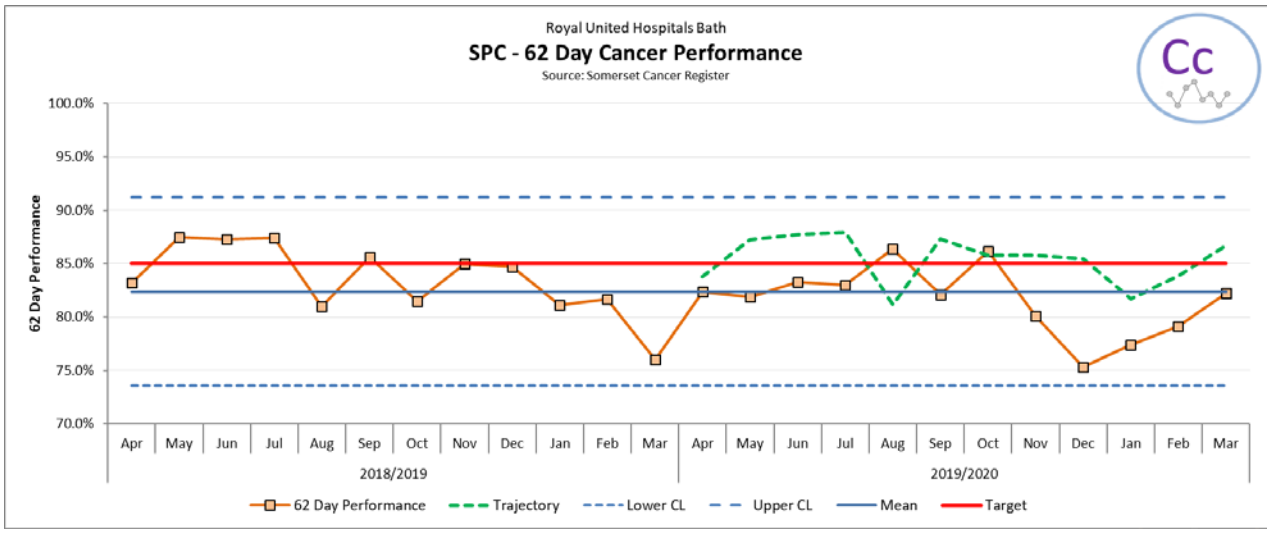
The specialties with highest growth in patients waiting are noted in Gynaecology and Urology resulting from an increase cancer referrals. The number of Cardiology patients waiting was artificially inflated due to a change in reporting of diagnostic activity.

During 2019/20 the Trust detailed, by specialty, the actions that would be taken to increase elective capacity across the wider health system in order to manage

demand more effectively. Performance has been particularly challenging in some medical specialties including Cardiology and Dermatology. Gastroenterology faced extraordinarily high cancer referral demand impacting on routine waiting times and resulting in multiple 52-week breaches.

Efforts to improve our service in these areas is a priority for service leads with an active focus on patient care. Whilst there are some areas of challenge, the Trust has continued to see improvements at a specialty level during the year for some surgical specialties, with particular improvement in Ophthalmology services.

Cancer



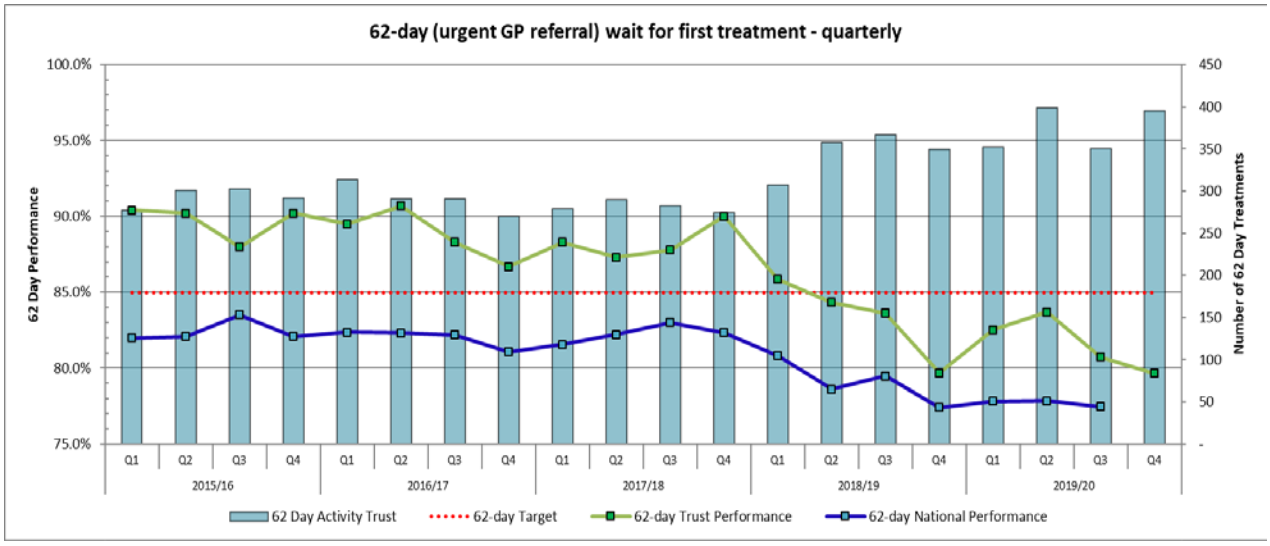
In 2019/20 Trust performance against the 62 Day GP Referral to Treatment standard has been challenged, with a decline in performance in the second half of the year. Despite this the RUH consistently delivered performance above the national average, achieving 81.7% against the national average of 77.1% The RUH ass also one of the higher performing Trusts in the South West.

Performance has been impacted by an increase of 8% in 62 Day activity in the past year. Furthermore, the growing complexity of clinical pathways with the increasing number of specialist diagnostics required impacted performance. This is most evident in the more complex clinical pathways of Colorectal, Prostate, Upper GI, Head & Neck and Lung. Consultant staffing vacancies in other key specialties of Breast and Skin also presented challenges in consistently delivering the standard.

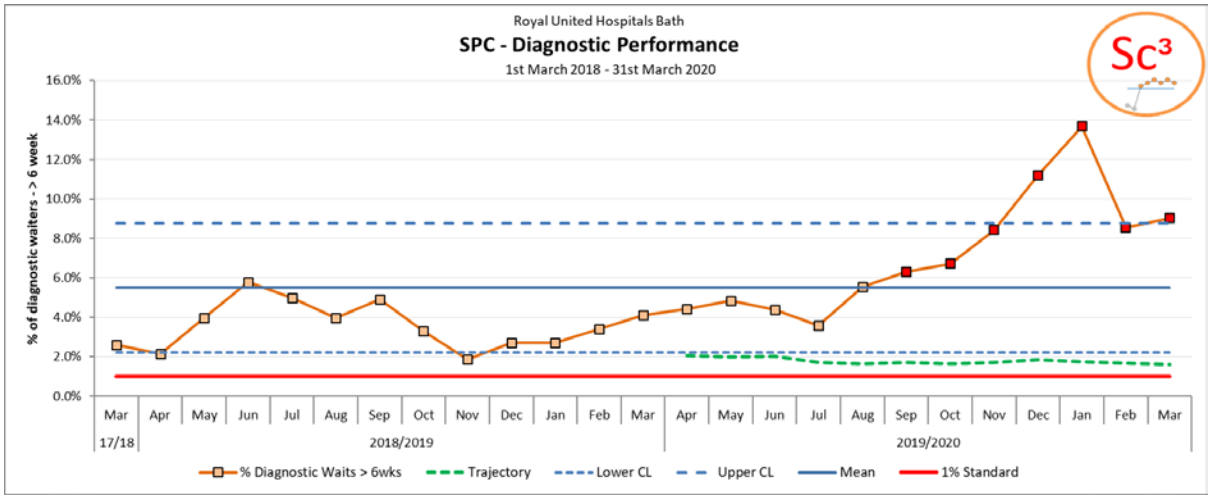
Working with the Cancer Alliance and STP and utilising the nationally available Cancer Transformation Funds, the RUH has made great improvements through implementation of early diagnostic pathways in key tumour sites. This is helping patients achieve a swifter diagnosis and more timely access for treatment for those patients with cancer. Establishment of the *Straight to Test* diagnostic pathway within in Colorectal has been a particular success in year, as has the implementation of a more efficient diagnostic pathway for Prostate cancer patients, both of which are supporting improvements in performance in those individual areas. In addition we

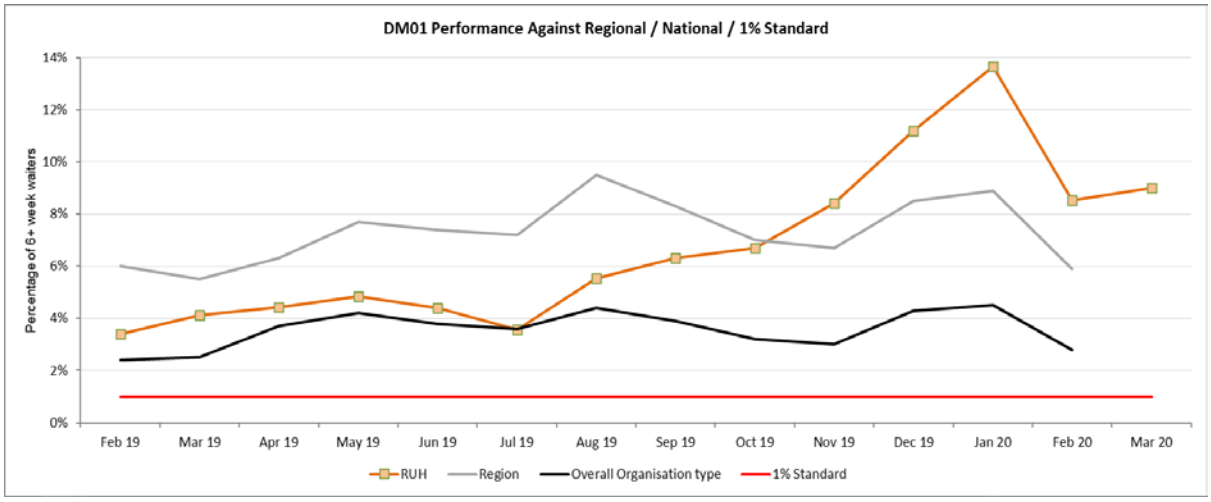
have established the administrative infrastructure required to manage patients against the new 28 Day Faster Diagnosis target and report activity and performance and are close to delivering the required standard through the early diagnosis pathway work.

The RUH has also taken steps to improve access to treatment for those patients requiring oncological care which has contributed to the RUH performance. Creation of a future state model for the Oncology service will support the long term planning for the department and achieve more timely access for chemotherapy and radiotherapy treatments.



Diagnostics





In 2019/20 the Trust has experienced significant growth in demand across every type of diagnostic investigation, especially CT and MRI. The priority pathways for diagnostic access are urgent & emergency care, in-patients, suspected cancer and planned cancer follow up resulting in performance against the maximum 6-week wait for outpatient diagnostics overall not being achieved. The Trust continues to maximise every opportunity to improve performance using the Improving Together methodology; monitoring each of the thirteen diagnostic pathways weekly in line with an agreed recovery trajectory which it was anticipated to achieve by September 2020.

The Trust has, in year, delivered an ambitious CT and MRI installation and replacement programme which completed in February 2020; we now have 6 state of the art CT and MRI scanners. In support of the capital programme the Trust procured mobile scanning capacity on site and sourced external capacity from alternative providers. The Clinical Cabinet has been tasked with reviewing clinical diagnostic pathways with a view to manage/reduce internal demand.

The COVID-19 pandemic led to the cancellation of all routine scanning and performance in April 2020 was 45.47% with 4147 diagnostics carried forward to May. It is anticipated that recovery will be challenging as capacity is reduced as a result of restrictions caused by the pandemic, including the requirement for staff to use PPE and social distancing in waiting areas.

Financial Performance

Overview

In 2019/20 the NHS saw the start of the Long Term Plan following the 3.4% funding settlement to help put the NHS back onto a sustainable financial path. This was a significant challenge considering the growing demand from an ever increasing and ageing population, something which is particularly relevant for the RUH. System

working via the Sustainability and Transformation Plan (STP) remains key in helping to establish better access to health services for all patients, increasing prevention and removing health inequalities.

The Provider Sustainability Funding (PSF) continued in 2019/20. The RUH were allocated £5.8m to support the delivery of an overall surplus of £1.8m (excluding exceptional items). The RUH has delivered an overall adjusted surplus of £56,000 for 2019/20. Included within this surplus was £2.0m PSF achieved in 2019/20 and £0.5m bonus PSF from 2018/19 which was a post accounts allocation.

COVID-19 had an impact on the Trust's finances in March when the NHS was required to take measures to prepare and start treating patients affected by the pandemic. This included £1m of capital spend, and £1m of additional costs and lost income from other sources. . These costs were funded centrally or through the STP thus limiting the financial pressure for the RUH.

The statement of comprehensive income shows an overall deficit of £7.7m – this includes technical accounting adjustments relating to the consolidation of the RUH Charitable Funds of £939,000. The Trust's overall deficit is £8.6m – this position reflects a number of accounting adjustments detailed in the table below:

	2019/20 £000
Trust deficit for the period as per Statement of Comprehensive Income	**-8,625**
Impairments resulting from an estate valuation in 2019/20	9,703
Capital donations	-520
Additional PSF from 2018/19	-502
Trust surplus on a control total basis	**56**

Adjusting for these items gives a total adjusted Trust surplus of £56,000.

The Trust has gone from a £16.5m surplus in 2018/19 to a £7.7m deficit in 2019/20, a movement of £24.7m. There has been a £23.7m increase in income from patient care activities compared to 2018/19 – these increases have been seen across all areas of clinical work including non-elective activity, A&E attendances, day cases, electives and high cost drugs. These increases have also been seen across all main commissioners.

Other operating income decreased by £5.2m. This relates to a £12.3m drop in PSF, although this was offset by a Marginal Rate Emergency Tariff (MRET) change in accounting for 2019/20 of £6.3m.

There has been a £42.5m increase in expenditure between 2018/19 and 2019/20. Staff costs accounted for £24m of this, the biggest drivers being a £2.4m agency spend, £9m accrual for pension costs (offset by corresponding income to finance this), and a £1m addition to the pay bill due to an increase in staff numbers. The impairment of plant, property and equipment contributed £7m to the movement, as did a £10.6m increase in non-pay costs spread over a large number of areas. One of

the biggest increases in non-pay spend was £2.9m in clinical supplies and services relating to pathology services provided in community clinics.

Overall, the Trust delivered a use of resource metric of 3 at the year-end (out of 4, where 4 is high risk and 1 is low risk). This was a deterioration from the previous financial year where a metric of 1 was reported. The distance from the financial plan was the main driver of the worsening rating, the result of failing to achieve the savings planned to deliver the surplus required, with agency spend above the agreed threshold also contributing to the overall rating of 3.

The Trust received an increase in income of £17m from its commissioners in 2019/20 compared to 2018/19, and saw a significant increase in non-elective activity levels. Like many hospitals, managing increases in patients admitted in an unplanned way represented the Trust's main operational and financial challenge during the year, including meeting the A&E four-hour emergency access target.

The table below shows the income and expenditure for the Group (includes NHS charitable funds) compared to previous year:

	2019/20 £m	**2018/19 £m**
Income	374.2	357.6
Expenditure	-376.2	-333.5
Financing Charges	-5.7	-5.5
Surplus before Gains	**-7.7**	**16.6**
Other Gains / (Losses)	0	-0.1
Surplus for the period	**-7.7**	**16.5**

The delivery of cost and quality improvement programmes, which the Trust calls QIPP, was challenging; however the Trust delivered £10.7m in year which was £2.1m below plan. The non-recurrent element of the QIPP achieved was £3.3m. The key schemes to deliver this year included:

- Workforce redesign (£2.2m);
- Non-pay efficiency programme (£3.9m);
- Other operating income sources realised (£3.1m); and
- Hospital Medicine and Pharmacy (£1.6m)

Capital investment

The Trust invested £26.5m in infrastructure and equipment during 2019/20 (£34m in 2018/19). This was funded internally through cash and I&E surpluses, donations and additional PDC from the Department of Health primarily for Winter Pressures and HSLI Digital Programme funding. The capital programme has continued to achieve a

balance between maintaining and replenishing the asset infrastructure, reducing risk and improving patient experience.

Significant in-year programmes included expenditure of:

- £3.8m on the completion of works for the new RNHRD & Therapies build (£10.7m spent in 2018/19);
- £5.3m on the RUH Redevelopment programme to complete the transfer of other services from the RNHRD site in Bath, including the Bath Chronic Pain Service patient accommodation and expansion to R&D offices;
- £4.0m on the second phase of the RUH Redevelopment programme, including RUH North decant and demolitions and fees for the Cancer Centre;
- £1.7m on upgrade to the Surgical Admissions Unit;
- £1m on the Sterile Services Department upgrade and decontamination centralisation (£2m in 2018/19);
- £1m on continued improvements to the Radiology department (£1.5m in 2018/19);
- £2.1m on the digital programme, including implementation Patient Flow (Bed Management) and E-Observations, as well as a code upgrade to the Electronic Patient Record System and continued investment in the roll-out of the Inventory Management System;
- £4.5m on medical equipment, including continued investment in Radiology equipment including upgrades to two of our MRIs, new X-Ray equipment and a new lease CT and replacement of our Anaesthetic Machines;
- £1.1m on schemes related to COVID-19, including IT equipment and Licences and the commencement of works to increase ITU bed capacity and convert the temporary ward to a Respiratory Assessment Unit.

Environmental matters

Sustainability Report

Living more sustainably can have a huge impact, both at work and at home. At the RUH, the Sustainability Team aims to enable the Trust to embed sustainable development into everything we do. To achieve this, actions are being targeted that will make a positive difference environmentally, socially and financially, and create an organisation that supports the long-term well-being of our staff, our patients and our wider community, through:

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

Our ***2020 Sustainability Performance Targets*** were set with reference to Government legislation and are summarised below:

	Energy and carbon management:	**Water:**	**Waste:**
Expenditure in 19/20	**£1.982m**	**£501k**	**£342k**
2020 performance target	28% reduction in CO_{2e} emissions against 2013 baseline by 2020[1].	25% reduction in water use against 2004/05 baseline by 2020[2].	10% saving against 2016/17 expenditure[3]: - reduce and reuse £15k worth of waste each year - save £30k per year from better segregation of residual waste.

As we come to the end of a five-year reporting period, during 2019/20 we have focused on developing the next five-year plan. This was guided by an assessment of the Trust's sustainability credentials in collaboration with key stakeholders from across the organisation. This work provided us with the opportunity to gather evidence of our achievements so far and generate ideas for improving in the future.

The assessment was developed by the Sustainable Development Unit and is made up of 296 statements that describe how we should be operating sustainably. It is aligned with the United Nations Sustainable Development Goals which aim to end poverty, protect the planet and bring prosperity to all by 2030. The Trust has scored an average of 33% across 10 modules as outlined below, and these will be used as a benchmark to drive progress in our approach to sustainable development:

- Corporate Approach 25%
- Asset Management & Utilities 38%
- Travel and Logistics 28%
- Adaptation 38%
- Capital Projects 40%
- Green Space & Biodiversity 18%
- Sustainable Care Models 24%
- Our People 60%

[1] Department of Health: 'HTM 07-02 (Part A), Making energy work in healthcare'
[2] Department of Health: 'HTM 07-04: Water management and water efficiency'
[3] Note, no specific waste target is set by the Department of Health, hence this target results from the waste hierarchy of: prevent, reuse, recycling, dispose); plus industry best practice performance on health care waste segregation.

- Sustainable use of Resources 35%
- Carbon / GHGs 24%

Sustainability successes

In addition to our successes over previous years, there have been some significant causes for celebration during 2019/20:

- The Trust started the year by winning two awards at the National NHS Sustainability Awards: the first for Staff Engagement (Plant Room Tours) and the second for Sustainable Infrastructure (the Spiritual Care Centre). The team and representatives from each category shortlisted attended the awards ceremony on 16 May.
- Carbon has been officially recognised as a key metric in measuring the sustainability of the Trust, with carbon reduction being embedded in the organisation's approach to reaching its strategic goal to be a sustainable trust that is fit for the future.
- The team expanded in size to include two additional roles: a Sustainability Manager and a Sustainability Officer, demonstrating the Trust's commitment to sustainability.
- A Sustainability Champion's Network was launched to maximise staff engagement across the Trust and support the delivery of the next five-year plan.
- 50% funding was secured to run a behaviour change programme designed to support staff to take suitable small actions that would collectively have a big impact.
- The Trust is working closely with B&NES Council to support them in reaching their target of carbon neutrality by 2030, focusing on three areas: making buildings more energy-efficient and to achieve zero carbon new builds; a shift to mass transport, walking and cycling; and a rapid and large-scale increase in renewable energy[4].
- The Trust signed up to the NHS Single-use Plastic Reduction Pledge and is on track to meet the requirements set out by NHSi, systematically removing unnecessary single-use plastic on site.
- A five-year Non-Patient Travel Plan has been developed and is being delivered, starting with work to improve the active travel facilities, including improvements to the locker facilities and providing bike maintenance stands.
- The Trust was shortlisted for Long Term Commitment to Sustainable Travel at the TravelWest Awards.
- The Trust encouraged participation in the annual TravelWest Challenge – a behaviour change campaign designed to encourage more sustainable forms of

[4] The COVID-19 pandemic has significantly impacted the use of public transport, and it is unclear if and when use will return to previous levels

commuting – in June. The RUH had the fourth highest number of activities for large businesses.

- The team worked in collaboration with the water provider to establish water efficiency measures. This uncovered a leak that was fixed, saving £150 of water per day. Further water efficiency opportunities will be worked on over the next year.
- With the support of the Estates team the Sustainability team trialled a re-use scheme. Staff were able to advertise unwanted items for people to collect and avoid them going to waste. For every hour invested into moving items, the Trust saved an average of £333 from avoided procurement and waste costs.
- With the initial campaign a huge success Switch Off When You Drop Off campaign was relaunched with new signage across the site. There has been a noticeable difference in the number of delivery vehicles switching off their engines in support.
- We continued running the Cyclescheme programme. Since inception, the scheme has provided 333 bikes, saving staff an average of £271 each and the Trust a collective £38,867. The scheme was enhanced during 2019/20 to provide staff with a wider selection of electric bicycles.

2019/20 performance

Energy and CO_2 performance

		2016/17	2017/18	2018/19	2019/20
Non-financial indicators (tonnes CO_2e)	**Total gross emissions**	**11,994**	**12,153**	**12,299**	**12,197**
	Electricity *	1,338	603	587	545
	Natural gas	10,431	11,359	11,587	11,565
	Fuel oil	123	150	94	56
	Waste	102	41	31	31
Related site energy consumption (millions kWh)	**Total**	**60.2**	**62.4**	**64.8**	**64.8**
	Electricity *	3.5	1.4	1.8	1.86
	Natural gas	56.7	61	63	62.9
Financial indicator (£k)	**Total**	**1,967**	**1,962**	**2,338**	**2318**
	Electricity	419	201	305	384
	Natural gas	1,090	1,339	1,608	1,580
	Fuel oil	26	25	20	12
	Waste	433	397	404	342

* Note: Electricity consumed refers to the net 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 2019/20, absolute CO_{2e} emissions have reduced by 0.8% in comparison with 2018/19. To date we have reduced our emissions by 10.4% against the 2013 baseline year for our 2020 target. This leaves an 18% saving to be accounted for when considering absolute emissions and our overall carbon budget. We are addressing this as part of our next five year strategy.

Work has been undertaken to assess the Trust's carbon emissions against the backdrop of increasing patient activity, and increasing floor area. This has demonstrated that when normalised against patient activity, the carbon emissions for the Trust have reduced significantly since the 2013 baseline, as per the following:

Year	Tonnes CO_{2e}	CO_{2e} / 1000 patients
2013	13,622	33.07*
2013/14	12,953	30.43*
2014/15	12,873	28.28*
2015/16	12,611	21.76
2016/17	11,994	20.45
2017/18	12,153	20.96
2018/19	12,299	19.22
2019/20	12,208	18.57
Reduction achieved	*10%*	*44%*

* Data for RNHRD is included as an average of typical patient numbers from April 2013-June 2015

Water performance

		2016/17	2017/18	2018/19	2019/20
Non-financial indicators	Water Consumption ('000m3)	184	179	168	175
Financial indicator (£k)	Water Supply Costs	308	301	307	328
	Sewerage Costs	185	186	188	173
	Total cost:	493	487	495	501

Water consumption over the year has increased slightly in 2019/20. This is likely to be due to the increased floor area and number of staff/visitors due to the opening of the RNHRD and Brownsword Therapies Centre. To further reduce our water consumption, we undertook a site wide water audit. This was completed in collaboration with our water provider and has created a list of options that we are in

the process of reviewing including: reducing water pressure where suitable, fixing leaking taps/toilets and sub metering.

Waste performance

		2016/17	2017/18	2018/19	2019/20
Non-financial indicators (tonnes)	**Total Waste**	**1,543**	**1,445**	**1,463**	**1,447**
	Incinerated Clinical Waste	155	153	149	148
	Alternative Treatment Clinical Waste	387	375	365	329
	Recycled	485	371	401	402
	Landfill	570	176	40	1
	Energy from Waste	N/A	371	508	488
Financial indicator (£k)	***Total Waste Disposal Cost***	***433***	***382***	***404***	***342***
	Incinerated	*62*	*63*	*94*	*75*
	Alternative Treatment	*156*	*154*	*134*	*113*
	Recycled	*87*	*49*	*56*	*48*
	Landfill	*127*	*68*	*40*	*0*
	Energy from Waste	*N/A*	*49*	*80*	*73*
	Offensive Waste	*N/A*	*N/A*	*N/A*	*33*

Waste volumes have remained at similar levels to the previous year. Reductions have been seen in general (municipal) waste and increases in clinical waste. However, a proportion of this waste is now sent as ‘offensive’ waste which reduces the required treatment of the waste. This has been achieved through the implementation of improved bin labelling for all waste streams at ward level.

A new waste auditing system to ensure segregation compliance has been implemented, involving the analysis of the contents of waste bins across the site. Results have driven improvements in practice to improve segregation of waste. A new e-learning package for waste management has been launched, and forms part of mandatory training for frontline staff.

Social, community, anti-bribery and human rights

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

Reporting on the gender pay gap at the RUH can be found within the Equality, Diversity and Human Rights section of the Trust website as below:

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

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

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

During 2019/20, the Trust had no social, community or human rights violation issues.

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

In March 2020, the coronavirus outbreak (COVID-19) was declared a pandemic by the World Health Organisation. Shortly thereafter, the Prime Minister introduced a lockdown, and a number of measures were subsequently taken to enable the NHS to deal effectively with this unprecedented public health emergency. For the RUH, like most other hospitals, this meant that most non-emergency work was suspended, and important changes were made to the physical configuration of the hospital, to enable it focus on the care and treatment of COVID-19 patients. All of the extra costs to the Trust of these changes will be accounted for during the course of 2020/21.

Details of overseas and subsidiary operations

The Trust has no branches or offices outside the UK.

In December 2015 the RUH became a founding partner in Wiltshire Health and Care, a Limited Liability Partnership (LLP) which from 1 July 2016 became responsible for the delivery of integrated adult community health services across Wiltshire for the next five years.

The West of England Academic Health Science Network (WEAHSN) is one of 15 such networks across England. Their mandate is to help improve the health of the

nation, while also generating economic growth, by spreading innovation at pace and scale. WEAHSN has its own Board, but the organisation is hosted by the RUH.

Signed 

Libby Walters

Interim Chief Executive (Accounting Officer)

Accountability report

Directors' report

Directors' responsibility for the annual report and accounts

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

Directors of the Trust

Directors of the Royal United Hospitals Bath NHS Foundation Trust during 2019/20:

Alison Ryan	Chair
Joanna Hole	Non-Executive Director Vice Chair and Senior Independent Director
Jeremy Boss	Non-Executive Director
Nigel Stevens	Non-Executive Director
Sumita Hutchison	Non-Executive Director (from September 2019)
Anna Mealings	Non-Executive Director (from September 2019)
James Scott	Chief Executive
Libby Walters	Deputy Chief Executive & Director of Finance
Bernie Marden	Medical Director
Rebecca Carlton	Chief Operating Officer
Lisa Cheek	Director of Nursing & Midwifery
Claire Radley	Director of People*
Jocelyn Foster	Commercial Director*

Brian Johnson	Director of Estates and Facilities*

*Non-voting members

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

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

The Board of Directors

Alison Ryan, Chair (Appointed: 1 April 2019)

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

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

Joanna chairs the Non-Clinical Governance Committee, is a member of the Audit Committee, and sits on the Board of Directors' Nominations and Remuneration Committee. She is also the Board lead for the Physical Environment and Complaints, and Champion for Adult and Children's Safeguarding, Resilience Planning and Freedom to Speak Up. She previously held a number of Senior Civil Service positions within the Ministry of Defence including Head of Safety, Sustainable Development and Business Continuity (civilian and military), Director of Business Continuity and Deputy Director of HR Development Framework (Civilian). Her earlier career was in HR, Estates Strategy, Procurement and Corporate Governance.

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

Jeremy serves as chair of the Audit Committee and of the Charities Committee and is a member of the People Committee, the Commercial Transactions Steering Group and the Board of Directors' Nominations and Remuneration Committee. He has a BSc (Hons) in Economics from the University of Warwick and is a Fellow of the British Computer Society and a Fellow of the Institute of Chartered Accountants in England and Wales (ICAEW). He has also served on the ICAEW governing council.

Jeremy's previous appointments include Chief Information Officer for both the Department of Energy and Climate Change and the Audit Commission. He is also currently a Non-Executive Director and Audit Chair at the Driver and Vehicle Licensing Agency (DVLA), and an independent advisor to the Audit and Corporate Governance Committee of the Care Quality Commission.

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

Nigel is Chair of the Clinical Governance Committee and is a member of the Board of Directors' Nominations and Remuneration and Audit Committees. He is also the Non-Executive Director champion for patient and families' experience. Nigel has a BA (Hons) in Politics and Geography and an MA in Defence Studies. After 20 years as a logistics officer in the Royal Air Force, Nigel moved into the commercial sector. Following eight years as Chief Executive Officer for the UK and Ireland Division of a major, global public transport group, he is now Chief Operating Officer for Keolis UK, a role he combines with wider work in the commercial and public sectors on future transport solutions.

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

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

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

Anna chairs the People Committee, and is a member of the Clinical Governance and the Board of Directors' Nomination and Remuneration Committees. Anna has a BCom degree in Economics, a BA in Anthropology and an MCom (hons) in Strategic Employment Relations. She has extensive experience in human resources management, organisational effectiveness and change management across a range of private sector industries, including at a number of large multinational organisations such as Rolls-Royce PLC, and is currently the Chief People Officer at XP Power PLC.

<u>Executive Directors (voting)</u>

James Scott, Chief Executive (Appointed: June 2007)

James has been a hospital Chief Executive for over 20 years in the West Country. Prior to this he obtained significant experience over 16 years in senior roles in NHS organisations across London. James is currently Vice Chair of the West of England

Academic Health Science Network, and has no declared conflict of interest. He announced his intention to retire from his role at the end of May 2020.

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

Libby has worked in the NHS for 24 years and prior to joining the RUH held positions as the Director of Finance and Resources at Dorset County Hospital NHS Foundation Trust and as the Director of Finance and Deputy Chief Executive at Yeovil District Hospital NHS Foundation Trust. She is a member of the Chartered Institute of Public Finance and Accountancy and has a particular interest in ensuring the focus on use of resources is intrinsically linked with improving the quality of care provided. Libby is also an active member of the Healthcare Financial Management Association South West Branch, and has no declared conflict of interest. Libby will take over as Interim Chief Executive of the Trust with effect from 1 June 2020.

Bernie Marden, Medical Director (From: April 2018)

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

Rebecca Carlton, Chief Operating Officer (Appointed: February 2019)

Rebecca has over 20 years' NHS experience. She has held a number of senior operational management roles including as the Director of Operations for Emergency Care and Acute Medicine in Barts Health Trust and more recently as Hospital Director at Morriston Hospital. She has an MSc in Health Policy, Finance and Planning and participated in the Hope European Exchange Programme as the NHS representative to Denmark. Rebecca has no declared interests.

Lisa Cheek, Director of Nursing & Midwifery (Appointed: November 2018)

Lisa is an experienced registered general nurse and has held a number of senior nursing roles across acute Trusts. She joined the RUH as Deputy Director of Nursing and Midwifery in July 2016. Prior to this Lisa was Deputy Director of Nursing at Kingston Hospital NHS Foundation Trust. Lisa gained her MSc in Health Service Management at South Bank University. She has no declared interests.

<u>Executive Directors (non-voting)</u>

Claire Radley, Director of People (Appointed: April 2018)

Claire was previously the Assistant Director of Organisational Development at Cardiff and Vale Health Board. Prior to this she held a number of local and national roles in policing, spanning research, performance management, quality, culture, leadership

and organisational development. She has a PhD in organisational and occupational culture. Claire is a member of the Honourable Company of Gloucestershire.

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 has an MBA, DPhil, and BSc (Hons) in Biological Sciences. Her declared interests for 2019/20 were as follows: Complaints Panellist - Dental Complaints Service and a financial interest in Veloscient Ltd (facilitating structured data capture for a range of markets, including healthcare).

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

Brian has over 30 years' experience working nationally and internationally across a broad range of technically challenging, high profile projects in a number of sectors including education, sport and health. His most recent previous role was as Head of Capital Projects at the RUH, and before this he was Regional Operations Director at Capita Health Partners. He has no declared interests.

Contact with the Directors

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

Register of interests

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

Additional Directors' report disclosure

Cost Allocation and Charging Requirements

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

Political Donations

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

Better Payment Practice Code

The Trust is required, by the national "better payment practice code", to aim to pay all valid invoices within 30 days of receipt, or the due date, whichever is the later. Over the 12 months to 31 March 2020, the Trust achieved the following performance:

Better payment practice code	**Actual Foundation Trust Number**	**Actual Foundation Trust £'000**
Non NHS		
Total bills paid in the year	77,674	226,427
Total bills paid within target	74,471	211,038
Percentage of bills paid within target	**95.9%**	**93.2%**
NHS		
Total bills paid in the year	1,692	11,748
Total bills paid within target	1,344	7,434
Percentage of bills paid within target	**79.4%**	**63.3%**
Total		
Total bills paid in the year	**79,366**	**238,175**
Total bills paid within target	**75,815**	**218,472**
Percentage of bills paid within target	**95.5%**	**91.7%**

Total interest paid to suppliers under the Late Payment of Commercial Debts Act 1998 was £0 (£0 in 2018/19).

Disclosures relating to NHS Improvement's Well-Led framework

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

In February 2020, the Trust received notification from the CQC of their intention to conduct a service inspection at the Trust, which would invariably incorporate a Well-Led assessment. As part of its preparation for this process, self-assessments were carried out to help ensure that the Trust's services are indeed well led, and to identify areas where additional support may be required.

The declaration of the COVID-19 pandemic meant that the inspection was suspended and did not take place during 2019/20, but the actions emerging from the self-assessment exercise will be captured and implemented over the coming months. Further information on the Trust's approach to ensuring that its services are well-led is set out in the Annual Governance Statement and the Performance Report sections of this Annual Report.

There are no material inconsistencies between the Annual Governance Statement, the Corporate Governance Statement and reports arising from the most recent planned and responsive reviews of the Trust's services carried out by the CQC. As a result of changes to the annual reporting process brought about by the COVID-19 outbreak, the Trust's Quality Report is being prepared to a different timetable and will be presented later in 2020/21, but the work that has been done so far also confirms that it does not contradict any of the contents in this report as to the extent to which the Trust's services are well-led.

Enhanced quality governance reporting

Patient care and stakeholder relations

During 2019/20, a number of developments and initiatives introduced by the Trust have brought about further improvements to the experience of patients and the quality of the care provided. As the direction of travel for health services continues to move towards greater integration in delivery, the Trust has built on progress already made in developing strong and collaborative relationships with partners across the local health and care economy. Partnership working is being enhanced, relationships with stakeholders deepened and staff are now more involved in decisions about how the Trust provides its services. Highlights of these developments are set out below and in the Performance Report section of this Annual Report. Further details will also be included in the Quality Report.

Patient care

Information about how we are using our Foundation Trust status to develop our services and improve the quality of the care that we provide to our patients can be found in the membership section of this report. Performance against key healthcare targets, and progress towards meeting other measures, as agreed with commissioners, along with details of other key quality improvements can be found in the Quality Report.

Monitoring improvements in patient care

The Trust did not receive any inspections from the CQC during 2019/20. The Trust last received an inspection from the CQC in June 2018, during which the Commission inspected five core services (urgent and emergency services, medical care, critical care, maternity care and children and young people's services) and

reviewed the management and leadership of the Trust to answer the key question about whether the Trust is well led. The CQC rated the Trust overall as ‘Good’ but identified four areas in which the Trust was required to improve. These all related to urgent and emergency services.

An improvement plan was developed and returned to the CQC detailing the actions to be taken to address the four compliance recommendations that had been identified. Implementation of this improvement plan has continued to be monitored on a quarterly basis through the Trust’s Management Board and the Board of Directors throughout 2019/20. The Quality Board also receives a detailed quarterly update from the matron for the Emergency Department which includes progress on implementing the agreed actions and performance data to assess the effectiveness of these actions and inform any further actions required.

The Trust’s internal auditors, Grant Thornton, carried out a review of the actions the Trust had taken following the CQC inspection to check that the issues raised had been addressed. The assessment included a review of documentation, observational visits to the Emergency Department and interviews with staff. The findings concluded that the processes that had been put in place provided significant assurance, with three low-level recommendations for improvement made.

Quality Governance

It is one of the Board of Directors’ main priorities to ensure that services provided by the Trust are safe and of a high quality. The organisation has put in place robust systems and reporting mechanisms that would help guarantee that quality priorities are identified, monitored and achieved. This includes the triangulation of multiple performance measures through mechanisms such as ward accreditation schemes and monthly triangulation reporting to the Board. Where performance is found to be below what is expected, the Board will ensure that suitable remedial action is taken to bring about improvements.

Both the Clinical and Non-Clinical Governance Committees have been given the remit of testing the organisation’s systems and processes and provide assurance to the Board as to their robustness in ensuring quality and safety.

The Trust has developed a Ward and Outpatient Accreditation programme to recognise and incentivise high standards of care and reduce variation in practice. It also provides assurance that the CQC’s fundamental standards are being met and is used to identify where any improvements in practice are required. The programme uses Performance Indicators to measure the quality and safety of the services provided at individual ward and outpatient level, and has expanded to include Maternity, Paediatrics, Critical Care and the Emergency department.

The programme takes a tiered approach to assessment from Foundation to Gold Level, and progression through each of the levels constitutes recognition of improvements in the quality of care provided. The assessments are made up of a

number of Key Performance Indicators, broken down under the five key areas of focus for the CQC: are services safe, effective, caring, responsive and well led.

Progress to date:

Ward Accreditation: A total of 31 clinical areas including 24 adult wards, Maternity ward (Mary), Bath Birthing Centre, NICU, Admissions suite, Children's ward, Critical Care Services and Emergency department are included in the Ward Accreditation programme. All areas have achieved Foundation level, 21 are at Bronze level and five at Silver level. Eight areas are in the process of working towards Silver assessment in the next six months

Assessment at Bronze level and above is based on performance information that is routinely available and monitored, observations of care and the environment and interviews with staff and patients.

The Silver level of assessment was introduced in 2019 and is designed to broaden the programme to include assessment of the Multidisciplinary team within wards and departments. Silver level indicators have been developed and the assessment process developed to include analysis of data, unannounced observations of care, inclusion of the Dementia and End of Life charter marks, and the development of a portfolio of evidence that members of the multidisciplinary team present to a panel of assessors. The portfolio is designed to showcase achievements and includes demonstration of improvements made to services following, for example, patient experience feedback and quality improvement projects.

The criteria for Gold level accreditation are to be determined in the coming months.

Outpatient Accreditation: A total of 24 areas including 23 adult areas and the Children's unit are included in the Outpatient Accreditation programme. All areas have achieved Foundation level.

Of the 24 Outpatient areas 19 have achieved Bronze level with the remaining undergoing reassessment.

Silver level was introduced in 2020 with the first area, Urology, undergoing assessment in February. As in the ward programme the level is designed to broaden the programme to include assessment of the Multidisciplinary team and it includes the development of a portfolio of evidence.

Evidence of excellent engagement with the programme continues to be seen across the hospital, and there is a clear link to the provision of improved and high quality patient care.

The local Clinical Commissioning Group (CCG) has undertaken several quality visits into clinical areas and a programme of visits has been established. Areas visited include the Medical and Surgical Assessment Units. The feedback from both visits was overwhelmingly positive, with a few areas for improvement identified and actioned.

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 included:

- Research & Development at the RUH
- The Role of Carers in Hospital
- New Developments at the RUH
- Stroke

Our Trust's integrated balanced scorecard is based on the CQC domains and our ward dashboards allow for the triangulation of data and information flows from ward to Board.

Patient and public experience activities

This year the Trust has continued to embed the Trust's Patient and Carer Experience Strategy 2017-20. The strategy sets out how we will continue to put patients and carers at the heart of everything we do and is centred on **three key ambitions**:

1. To **listen to patients and carers** – supporting staff to actively engage with patients and carers, encouraging all feedback and learning from listening to their experiences and making improvements, where necessary, as a result of their feedback.

2. To **communicate clearly and effectively** - ensuring that we meet the emotional needs of patients/carers by communicating effectively with them and providing information in a way that they can understand

3. To **involve patients and carers in improving services** – to involve patients in the design of new services and making improvements to existing services, providing toolkits/guides.

Some of the highlights and improvements this year are set out below:

1. We will listen to patients and carers

We collect patient and carer experience feedback through a variety of real-time and post-discharge methods using the Trust's in house 'e-Quest' system which enables feedback to be collected and recorded electronically.

Achievements

Since the launch of the Patient and Carer Experience Strategy the Patient Experience team has supported 148 services (as at 6 March 2020) to collect patient and carer feedback and use the information to improve their service. Patients can complete feedback through e-Quest which is now on the RUH website, and questionnaires, including Friends and Family Test (FFT). Information on the changes made as a result of patient and family feedback is shared through social media, the Trust's 'Insight' magazine and in ward and outpatient areas on information boards. We will continue to focus on how we share the learning from patient feedback with our community in a campaign next year, *'What Matters to You Matters to Us'.*

Patient Stories

Each month a patient/carer story is heard at the Board of Directors. This is the first item on the Board agenda and staff involved in the care of the patient attend the Board meeting to share what has changed as a result of the patient/carer story. Their story is either filmed, voice-recorded or the patient/family member shares their experience in person by attending the Board meeting. Their stories are available on the Trust Intranet for staff to use in training and education.

As a result of listening to patient/family stories we have improved the care we provide by:

- Improving the experience of patients in our Medical Therapies Unit (MTU). Patients having regular infusions for conditions such as Multiple Sclerosis (MS) no longer have to access MTU through the Cardiac ward which was difficult for patients with limited mobility. As a result of a patient story, patients coming to MTU for treatment walk through Vascular Outpatients. This is a shorter walk and is easier and more straightforward for patients with limited mobility. It has also helped to improve infection control on the Cardiac Ward.
- Patients staying in the Intensive Care Unit (ICU) as part of their hospital admission now have the support of a clinical psychologist to help manage the physiological and psychological impact on them and support their ongoing recovery following ICU admission. This support is for families as well who will have been affected by their loved ones' ICU experience.
- Developing the **Day room to Doorstep'** model on Combe ward. The ward cares for older patients many of whom suffer with Dementia. The model demonstrated that the ward saved 96 bed hours by allowing patients to wait for discharge in the day room, and further supported discharges from the hospital before midday. The activities in the Day Room, including group music, exercise and creative sessions have a positive effect on the patients, encouraging interactions and common interests to be developed among them. The sessions also encourage movement to avoid deconditioning.

See It My Way

In 2019/20, the Trust continued with its very successful 'See It My Way' programme in which patients and carers come to the hospital to share their experiences of a condition and/or care. This year we have held the following:

- 'See it my Way – losing a loved one' May 2019
- 'See it my Way – living with pregnancy loss' October 2019
- 'See it my Way – living with and beyond cancer' February 2020

The events are open to all staff across the hospital and are well attended. A short film is produced following each event and is available on the Intranet for staff to use in education and training.

2. We will communicate clearly and effectively

We have been working to improve our written and verbal communication with patients and carers by providing information that is in 'Plain English', meets Accessibility Information Standards, improves accountability, supports efficiency and improves patient experience.

Achievements

We now have guidelines for staff on how to write good patient information. Our Readers' Panel (consisting of approximately 50 patients) was set up to review all new patient leaflets produced by the Trust.

We know from our Inpatient Survey results that there are gaps in patient/family information when leaving hospital and the Patient Experience team will be working with the Surgery Division to improve the information that is provided on discharge, particularly on what follow-on care is needed and when patients can return to their normal activities.

3. We will involve patients and carers in improving services

We have developed guidelines and other resources (including case studies) for staff to involve patients and carers in the design and development of RUH services and buildings.

Achievements

The 'Patient Experience Matters' intranet pages were launched this year and training is taking place with staff across the Trust on how to involve patients and their families/carers in the development/improvement of services.

Patients and their families/carers have been involved in Quality, Service, Improvement Redesign (QSIR) projects such as the changes to the Paediatric pathway; pharmacy outsourcing, RNHRD new build and the frailty project. There has also been an increase in the number of patient experience-led projects. Some examples of the improvement projects are listed below:

Oncology Therapies: The Oncology Therapies Team provides physiotherapy and occupational therapy support for cancer patients. The project aims to ensure that the service that is provided meets the needs of patients throughout their cancer pathway. Feedback received from patients identified the main areas to address, and the service has worked with clinical teams to increase awareness of what they offer. One of the outputs from the project was the publication of an information leaflet for patients outlining the services available. The move to the Brownsword Therapies Centre has also provided a much better therapeutic environment to be treated in.

Gastroenterology Outpatient Department - Inflammatory Bowel Disease (IBD) Clinic: IBD is a chronic condition of the gastrointestinal tract. The IBD team gathered feedback from patients to review the clinic service and the information they provided to patients. As a result, they have increased the promotion of the 'IBD evening' they run and used it to provide a range of quality informative sessions for patients. The support group will meet twice a year.

This year we will be developing a patient panel consisting of patient representatives with special interests (e.g. mental health, End of Life, children and young people) to lead the involvement of patients and their carers in designing and improving services.

<u>Using patient feedback to improve services</u>

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

- Friends and Family Test (FFT)
- Patient Advice and Liaison Service (PALS) Concerns and Complaints
- Patient Stories
- Hospital questionnaires
- Social media – NHS Choices website/Twitter/Facebook
- PLACE (Patient-Led Assessment of the Care Environment)
- Annual and bi-annual National Patient Experience Surveys – Inpatient/Maternity/Emergency Department/Cancer

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

Improving patient and family experience is one of the objectives of the Trust's vision to deliver the highest quality care, delivered by an outstanding team who all live by our values. For our patients and carers this means that it is our ambition to be a *'listening organisation, patient centred and compassionate'.* We have used a problem-solving tool called an A3 to identify areas where we know from patient feedback that we do less well, such as information on discharge and communication in the Emergency Department.

Information on complaints handling

Our Patient Advice and Liaison Service (PALS) aims to resolve patient and carer concerns and answer questions regarding treatment and care within 48 hours. The Trust sees complaints as a valuable source of feedback as it shows us where our services have not provided high quality care and gives early signs of service failures. The process of learning from complaints will be prioritised in 2020/21, to include how this learning is recorded and how we communicate it to the complainant. The Trust is keen to hear from patients and their families when their care and treatment goes well but also when concerns have been raised so that we can use this information to learn and improve.

Unfortunately, this year we have seen an increase in the number of formal complaints lodged (264) compared to the previous year (215). Our focus is still to try and resolve queries or concerns at an early stage at departmental level, wherever possible. The majority of complaints relate to communication and clinical care and concerns.

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

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

Clinical leads and managers are responsible for investigating and responding to complaints made in their respective areas. The Heads of Nursing and Midwifery have oversight of all complaints, the investigations and the Trust's response. All formal complaints are reviewed by the Director of Nursing and Midwifery or Medical

Director and responses signed by the Chief Executive. Complaints are discussed at nursing and governance meetings and the learning from complaints is included in the quarterly Patient Experience report to the Quality Board and the Board of Directors.

Stakeholder relations

West of England Academic Health Science Network (WEAHSN)

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

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

Third Sector

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

We continue to work with RICE and the Alzheimer's Society on the Friendly Faces project which is now in its third year and has provided 2,065 volunteer contact hours with patients this year up to the end of February 2020 covering 20 wards.

We also launched an exciting new initiative between our Specialist Palliative Care Team and Dorothy House Hospice Care. The Compassionate Companions Service is available to support patients in their last days of life and provide respite for their families. The volunteers offer:

- Companionship – sitting with the dying person, listening, holding their hand, reading to them, being with them
- Compassionate respite - for family, friends or carers who may not wish to leave their loved one alone
- Compassionate support – liaising with ward staff to let them know when the dying person requires additional care and support.

The service is now supporting 10 wards.

Undergraduate and postgraduate medical training

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

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

Postgraduate Doctors: The RUH continues to respond to and embed the changes in Post-Graduate Medical Education precipitated by the 2016 Junior Doctors Contract. Results from the National Training Survey and Quality Panels have shown the RUH continues to offer excellent training. The pioneering Local Trainee Support Faculty run by the Associate Director of Medical Education for Support is in place to help those trainees who need additional advice and guidance.

The General Medical Council and Health Education England are moving forward on a multi-professional education agenda. At the RUH, we continue to explore non-medical workforce options, such as Physician Associates and Advanced Nurse and Physiotherapy Practitioners. A new Educational Governance structure, the Trust Education Group, has been established and successful multi-professional skills days to further integrate those groups in clinical practice have taken place.

RUH Estates Redevelopment

The last 12 months have seen the successful completion and delivery of multiple estates improvements and changes at the Combe Park estate.

April 2019;

- Opened the new 27 bed decant ward which will be an enabler for our future ward refurbishment program.

- Our first ward, Surgical Assessment Unit (SAU) moved in for us to commence refurbishment of the SAU space.
- Completed works to the main staff car park, to improve circulation, lighting and access

May 2019;

- Opened the new Oral Maxillofacial and orthodontics facility, moving the service into new state of the art facilities and out of the dated accommodation of RUH ‘North’.

June 2019;

- Completed the refurbishment of the Sterile Services Department (SSD). We have modernised and updated our central sterilisation facilities which now handles some 27,000 surgical instruments per month.
- Completed construction of a new high voltage substation essential to provide power supplies to our new RNHRD and Brownsword Therapies Centre and upgrade power supplies to our radiology department.

September;

- Completed construction of the new RNHRD and Brownsword Therapies Centre. The building provides accommodation for services and staff previously at the RNHRD's Mineral Water Hospital site (in the centre of Bath) but also co-locating staff from poor quality areas of RUH ‘North’ for pain and therapies services.
- Completed refurbishment and enabling works within our Nuclear Medicine department to accommodate Clinical Measurement services out of the RNHRD's Mineral Water Hospital.

October;

- Completed combined new build and refurbishment of spaces within the Wolfson block.

November;

- Completed construction and refurbishment of areas to Bernard Ireland House to accommodate the Bath Centre for Pain Services which was relocating out of the RNHRD's Mineral Water Hospital.

December;

- Successfully concluded all removals from the RNHRD Mineral Water Hospital in the centre of Bath in order to return the building to its new owners, to the agreed timescales.

March 2020;

- Completed refurbishment works to the Surgical Assessment Unit (SAU).

We have concluded all final design work for the new Dyson Cancer Centre and obtained full planning permission. Work continues to prepare for demolition of areas of RUH North during 2020 with a planned commencement for Cancer centre construction in early 2021.

Alongside the major capital redevelopment of our estate, we continue to operate and maintain the built environment of the hospital and 2020/21 will see continued work to update and replace elements of our infrastructure.

We have increased focus on sustainability across the Trust and will continue this through 2020 and into 2021. We have adopted a Sustainable Development Assessment Tool giving us an overarching framework to measure and monitor our approach to sustainability; increased recycling and signed up to the plastics pledge to remove single use plastics from the RUH. We continue to review energy usage, have provided improved facilities to encourage more staff cycling to work, have launched a new staff car share app and increased our engagement with B&NES to support improvements in sustainable travel to the RUH.

The Dyson Cancer Centre will be the concluding piece of our current 10 year estates strategy and our attention now turns to preparation of a new estate strategy for the next 10 years and beyond.

The current COVID-19 pandemic has clearly impacted the way we work and deliver our services at the RUH and we have had to modify areas of our estate and facilities at pace. The effects of the pandemic will be far reaching, not least how we deliver our services in future and how our estate should be configured to align with new thinking, working practices and models of care.

Primary care services

During 2019/20, the Trust worked closely alongside primary care colleagues across the newly created Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (BSW CCG) to support the development of the new primary care networks.

Community services

In July 2016, Wiltshire Health and Care (a limited liability partnership (LLP) created between Great Wester Hospitals Foundation Trust, Salisbury Foundation Trust and the RUH) commenced its £40 million a year contract to deliver seamless and improved community services across Wiltshire. Since launch, the Trust's relationships with its partners across Wiltshire have been strengthened, and opportunities for improved pathway development have been realised – including the rolling out of the Home First pathway with Wiltshire Health and Care. Home First builds on a successful active rehabilitation project, helping patients with therapy requirements to return home from hospital earlier than would otherwise have been the case. The partnership has further strengthened the RUH's ability to work jointly

on inpatient delays. This relationship was particularly helpful in swiftly addressing the need for most of the hospital's beds to be freed up in anticipation of a surge in demand as a result of the COVID-19 outbreak.

Learning from best practice networks

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

In 2019/20 the Trust has continued on its organisational development journey, rolling out the training on the Improving Together methodology to more and more of its frontline and support teams. It is supported in doing this as part of a worldwide network of organisations (hosted by US founders Catalysis) each working on Lean implementation in healthcare. This transformation programme commenced in July 2018 with the aim of building the RUH's staff into an army of improvers taking responsibility for suggesting and making changes in each of their areas thus bringing about improved quality, safety and efficiency across the organisation.

Consultation with local groups and organisations

Throughout 2019/20, the Trust worked with local overview and scrutiny committees, including on arrangements for the transfer of RNHRD services from the old Mineral Hospital in the centre of Bath to new, state of the art facilities at the new RNHRD nd Therapies Centre which opened on the RUH site in October 2019.

The Trust held a series of events across the communities that it serves with a view to engaging directly with local people, patient and other groups both to inform them about what the organisation is doing and its plans for the future, and to hear their views about the hospital. Members of our Council of Governors were heavily involved in the setting up and running of these meetings and further details are set out later in this report.

The Trust has also actively supported the consultation conducted by the Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care System on transforming maternity care.

Research

The RUH continued during 2019/20 to build on its strong reputation for undertaking clinical research. Its research and clinical trials teams worked collaboratively during

the year with universities, other NHS trusts and the pharmaceutical industry to run around 300 different research studies. These ranged from trials into new treatments for cancer, rheumatology and stroke, through to studies that support patients with rehabilitation or chronic conditions like diabetes and heart disease.

In November 2019, a refurbished and extended Research and Clinical Trials Centre was opened at the RUH, providing facilities such as five new spacious clinic and examination rooms for research patients and volunteers, new consulting and resource rooms, and refurbished patient waiting areas.

The RUH has also been part of a large international study since the start of the pandemic on COVID-19 involving patients who have tested positive, seeking to help scientists understand more about the virus. In addition, a number of studies have been taking place in the hospital’s Intensive Care Unit trailing new treatments and identifying genes that may make some patients more unwell.

Statement as to disclosure to the auditor

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

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

Accounting Policies

NHS Improvement has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (GAM) agreed with HM Treasury. Consequently the Trust's financial statements have been prepared in accordance with the 2019/20 DH GAM issued by the Department of Health. 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.

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.

Investments

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

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

The Trust provides Financial Services to Wiltshire Health and Care managed through a Service Level Agreement.

RUH Charitable Funds

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

Remuneration report

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

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

Annual Statement on Remuneration

Chair of the Remuneration Committee's annual statement on remuneration

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

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

Senior Managers' Remuneration Policy

With the exception of the Chief Executive, Executive Directors and apprentices, all non-medical employees of the Trust are remunerated in accordance with the national NHS Agenda for Change pay structure. Medical staff are remunerated in accordance with national terms and conditions of service for doctors and dentists. The pay, terms and conditions for the Medical Director are determined by the national Consultant Contract and the associated Medical Terms and Conditions. An additional payment is made which reflects the additional responsibilities for the role of Medical Director. The Medical Director was eligible to apply for discretionary performance-related pay under Medical Terms and Conditions but is excluded from eligibility for the Directors' Bonus Payments Scheme. However, in March 2020, the Nominations and Remuneration Committee approved a proposal to amend the Medical Director's contract, to better reflect the relative amount of his time spent on his management responsibilities compared to his duties as a consultant.

The remuneration of the Chief Executive and Executive Directors is determined by the Board of Directors' Nominations and Remuneration Committee taking into account market levels, key skills, performance and responsibilities. In reviewing remuneration, including making decisions about whether to pay the Chief Executive and any of the individual Executive Directors more than £150,000 per annum, as outlined in the guidance issued by the Cabinet Office, the Committee has regard to the Trust's overall performance, delivery of agreed objectives, remuneration benchmarking data in relation to similar NHS Foundation Trusts and the wider NHS and the individual Director's level of experience and development of the role.

Remuneration of Senior Managers

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

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

Objectives for each Executive are set at the start of the financial year in order to deliver the strategic intentions (longer-term) and the operational plans (short to medium term). These SMART objectives are the performance measures for the individual Executives. The objectives/performance measures are reviewed during the year and progress is recorded.

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

The Board of Directors' Nominations and Remuneration Committee met on 25 March 2020 to consider among other items the Chief Executive and Executive Directors' remuneration and performance bonus for 2019/20. The meeting was chaired by Alison Ryan, Chair, and was attended by Jeremy Boss, Joanna Hole, Sumita Hutchison and Nigel Stevens, Non-Executive Directors. Apologies had been received from Anna Mealings, Non-Executive Director.

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

Remuneration of the Chair and Non-Executive Directors

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

The Committee first met on 6 November 2014 to consider the remuneration of the Trust Chair and other Non-Executive Directors. The Committee reviewed national NHS Trust Chair and Non-Executive Directors' remuneration benchmarking data and agreed to recommend to the Council of Governors that the level of remuneration for the Trust Chair 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 outlined below:

Non-Executive Director Remuneration

	Per annum
Basic pay	£12,500
Allowances (payable to the Chair of Non-Clinical and Clinical Governance Committees	£1,000
Chair of Audit Committee	£14,000
Senior Independent Director	£14,000
Chair	£47,500

In November 2019, NHS Improvement published a document entitled *Structure to align remuneration for Chairs and non-executive directors of NHS trusts and NHS foundation trusts.* In it, they published research on the pay rates for chairs and non-executive directors of trusts and foundation trusts of different sizes, comparing them to rates paid to directors of private sector companies with similar turnovers. They then made recommendations aimed at aligning pay to directors of trusts and foundation trusts based on their turnover. At a meeting of the Council of Governors' Nomination Committee in February 2020, it was decided that as the pay to the RUH Chair and non-executive directors is already in line with the suggested rates for a trust of its size, no changes would be made.

Annual Report on Remuneration

Service Contracts

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

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

Name	**NHS FT terms of office**	**Current term of Office**	**Notice period**
Alison Ryan **Chair**	01-Apr-2019- 31-Mar-2022	1-Apr-2019- 31-Mar-2022	3 months
Joanna Hole **Non-Executive Director**	01-Nov-2014- 31-Oct-2018	01-Nov-2018 -31 Oct-2020	3 months

Jeremy Boss, **Non-Executive Director**	6 March 2017– 8 Feb-2020	9-Feb-2020– 8-Feb 2023	3 months
Nigel Stevens **Non-Executive Director**	01-April 2018- 31 Mar 2021	01-April 2018- 31 Mar 2021	3 months
Sumita Hutchison **Non-Executive Director**	04-Sept-2019- 31-Aug-2022	04-Sept-2019- 31-Aug-2022	3 months
Anna Mealings **Non-Executive Director**	04-Sept-2019- 31-Aug-2022	04-Sept-2019- 31-Aug-2022	3 months
Nigel Sullivan **Non-Executive Director**	01-Nov 2014- 31-Jul-2016	01-Aug-2016- 31-Jul-2019	3 months
Jane Scadding **Non-Executive Director**	01-Nov-2015- 31-Oct-2018	1-Nov-2018- 31-Aug-2019	3 months
James Scott **Chief Executive Director**	01-Jun-2007	N/A	6 months
Libby Walters **Deputy Chief Executive & Director of Finance**	04-Jun- 2018	N/A	6 months
Bernie Marden **Medical Director**	30-Apr-2018	N/A	6 months
Rebecca Carlton **Chief Operating Officer**	13-Feb-2019	N/A	6 months
Lisa Cheek **Director of Nursing & Midwifery**	07-Nov-2018	N/A	6 months
Claire Radley **Director of People***	1 April 2018	N/A	6 months
Jocelyn Foster **Director***	30-Jul-2012	N/A	6 months
Brian Johnson **Director of Estates and Facilities****	01-Apr-2019	N/A	6 months

*Indicates non-voting members of the Board of Directors

Disclosures in accordance with the Health and Social Care Act

Director and governor expenses

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

Directors' expenses

No taxable expenses were paid to any Executive or Non-Executive Director during the reporting period or the previous financial year.

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 £1,395.78 was paid to 10 Governors (out of 21 Governors) in the period 1 April to 31 March 2020 (£1,904.47 was paid to 9 Governors (out of 21 Governors) in the period from 1 April 2018 to 31 March 2019).

Senior Managers' Remuneration (subject to audit)

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

Remuneration for Senior Managers for 2019-20:	**Salary and Fees (bands of £5,000)**	**Salary and Fees for Clinical Duties (bands of £5,000)**	**Annual Performance Related Bonuses (bands of £5,000)**	**Pension Related Benefits (bands of £2,500)**	**Total (bands of £5,000)**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
James Scott **Chief Executive**	200-205	-	10-15	0-2.5	215-220
Libby Walters **Director of Finance & Deputy Chief Executive**	145-150	-	5-10	100-102.5	255-260
Rebecca Carlton **Chief Operating Officer**	120-125	-	-	20-22.5	140-145
Bernie Marden **Medical Director**	60-65	130-135	-	0-2.5	195-200
Lisa Cheek **Director of Nursing & Midwifery**	110-115	-	5-10	75-77.5	195-200
Claire Radley **Director of People**	110-115	-	5-10	25-27.5	145-150
Jocelyn Foster **Commercial Director**	115-120	-	5-10	32.5-35	160-165
Brian Johnson **Director of Estates and Facilities** from 01.04.2019	95-100	-	-	20-22.5	115-120
Alison Ryan **Chair**	45-50	-	-	-	45-50
Jeremy Boss **Non Executive Director**	10-15	-	-	-	10-15

Joanna Hole **Non Executive Director**	10-15	-	-	-	10-15
Jane Scadding **Non Executive Director** to 31.08.19	5-10	-	-	-	5-10
Nigel Sullivan **Non Executive Director** to 31.07.19	0-5	-	-	-	0-5
Nigel Stevens **Non Executive Director**	10-15	-	-	-	10-15
Sumita Hutchinson **Non Executive Director** From 04.09.19	5-10	-	-	-	5-10
Anna Mealing **Non Executive Director** From 04.09.19	5-10	-	-	-	5-10

Remuneration for Senior Managers 2018-19

	Salary and Fees (bands of £5,000)	**Salary and Fees for Clinical Duties (bands of £5,000)**	**Annual Performance Related Bonuses (bands of £5,000)**	**Pension Related Benefits (bands of £2,500)**	**Total (bands of £5,000)**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
James Scott **Chief Executive**	185-190	-	10-15	-	195-200
Libby Walters **Director of Finance & Deputy Chief Executive** from 04.06.18	115-120	-	-	75-77.5	190-195
Peter Hollinshead **Interim Director of Finance** to 01.06.18	35-40	-	-	-	35-40
Francesca Thompson	100-105	-	5-10	-	105-110

Chief Operating Officer to 13.02.19					
Helen Blanchard* **Director of Nursing** to 30.09.18	60-65	-	5-10	60-62.5	130-135
Lisa Cheek **Director of Nursing & Midwifery** from 01.07.18	80-85	-	-	95-97.5	175-180
Bernie Marden **Medical Director** from 30.04.18	55-60	100-105	-	297.5-300	455-460
Claire Radley **Director of People** from 02.04.18	100-105	-	-	37.5-40	140-145
Jocelyn Foster **Director of Strategy**	110-115	-	5-10	40-42.5	155-160
Rebecca Carlton **Chief Operating Officer** from 27.02.19	10-15	-	-	2.5-5	10-15
Brian Stables **Chair**	45-50	-	-	-	45-50
Nigel Stevens **Non-Executive Director**	10-15	-	-	-	10-15
Jeremy Boss **Non-Executive Director**	10-15	-	-	-	10-15
Joanna Hole **Non-Executive Director**	10-15	-	-	-	10-15
Jane Scadding **Non-Executive Director**	5-10	-	-	-	5-10
Nigel Sullivan **Non-Executive Director**	0-5	-	-	-	0-5

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 2020 (bands of £5,000)	Lump Sum at Pension Age, Related to Accrued Pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019	Real Increase in Cash Equivalent Value Transfer	Cash Equivalent Transfer Value at 31 March 2020	Employer's Contribution to Stakeholder Pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
James Scott **Chief Executive**	0-2.5	7.5-10	75-80	230-235	1,849	31	1,894	14
Lisa Cheek **Director of Nursing & Midwifery**	10-12.5	10 - 12.5	45 - 50	135 - 140	904	95	1,015	16
Jocelyn Foster **Director of Strategy**	2.5 - 5	0 - 2.5	15 - 20	20 - 25	249	24	290	17
Bernie Marden **Medical Director**	0 - 2.5	0 - 2.5	60 - 65	135 - 140	1,136	0	1,148	26
Libby Walters **Director of Finance & Deputy Chief Executive**	5 - 7.5	0 - 2.5	45 - 50	110 - 115	757	71	842	14
Claire Radley **Director for People**	0 - 2.5	0 - 2.5	5 - 10	0 -5	60	10	86	16
Rebecca Carlton **Chief Operating Office**	0 - 2.5	0 - 2.5	30 - 35	65 - 70	525	14	556	17
Brian Johnson **Director of Estates and Facilities**	0 - 2.5	0 - 2.5	0-5	0-5	9	8	31	14

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

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

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

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

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

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

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

Any performance pay is paid retrospectively for the previous annual period of performance. For 2019/20, the Committee agreed to award a 10% bonus to all the members of the executive team.

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

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

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

There have been no new components within the pay for Executive Directors or other senior managers for the 2019/20 period.

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

Statement of consideration of employment conditions elsewhere in the Trust

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

Fair Pay Multiple (subject to audit)

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. This is calculated on a whole-time equivalent basis.

The banded remuneration for the highest paid Director in the Royal United Hospitals Bath NHS Foundation Trust for the year to 31 March 2020 was £215,000-£220,000 (to 31 March 2019: £195,000-£200,000). This was 7.1 times the median

remuneration of the workforce (31 March 2019: 6.7), which was £30,448 (31 March 2019: £29,716).

In 2019-20, four employees received remuneration in excess of the highest paid Director (31 March 2019: five).

Remuneration ranged from £10,000 to £223,297 (31 March 2019: £9,975 to £208,061).

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.

Payments for loss of office

There have been no payments made to any senior manager during 2019-20 and 2018-19 for loss of office. Any compensation payable for loss of office is conducted under the terms and conditions of the appropriate contract of employment.

Payments to past senior managers

One past Senior Manager received a payment of £8,073 during the reporting period (31 March 2019: none). This payment was a performance bonus which was paid in the current year in respect of performance during 2018/19.

Signed

Libby Walters

Interim Chief Executive (Accounting Officer)

24 June 2020

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)

	2019/20	2018/19
Medical and dental	600	589
Ambulance staff	2	3
Administration and estates	766	761
Healthcare assistants and other support staff	1,535	1,521
Nursing, midwifery and health visiting staff	1,373	1,294
Scientific, therapeutic and technical staff	424	424
Healthcare science staff	143	147
Total average numbers	4,843	4,739
Of which:		
Number of employees (WTE) engaged on capital projects	17	10

Analysis of staff costs for 2019/20

	Permanently Employed £000	**Other £000**	**Total £000**
Salaries and wages	176,690	3,112	179,802
Social security costs	17,716	-	17,716
Apprenticeship levy	1400	-	1,400
Pension cost - employer contributions to NHS pension scheme	30,907	-	30,907
Temporary staff - agency/contract staff	-	7,276	7,276
NHS charitable funds staff	559		559
Total Staff Costs	**227,272**	**10,388**	**237,660**

Analysis of staff costs for 2018/19

	Permanently Employed £000	**Other £000**	**Total £000**
Salaries and wages	170,529	-	170,529
Social security costs	16,608	-	16,608
Apprenticeship levy	839	-	839

Pension cost - employer contributions to NHS pension scheme	20,329	-	20,329
Temporary staff - agency/contract staff	-	4,487	4,487
NHS charitable funds staff	536		536
Total Staff Costs	**208,841**	**4,487**	**213,328**

Gender analysis

The number of male and female, senior managers and employees as at 31 March 2020:

Staff Group	**Female**	**Male**	**Total**
Directors	5	3	8
Other Senior Managers	57	35	92
Other employees	4,174	1,240	5,414
Total	4,236	1,278	5,514

Sickness absence data

Sickness absence data is not required to be disclosed for 2019/20; the latest sickness absence information can be found at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates.

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

Staff policies and actions applied during the financial year:

The Trust's Equality, Diversity and Inclusion 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 any individual with a protected characteristic; and for continuing the employment of, and arranging appropriate training for, employees who have become disabled during their employment; 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

Equality and Health Inequality Assessments are undertaken when writing or refreshing policies and our recently established staff networks review and comment on policies as part of the consultation process.

Engaging and consulting our employees

The Trust continues to engage with all employees and to provide staff with information on a systematic basis on matters of concern to them. For example, RNHRD staff were consulted extensively on the development of their new premises on the RUH site and their move from the Mineral Water Hospital, and the views of colleagues in the oncology teams are being sought in the development of the new Dyson Cancer Centre. The Trust's staff governors also act as an important conduit for two way communication between frontline colleagues and senior management.

The Trust is in the second year of a four-year programme of organisation development, Improving Together, which focuses on continuous improvement at the local level, engaging staff through team-based approaches to problem solving. Staff are being trained in new methods to give them the skills to resolve issues within their working environment that will benefit patients, their care and staff experience. By February 2020, 314 staff had received training in the improvement methodology.

The Trust also engages and consults both directly with employees or their representatives on a regular basis. The Trust employs a pulse survey to engage with employees on a quarterly basis. The aim of this is to capture the views of staff and encourage their involvement in decision-making. The results of the pulse surveys are monitored by a Staff Engagement Group, which takes responsibility for communicating about the results and sharing the concerns raised, with ideas for improvements. This group meets quarterly in line with the survey results.

The Trust has formal consultation arrangements through the joint staff consultative and negotiating committee to provide information to staff, consult with them through their designated local representatives and take their views into account. This partnership agreement was renewed in 2019/20. 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

- 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 via '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
- Go Engage quarterly pulse surveys
- Team Go Engage programme, specifically targeted to encourage engagement in teams (launching April 2020)
- Mo - our web-enabled engagement tool enabling managers and colleagues to thank each other and recognise the thanks against the Trust Values
- 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 a staff twitter account
- 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
- Pay-slip bulletin – information pertinent to everyone (corporate development, employment issues etc) circulated to every member of staff with their monthly pay-slip
- The Trust has in the last year encouraged three staff networks to develop: BAME (Black, Asian and ethnic minorities), Equal Abilities (staff with disabilities) and LGBT+ and allies, (lesbian, gay, bisexual and transgender). As well as providing support for these staff groups the networks are very much an opportunity for these staff to voice concerns and comment on the work of the Trust and provide feedback to the executive team.

Our People Strategy outlines how to be an outstanding employer where staff can flourish, through a full range of HR and OD work. It continues to be reviewed to ensure that it reflects the Trust's needs within the national context.

Health and safety performance, Occupational health and wellbeing

As part of the Trust's arrangements for Health and Safety compliance under the Health and Safety at Work etc. Act 1974, the Trust has in place a Health and Safety governance framework including a Health and Safety Committee. The Trust has a number of policies that relate to Health & Safety which are all in date and regularly reviewed.

Training figures for the Trust have continued to improve since last year.

	Number of staff requiring training	2018-2019	2019-2020	% difference in last 12 months
Health, Safety & Welfare training	6,105	89.2%	90.0%	0.8% ⇧
Moving & Handling Level 1	6,105	90.3%	91.3%	1% ⇧
Moving & Handling Level 2	3,021	78.9%	83.9%	5% ⇧

In the last year we had an increase of four RIDDORs totalling 38 for the year. All RIDDORs reported are investigated by the Health and Safety Team with input from the department involved before reporting to the HSE.

Throughout the year the top three personal accidents reported for staff via Datix are consistently the same with no noticeable trends.

- Staff accident – involving sharps /needlestick
- Staff accident – collision or contact with an object
- Staff accident – Slip, trip and fall

All incidents reported on Datix are investigated by the department manager and where required supported by the Health and Safety team.

The health and safety risk identification checklist returns are now 100% completed; this gives the Trust wide overview of the status of risk assessments in each department.

In the last year we have not had any HSE related inspections.

All staff have access to Occupational Health Services and an in-house Employee Assistance Programme which includes 1:1 counselling, workshops and training opportunities focused on self-care and resilience, mental health awareness, stress management etc. The EAP service also co-ordinates the Trust's trauma risk management (TRiM) interventions for staff who have been exposed to traumatic incidents. The Health & Wellbeing Strategy Group began the process of refreshing the HWB strategy (2016-21) in November 2019 and will continue to take responsibility for monitoring the strategy and work plan as the strategy refresh is embedded from April 2020. The strategy group reports to the Strategic Workforce Committee and through that to the People Committee and Board.

We support staff to maintain their health and wellbeing through interventions and activities including:

Physical Health & Wellbeing	✓ Smoking cessation support

	✓ Exercise classes ✓ Phased & supported returns to work ✓ Staff physiotherapy service ✓ Staff gym & swimming pool ✓ Couch to 5k ✓ Weight Watchers group on site ✓ Menopause events, support and information ✓ Sustainable/active travel plan ✓ Aqua-natal classes
Mental & Emotional Health & Wellbeing	✓ Staff counselling service ✓ EAP workshop programme ✓ TRiM ✓ Schwartz Rounds ✓ Mental Health First Aid
Spiritual & Cultural Wellbeing	✓ Spiritual Care Centre ✓ Art at the Heart exhibitions ✓ Celebrations of cultural diversity ✓ Library events
Financial & Social Wellbeing	✓ Retirement workshops ✓ Payroll advances (NB payback arrangements) ✓ Social prescribing project
Equality, Diversity & Inclusion	✓ Staff networks ✓ Reverse mentoring ✓ Awareness raising, e.g. Rainbow badges & lanyards ✓ Communications content reflecting organisational diversity

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

The Trust has policies in place with respect to countering fraud**,** bribery and corruption. We take a proactive approach to raising awareness of the potential for fraud**,** bribery and corruption amongst our staff and work closely with the Counter Fraud service to ensure preventative measures are in place**.** The Trust has an annual work plan in place which reflects activity relevant to the Trust and the NHS Protect Standards for Providers: Fraud, Bribery and Corruption, and engages an accredited Counter Fraud Specialist to support the activity detailed within the counter-fraud work plan.

Additional mandatory disclosures – Disclosures on Trade Union Facility Time

Relevant union officials

The total number of employees who were relevant union officials during 2019/20 was:

Number of employees who were relevant union officials 19/20	Full-time equivalent employee number
45	4930.8

Percentage of time spent on facility time during 2019/20

Percentage of time	Number of employees
0%	-
1-50%	44
51%-99%	1
100%	-

Percentage of time spent on facility time during 2019/20

Total cost of facility time	£72,971.68
Total Trust pay bill	£226,522,214
% of total pay bill spent on facility time	0.03%

Paid trade union activities during 19/20

Time spent on paid trade union activities as a percentage of total paid facility time hours	18.5%

Off payroll arrangements

The Trust only uses off-payroll arrangements in exceptional circumstances. The Trust does not use off-payroll arrangements for members of the Board of Directors and/or senior officials with significant financial responsibility. In exceptional circumstances where off-payroll arrangements are used the Trust follows its own policy, Standing Financial Instructions and all relevant HM Treasury guidance. As at 31 March 2020 the Trust did not have any off-payroll engagements. There have been no new off-payroll engagements for more than £245 per day entered into during the year ended 31 March 2020. There have been no off-payroll engagements in respect of Board members or senior officials with significant financial responsibility in the year ended 31 March 2020.

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. Our staff engagement score for 2019 was 7, and shows a small decrease since 2018 (score 7.1).

The Trust's focus for staff engagement in the year 2019/20 was to implement a quarterly survey to check in with staff on a more regular basis. This pulse survey is called Go Engage. We survey a quarter of the organisation every quarter, so staff will receive the survey once in the year. This is by email for staff with an NHS email address, and paper copies for those without.

To complement the regular engagement survey the Staff Engagement and Organisation Development team have been preparing for the roll-out of a new Team Go Engage programme – an engagement programme designed specifically for teams.

Equality, Diversity and Inclusion has remained a significant area of work during 2019/20, with the three staff Networks gaining momentum. We are focused on improving the opportunities for staff from all backgrounds whilst recognising that we have some targeted work to do.

We continue to embed the values co-created with staff, patients, carers and their families. To enable this, our values are introduced to all new staff at induction, all staff discuss how they put the values into practice in their work at their annual appraisal and the values underpin key people management policies. We have updated our Values video which introduces the values to all new staff at induction.

Recognising and appreciating colleagues remains a key priority at the RUH. This year we have relaunched Mo (formerly Thanxbox), our organisational feed of positive moments and thanks. We have seen usage increase since the relaunch, and further work is being done to make it easier to use.

Feedback about plans to address issues raised in the staff survey are shared with staff in the Trust's corporate publications, @RUH and the weekly email bulletin sent to all staff.

Summary of performance – NHS Staff Survey

All staff across the Trust were invited to complete the annual NHS Staff Survey. A total of 2,173 responses were received, equivalent to a response rate of 42%.This is slightly lower than last year's response rate (46%) and falls below the median response rate for our benchmarking group (Acute Trusts in England - 47%). However, this slight decline in response rate should be contextualised by the fact that the Trust now runs a quarterly pulse check survey to monitor staff engagement more frequently, reflecting its continued commitment to being 'an outstanding place

to work where people can flourish'. The Quarter 2 pulse check survey – which was run in the month preceding the national survey - provided an alternative opportunity for staff to express their thoughts and opinions and may have inadvertently diverted some attention away from the national survey.

	2019/20		2018/19		2017/18	
	Trust	**Benchmarking Group**	**Trust**	**Benchmarking Group**	**Trust**	**Benchmarking Group**
Equality, diversity and inclusion	9.1	9.0	9.2	9.1	9.1	9.1
Health and Wellbeing	5.9	5.9	6.0	5.9	6.1	6.0
Immediate Managers	6.8	6.8	6.8	6.7	6.8	6.7
Morale	6.2	6.1	6.1	6.1	N/A	
Quality of Appraisals	5.7	5.6	5.6	5.4	5.5	5.3
Quality of Care	7.2	7.5	7.1	7.4	7.1	7.5
Safe environment – B&H	7.9	7.9	8.0	7.9	8.0	8.0
Safe environment – violence	9.4	9.4	9.5	9.4	9.4	9.4
Safety culture	6.5	6.7	6.4	6.6	6.4	6.6
Staff engagement	7.0	7.0	7.1	7.0	7.0	7.0
Team Working	6.5	6.6	N/A		N/A	

<u>Addressing our key priorities and targets</u>

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. Action plans include a corporate plan and divisional plans enabling tailored actions to be put in place and to monitor improvements.

The Trust identified key areas for work during 2019/20 and in light of the results these areas remain the focus for action and improvement this year (2020/21). These include:

Trust Values	Area of activity	
Everyone Matters	To improve the experiences of work for BAME staff and staff with disabilities	To improve the health and wellbeing offer to staff
Working Together	To improve staff engagement	Develop our teams to be effective in their clinical areas and across other areas too
Making a	Support staff to feel that they	Support staff to gain feedback about

Difference	are able to provide the care they aspire to give	changes made in response to reported errors, near misses and incidents

A Staff Engagement Group has been established to monitor the Trust's staff engagement work. The group is chaired by the Deputy Director for People and meets quarterly.

Monitoring arrangements for the Trust's staff engagement work is through the Trust's governance committees, Strategic Workforce Committee, People Committee, Improving Together Programme Board, Management Board and the Board of Directors. Work is being done across the organisation to get staff more involved in the delivery of its strategy.

The development and monitoring of the plans is co-ordinated through a Working Group reporting to the Strategic Workforce Committee, through the Safe-Staffing Group reporting to the Health and Safety Committee, and via the Diversity and Inclusion Steering Committee (DISCo). These committees report into the Trust Board of Directors. Progress against key priority areas of the programme will be kept under regular review via the Executive Performance Reviews and monitored bi-annually by the Board of Directors.

Off-payroll Engagements

The Trust has not engaged any off-payroll arrangements in 2019/20.

Expenditure on consultancy

Expenditure on consultancy, as defined in the Department of Health's Group Accounting Manual during 2019/20 was £1,327k (£921k in 2018/19).

Exit Packages

Details of exit packages for 2019/20:

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	2	12	14
£10,000 - £25,000	-	-	
£25,001 - £50,000	-	-	-
£50,001 - £100,000	-	-	-

£100,001 - £150,000	-	-	-
>£150,000	-	-	-
Total number of exit packages by type	2	12	14
Total resource cost (£'000)	10	34	44

Details of exit packages for 2018/19:

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1	12	13
£10,000 - £25,000	-	1	1
£25,001 - £50,000	2	-	2
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
>£150,000	-	-	-
Total number of exit packages by type	3	13	16
Total resource cost (£'000)	77	61	137

Details of other departures payments 2019/20 and 2018/2019:

	2019/20		2018/2019	
	Agreements Number	Total Value of Agreements £000	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs.	-	-	-	-
Mutually agreed resignations (MARS) contractual costs.	-	-	-	-
Early retirements in the efficiency of the service contractual costs.	-	-	-	-
Contractual payments in lieu of notice.	12	34	13	61
Exit payments following Employment Tribunals or court orders.	-	-	-	-
Non-contractual payments requiring MHT approval.	-	-	-	-

Total	12	34	13	61

Payments for loss of office	£0
Payments to past senior managers	£8,073

Governance of the Trust

Role of the Board of Directors

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

The Board of Directors is responsible for:

- Determining the strategic direction of the Trust in consultation with the Council of Governors;
- Setting targets, monitoring performance and ensuring 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 required. The Board has a formal schedule of matters specifically reserved for its decision. This includes approving strategy,

business plans and budgets, approving high value expenditure and contracts, regulations and control, annual reporting 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

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

Board meetings follow a formal agenda which 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 views of governors and members/stakeholders through a variety of mechanisms. This includes Executive and Non-Executive Director attendance at meetings of the Council of Governors and its working groups; attendance at joint Board and Council away day events; participation in meetings involving members, such as at the Annual Members' Meeting, at the Members' *Caring for You* events; and Executive Director attendance at Governor Constituency meetings.

Role of the Chair

The Chair 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.

Role of the Non-Executive Directors

Non-Executive Directors share the corporate responsibility for ensuring that the Trust is run efficiently, economically and effectively. Non-Executive Directors use their expertise and experience to scrutinise the performance of management, monitor the reporting of performance and satisfy themselves as to the integrity of financial, clinical and other information. The Non-Executive Directors also fulfil their responsibility for determining appropriate levels of remuneration for Executive Directors.

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

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

Board of Directors Completeness

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

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

The balance, completeness and appropriateness of the Board of Directors is reviewed at least annually to ensure its effectiveness. At the present time, although the Board is satisfied as to its balance, completeness and appropriateness, the decision has been made to seek to appoint an additional non-executive director, preferably with a clinical background. This appointment will be made in 2020/21.

Non-Executive Director Appointments

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

In May 2019, the Council of Governor's Nominations Committee agreed to commence the process of appointing two new Non-Executive Directors; one to replace Nigel Sullivan whose term of office was to end in July 2019, and the other to increase the complement of NEDs. Following a competitive tender process, Gatenby Sanderson were appointed to support the process. The posts were advertised in May, and attracted a total of 52 candidates, 12 of whom were longlisted, and 6 eventually invited for interviews on 6 August 2019.

The Interview Panel comprised of:

- The Trust Chair
- Nick Marsden, Chair, Salisbury NHS Foundation Trust
- James Colquhoun, Lead Governor
- Shaun Lomax, Staff Governor
- Chris Callow, Public Governor

At the end of the process, which also included focus group meetings with other Governors, NEDs and Executive Directors, the Nomination Committee recommended to the Council of Governors that Anna Mealings and Sumita Hutchison be appointed to the Board. This recommendation was approved and both candidates agreed to join the RUH Board of Directors in September 2019.

Board evaluation and development

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

The Board of Directors undertakes an annual development review of its performance and its effectiveness as a unitary board. The Board of Directors holds a minimum of four away day sessions during the year, which provide an opportunity for the Board to debate strategic issues in an informal setting. The Board of Directors also has a programme of Board Seminars held after Board meetings 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.

In March 2020, the Trust appointed Cara Charles-Barks to take over as Chief Executive with effect from September 2020

Board Committees

The Board of Directors has 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 the Chief Executive, and has delegated powers from the Board of Directors to oversee the day-to-day management of an effective system of integrated governance, risk management and internal control

across the whole organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives. The Management Board also has delegated authority to approve business cases for the establishment of new clinical posts and service developments. During the course of the year, as the Improving Together quality improvement methodology became more embedded across the organisation, the Management Board took on the role of monitoring progress in the rolling out of training and the completion of projects.

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

Audit Committee

The Audit Committee is chaired by Jeremy Boss, 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; and
- 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, which also include 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.

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

The Audit Committee is also responsible for monitoring the external auditor's independence and objectivity, including the effectiveness of the audit process.

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

The current external auditor, Deloitte, was appointed in 1 April 2016 following a compliant tender process, and their appointment was approved by the Council of Governors, as required by the Trust Constitution, and following recommendation by the Committee.

Deloitte has not provided any non-audit services for the Trust in 2019/20.

Non-Clinical Governance Committee (NCGC)

The Non-Clinical Governance Committee 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 Is chaired by Nigel Stevens, Non-Executive Director. The Committee focuses primarily on providing assurance to the Board that the Trust has a robust framework for the management of risks arising from or associated with clinical 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.

People Committee

The People Committee is new and was established in 2019/20, and took on that part of the Non-Clinical Governance Committee's role relating to human resources and organisational development. It is chaired by Anna Mealings, Non-Executive Director, and its role is to provide assurance to the Board that people-related risks are being appropriately managed, and that the Trust's employment processes are fit for purpose and legally compliant. In 2019/20 the Committee has been particularly focused on ensuring that the Trust remains an attractive employer and has effective systems in place to ensure that staff are valued and supported.

In the latter part of the year, work was started to broaden the role of the Non-Clinical and Clinical and People Committees, to increase the amount and range of work that can be delegated by the Board to enable the Board to focus more time on strategic matters. The results of this work will be realised during 2020/21.

Board of Directors' Nominations and Remuneration Committee

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

The Charities Committee

From March 2017, the Charities Committee has been chaired by Jeremy Boss, 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").

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 100 separate funds.

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

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

Commercial Transactions Steering Group

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

Strategic Assurance Committee

The Strategic Assurance Committee was chaired by the Chief Executive. The primary objective of this committee was to provide assurance to the Board of Directors on strategic direction, alignment and delivery. This Committee was stood

down during 2019/20 and its roles will now be jointly undertaken by a new Strategic Development Group and the Board of Directors itself.

	Board of Directors (11 meetings)	Audit Committee (4 meetings)	Non-Clinical Governance Committee (6 meetings)	Clinical Governance Committee (6 meetings)	Board of Directors' Nominations and Remuneration Committee	Commercial Transactions Steering Group (2 meetings)	Charities Committee (4 meetings)	Strategic Assurance Committee (3 meetings)	Management Board (12 meetings)	People Committee (2 meetings)
Alison Ryan **Chair**	11/11	-	-	-	5/5	-	3/4	2/3	-	-
Joanna Hole **Non-Executive Director, Vice Chair and Senior Independent Director**	10/11	4/4	6/6	-	5/5	-	-	-	-	-
Jane Scadding **Non-Executive Director** *(until 31 August 2019)*	3/4	-	-	2/2	0/1	-	-	0/1	-	-
Nigel Sullivan **Non-Executive Director** *(until 31 July 2019)*	3/4	-	2/2	-	-	-	-	-	-	-
Jeremy Boss **Non-Executive Director**	10/11	4/4	-	-	5/5	2/2	4/4	-	-	2/2
Nigel Stevens **Non-Executive Director**	9/11	2/4	-	5/6	3/5	1/2	-	1/2	-	-
Sumita Hutchison **Non-Executive Director** *(from 1 September 2019)*	5/7	-	1/3	-	3/4	-	-	-	-	2/2

	Board of Directors (11 meetings)	Audit Committee (4 meetings)	Non-Clinical Governance Committee (6 meetings)	Clinical Governance Committee (6 meetings)	Board of Directors' Nominations and Remuneration Committee	Commercial Transactions Steering Group (2 meetings)	Charities Committee (4 meetings)	Strategic Assurance Committee (3 meetings)	Management Board (12 meetings)	People Committee (2 meetings)
Anna Mealings **Non-Executive Director** *(from 1 September 2019)*	7/7	-	-	2/2	3/4	-	-	-	-	2/2
James Scott **Chief Executive**	11/11	-	-	-	-	1/2	-	3/3	7/12	1/2
Libby Walters **Deputy Chief Executive & Director of Finance**	11/11	4/4	5/6	-	-	2/2	4/4	2/3	9/12	2/2
Lisa Cheek **Director of Nursing & Midwifery**	11/11	-	-	5/6	-	-	2/4	2/3	11/12	2/2
Bernie Marden **Medical Director**	11/11	-	-	6/6	-	-	-	2/3	10/12	-
Jocelyn Foster **Director of Strategy**	10/11	-	3/6	-	-	2/2	3/4	3/3	10/12	2/2
Rebecca Carlton **Chief Operating Officer**	11/11	-	5/6	-	-	-	-	1/3	8/12	1/2
Claire Radley **Director for People**	11/11	-	6/6	-	4/5	-	-	3/3	11/12	2/2

	Board of Directors (11 meetings)	Audit Committee (4 meetings)	Non-Clinical Governance Committee (6 meetings)	Clinical Governance Committee (6 meetings)	Board of Directors' Nominations and Remuneration Committee	Commercial Transactions Steering Group (2 meetings)	Charities Committee (4 meetings)	Strategic Assurance Committee (3 meetings)	Management Board (12 meetings)	People Committee (2 meetings)
Brian Johnson **Director of Estates & Facilities**	10/11	-	6/6	-	-	2/2	-	2/3	12/12	2/2

The Council of Governors

Composition, roles and responsibilities

The Council of Governors consists of 21 Governors:

- 11 Public Governors (elected by public members)
- 5 Staff Governors (elected by staff members)
- 5 Stakeholder Governors (appointed by their organisation)

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

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

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

- Appoint and, if appropriate, remove the Chair and other Non-Executive Directors;
- Determine the remuneration and allowances and other terms and conditions of office of the Chair 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; and
- 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.

2019/20 Governor Elections

During 2019/20 the Trust held an election to elect three staff governors and five public governors across five constituencies. This was the second constituency-wide election for new governors since becoming an NHS Foundation Trust hospital in 2014.

Each constituency had a contested election and the voting turnout was good ranging from 13.01% - 17.12%. The full election report is available from the Membership Office ruhmembership@nhs.net.

Register of Governors

The register of Governors for the period 1 April 2019 to 31 March 2020 is:

Name	Constituency	Term of Office ends
Public Governors		
Amanda Buss	City of Bath	31 October 2020
Mike Midgely*	City of Bath	31 October 2022
Helen Rogers	North East Somerset	31 October 2020
Nick Houlton	North East Somerset	31 October 2019
Melanie Hilton	North East Somerset	31 October 2022
Michael Welton	Somerset (Mendip)	31 October 2020
Anne Martin*	Somerset (Mendip)	31 October 2022
Chris Callow	North Wiltshire	31 October 2019
Jerry Willmott**	North Wiltshire	31 October 2022 (stood down Jan 20)
Jacek Kownacki	North Wiltshire	31 October 2020
James Colquhoun	South Wiltshire	31 October 2019
Gill Little	South Wiltshire	31 October 2022

Chris Hardy	South Wiltshire	31 October 2020
Andrew Simkins	Rest of England & Wales	31 October 2020
Staff Governors		
Julie Scriven	Staff	31 October 2019
Mike Coupe	Staff	31 October 2020
Darrin King	Staff	31 October 2020
Shaun Lomax	Staff	31 October 2019
Andrew Owens**	Staff	31 October 2020 (stood down Sept 19)
Sophie Legg	Staff	31 October 2022
Sarah Bond	Staff	31 October 2022
Narinder Tegally	Staff	31 October 2022
Stakeholder Governors (appointed)		
Dr Ian Orpen	BaNES CCG	31 October 2020
Cllr Vic	BaNES Council	31 October 2020 (stood down May 19)
Dr Andrew	Wiltshire CCG	31 October 2020
Cllr Johnny	Wiltshire Council	30 September 2020
Cllr Rob	BaNES Council	30 April 2022
Dr Vivien Gibbs	Uni of the West of	31 March 2021

* These Governors were re-elected in 2019

** Jerry Wilmott, Public Governor stood down in January 2020
Andrew Owens, Staff Governor stood down in September 2019
Cllr Vic Pritchard, Stakeholder Governor stood down in May 2019

Lead Governor

During the Council of Governors' meeting held on 4 December 2019, the Chair highlighted that the Lead Governor had not been re-elected in the 2019 elections and that as no one had put themselves forward for the role, the Council of Governor Nominations and Remuneration Committee had suggested it was discussed further as part of their main meeting. At this meeting, the Council of Governors discussed the role and confirmed the appointment of Amanda Buss, Public Governor as Lead Governor. Amanda Buss's term as Lead Governor will cease on 31 October 2020 unless she is re-elected as a Governor during the 2020 election process, in which case it will cease on 30 November 2021.

Link with the Board of Directors

The Council of Governors holds the Non-Executive Directors to account for the performance of the Board. 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 Chair of the Trust and these meetings are attended by the Chief Executive. Non-Executive Directors are invited to attend meetings and other Directors attend to report on items relating to their responsibilities. Non-Executive Directors take part in a programme of seminars in order to provide further information on the work of their Committees. The Governor working groups have 'link NEDs' who are available to answer any further reassurance questions Governors may have.

The Board of Directors and Council of Governors also hold an annual joint away day to provide an opportunity for informal discussions and to focus on the Forward Plan. Although meetings of the Board of Directors are held in public and Governors can and do attend, the Chair 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 Chair would endeavour to resolve the dispute. If the Chair 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 the 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

Each month a small group of Public Governors attends meetings of the Board of Directors (BoD) 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.

Council of Governor Meetings

The Council of Governors has met on the following occasions:

- 6 June 2019
- 4 September 2019
- 4 December 2019
- 5 March 2020

The following table summarises Governor attendance at Council of Governor meetings 1 April 2019 to 31 March 2020:

Name	Constituency	Attendance
Public Governors		
Amanda Buss	City of Bath	4 of 4
Mike Midgley	City of Bath	4 of 4
Helen Rogers	North East Somerset	2 of 4
Nick Houlton	North East Somerset	2 of 2
Melanie Hilton	North East Somerset	2 of 2
Michael Welton	Somerset (Mendip)	3 of 4
Anne Martin	Somerset (Mendip)	4 of 4
Chris Callow	North Wiltshire	2 of 2
Jerry Willmott	North Wiltshire	1 of 1
Jacek Kownacki	North Wiltshire	2 of 4
James Colquhoun	South Wiltshire	1 of 2
Gill Little	South Wiltshire	2 of 2
Chris Hardy	South Wiltshire	3 of 4
Andrew Simkins	Rest of England & Wales	4 of 4
Staff Governors		
Shaun Lomax	Staff	1 of 2
Michael Coupe	Staff	4 of 4
Julie Scriven	Staff	2 of 2
Darrin King	Staff	3 of 4
Andrew Owens	Staff	0 of 2
Sophie Legg	Staff	0 of 1
Sarah Bond	Staff	1 of 1
Narinder Tegally	Staff	1 of 1
Stakeholder Governors (appointed)		
Dr Ian Orpen	BaNES CCG	3 of 4
Cllr Vic Pritchard	BaNES Council	0 or 0
Dr Andrew Girdher	Wiltshire CCG	2 of 4
Cllr Johnny Kidney	Wiltshire Council	4 of 4
Cllr Rob Appleyard	BaNES Council	3 of 4

Dr Vivien Gibbs	University of the West of England	3 of 4

The Chief Executive attended three of four Public Council of Governor meetings with the Deputy Chief Executive deputising for 1 of 4. Other Directors attended as requested by the Governors.

Council of Governors' Nominations and Remuneration Committee

During 2019/20 the Nominations and Remuneration Committee has undertaken the following work:

- Participated in the recruitment and appointment process for two new Non-Executive Directors and made a recommendation to appoint Anna Mealings & Sumita Hutchison to the Council of Governors' for approval.
- Approved the extension of Jeremy Boss's, Non-Executive Director's term until February 2023;
- In February 2020, approved the recruitment process to appoint a Non-Executive Director with a clinical background.

Governor working groups

Governors continue to fulfil both their statutory and non-statutory duties through working groups. These have been set up to further assist Governors in their role of holding the non-executive directors to account for the performance of the Board. Governor working groups are supported by the Deputy Head of Corporate Governance, and include an Executive Director lead. All working group agendas include an item for the Governors to develop assurance questions to ask the Non-Executive Directors should further assurance be required.

The working groups which have been developed are:

- Governor Strategy & Business Planning Working Group
- Governor Quality Working Group
- Governor Membership & Outreach Working Group

In December 2019, it was agreed that the Council of Governors would establish a People Working Group to ensure that members' views relating to staff engagement and experience are considered and addressed. Because of the Covid-19 pandemic, this group has not met formally to agree its terms of reference, but work will continue during 2020/21.

The working groups do not have decision-making powers, but will make recommendations for the approval of the full Council of Governors. Each group is chaired by a Governor.

There are a number of 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, 01225 826288 or 01225 821262

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 membership is made up 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;
- Take part in focus groups and surveys to help improve patient experience.

Public members

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

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

Staff members

Staff who are permanently employed or hold a fixed term contract of at least 12 months are invited to become staff members of the Trust. Staff members are represented by five governors.

Developing a representative membership

The Board of Directors and the Council of Governors are committed to ensuring that the membership is representative of the local community served by the Trust. The Council of Governors' Membership and Outreach Working Group reviews membership data on an annual basis and is content that the Trust's membership is representative of the community who use our services. At the Council of Governors meeting held on 5 March 2020, the Governors agreed to increase membership again in 2020/21.

The table below highlights the Trust's actual public membership figures as at 31 March 2020:

Category	**Actual 31 March**
Public	11,616
Staff	5,442
Total	17,058

The number of members within each constituency is as follows:

Constituency breakdown	**As at 31 March 2020**
City of Bath	2,484
North-East Somerset	1,958
Mendip	1,259
North Wiltshire	1,743
South Wiltshire	2,327
Rest of England and Wales	1,824
Out of Trust Area	21

The Public & Staff Membership Development Strategy 2019/20 has been developed by the Deputy Head of Corporate Governance in conjunction with the Governor Membership and Outreach Working Group. The working group supports the Trust in maintaining 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. It also ensures that the Council of Governors and the Trust take account of the views of its membership, particularly at the Annual Members' Meeting. The Public and Staff 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 maintain 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 11,616 local people registered as members of the Trust, and a further 5,442 staff members. This is an audience of 17,058 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 and Insight magazine
- Staff monthly magazine and weekly newsletter
- E-communications
- Caring for You events
- Governor Constituency meetings
- Online surveys
- Annual Members' Meeting

Throughout 2019/20 the Trust has run a number of engagement events with the public ranging from Caring for You events to Governor Constituency meetings. In 2019/20 there were six constituency meetings held across the region. Four other constituency meetings had been planned but had to be cancelled due to purdah for the European elections. Of the meetings that took place, each constituency meeting aimed to inform attendees about the Trust, and also seek their views about what could be improved and what was going well. Additional articles and information were also included in the quarterly members' magazine Insight, which is disseminated to all public members by post or email.

Throughout 2019/20, the Staff Governors continued to engage with staff by attending team meetings to find out more about the experiences of staff and to also inform them about the role of a governor.

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. Each event continues to attract 70-120 members and events in 2019/20 included Research and Development, the Role of Carers, New

Developments at the Hospital and Stroke Care. The aim of the events is to enable members to understand more about the work of the hospital and how it supports the health and wellbeing of the local communities, 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 NHS Improvement.

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

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

Ref No	Code Provision	Annual Report and Accounts Section
A.1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions taken by each of the Boards, and which are delegated to the Executive management of the Board of Directors.	Directors' Report
A.1.2	The annual report should identify the Chairperson, the Deputy Chairperson, the Chief Executive, the Senior Independent Director and the chairperson and members of the Nominations, Audit and Remuneration Committees. It should also set out the number of meetings of the Board and those committees and individual attendance by Directors.	Directors' Report
A.5.3	The annual report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the	Directors' Report

Ref No	Code Provision	Annual Report and Accounts Section
	duration of their appointments. The annual report should also identify the nominated Lead Governor.	
FT ARM	The annual report should include a statement about the number of meetings of the Council of Governors and individual attendance by governors and Directors.	Directors' Report
B.1.1	The Board of Directors should identify in the annual report each Non-Executive Director it considers to be independent, with reasons where necessary.	Directors' Report
B.1.4	The Board of Directors should include in its annual report a description of each Director's skills, expertise and experience. Alongside this, in the annual report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS Foundation Trust.	Directors' Report
FT ARM	The annual report should include a brief description of the length of appointments of the Non-Executive Directors, and how they may be terminated.	Directors' Report & Remuneration Report
B.2.1	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to Board appointments.	Directors' Report & Remuneration Report
FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a Chair or Non-Executive Director.	Directors' Report
B.3.1	A Chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the annual report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next annual report.	Directors' Report
B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed Governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy, and their views	Governance of the Trust

Ref No	Code Provision	Annual Report and Accounts Section
	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.	
FT ARM	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the Directors to attend a Governors' meeting for the purpose of obtaining information about the Foundation Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or Directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act (2012)	This power has not been exercised.
B.6.1	The Board of Directors should state in the annual report how performance evaluation of the Board, its committees, and its Directors, including the chairperson, has been conducted.	Directors' Report
B.6.2	Where there has been external evaluation of the Board and/or governance of the Trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the Trust.	Governance of the Trust
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	Annual Governance Statement

Ref No	Code Provision	Annual Report and Accounts Section
	Statement (within the annual report).	
C.2.1	The annual report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	Annual Governance Statement
C.2.2	A trust should disclose in the annual report: a) If it has an internal audit function, how the function is structured and what role it performs; or b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Annual Governance Statement
C.3.5	If the Council of Governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the Board of Directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	N/A
C.3.9	A separate section of the annual report should describe the work of the [Audit] committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Governance of the Trust – Audit Committee

Ref No	Code Provision	Annual Report and Accounts Section
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 of the Trust
E.1.5	The Board of Directors should state in the annual report the steps they have taken to ensure that the members of the Board, and in particular the Non-Executive Directors, develop an understanding of the views of governors and members about the NHS Foundation Trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	Governance of the Trust
E.1.6	The Board of Directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Governance of the Trust
FT ARM	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Governance of the Trust

Ref No	Code Provision	Annual Report and Accounts Section
FT ARM	The annual report should disclose details of company Directorships or other material interests in companies held by governors and/or Directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS Foundation Trust. As each NHS Foundation Trust must have registers of governors' and Directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 7.33 as Directors' report requirement.	Directors' Report

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:** All three clinical divisions (Medicine, Surgery, Women & Children) hold regular, formal divisional clinical governance meetings and report to the Operational Clinical Governance Committee. An internal audit of the Trust's divisional governance processes was completed in May 2018 which gave significant assurance with minor improvement opportunities. The Trust's approach to governance and quality improvement is led by the Director of Nursing and Midwifery and the Medical Director. The Medical Director chairs the Quality Board, which is responsible for ensuring that the Trust has effective and efficient arrangements in place for quality assessment, quality improvement and quality assurance. Quality Board provides assurance to the Board of Directors on the

		quality of care and treatment provided by services in the Trust. Quality Board's work plan includes a rolling programme of updates on Quality Accounts priorities, patient experience and the key patient safety and quality improvement priorities identified in the Patient Safety and Quality Improvement Triangle. Each priority has an established clinical leader, and an executive sponsor, who are responsible for setting the work-plan with agreed process and outcome measures. 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 NHS Improvement for advising the Board and the Council and for recording and submitting objections to decisions.	**Confirmed:** the Chief Executive is aware of this provision in the Accounting Officer Memorandum.
A.1.8	The Board should establish the constitution and standards of conduct for the NHS Foundation Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life.	**Confirmed:** the Trust has a Constitution, which was last updated in October 2019. Staff are required to sign the Trust's Code of Conduct. The Board of Directors annually confirms its adherence to the Nolan standards of public life and the Fit and Proper Person Requirements.
A.1.9	The Board should operate a code of conduct that builds on the values of the NHS Foundation Trust and reflect high standards of probity and responsibility.	**Confirmed:** The Trust has a Code of Conduct based on the Trust's values. There are separate codes of conduct for the members of the Board of Directors and Council of Governors. The Board of Directors' Code of Conduct reflects the requirements of the Fit and Proper Persons Test.
A.1.10	The NHS Foundation Trust should arrange appropriate insurance to cover the risk of legal action against its Directors.	**Confirmed:** the Trust is a member of NHS Resolution and is covered by its indemnity scheme. The Trust's NHS Foundation Trust Constitution states that providing Directors act honestly and in good faith, any legal costs incurred in the execution of

		their functions will be met by the Trust.
A.3.1	The Chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A Chief Executive should not go on to be the Chairperson of the same NHS Foundation Trust.	**Confirmed:** The Trust Chair and Chief Executive are compliant with this provision. The Trust's Chair meets the independence criteria.
A.4.1	In consultation with the Council, the Board should appoint one of the independent Directors to be the Senior Independent Director.	**Confirmed:** The Vice Chair is the Senior Independent Director. The current Vice-Chair and Senior Independent Director, Joanna Hole, took up office on 1 November 2015.
A.4.2	The Chairperson should hold meetings with the Non-Executive Directors.	**Confirmed:** The Trust Chair holds regular meetings with Non-Executive Directors.
A.4.3	Where Directors have concerns that cannot be resolved about the running of the NHS Foundation Trust or a proposed action, they should ensure that their concerns are recorded in the Board minutes.	**Confirmed:** All discussions at the Board of Directors' meetings are contained in the minutes of each meeting.
A.5.1	The Council of Governors should meet sufficiently regularly to discharge its duties.	**Confirmed:** The Council of Governors meets quarterly which accords with other NHS Foundation Trusts. There is provision to hold additional meetings if required.
A.5.2	The Council of Governors should not be so large as to be unwieldy.	**Confirmed:** The size of the Council of Governors is considered to be appropriate and is regularly reviewed.
A.5.4	The roles and responsibilities of the Council of Governors should be set out in a written document.	**Confirmed:** A document setting out the roles and responsibilities of the Council of Governors is available from the Trust's public website and is also set out in the NHS Foundation Trust's Constitution.
A.5.5	The Chairperson is responsible for leadership of both the Board and the Council but the Governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive to their meetings and	**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 the Council of Governors and the Board of Directors. Executive and Non-Executive Directors are invited to Governor Working Group

	inviting attendance by other Executives and Non-Executives, as appropriate.	meetings.
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 through open discussions at Board and Council away days and at Board and Governor lunches held at every other Board meeting.
A.5.8	The Council should only exercise its power to remove the Chairperson or any Non-Executive Directors after exhausting all means of engagement with the Board.	**Confirmed:** The process for removing the Chair and Non-Executive Directors is set out in the Trust's NHS Foundation Trust's Constitution. Governors are aware of this provision and of the consequences of exercising this power.
A.5.9	The Council should receive and consider other appropriate information required to enable it to discharge its duties.	**Confirmed:** The Trust is compliant with this provision and provides extensive information to the Council of Governors via regular reports and through the Council's various working groups and at its formal meetings.
B.1.2	At least half the Board, excluding the Chairperson, should comprise Non-Executive Directors determined by the Board to be independent.	**Confirmed:** The Trust is compliant with this provision. All Non-Executives are considered to be independent. Other than the Chair and Chief Executive, the Board consists of five non-executive and four voting executive directors.
B.1.3	No individual should hold, at the same time, positions of Director and governor of any NHS Foundation Trust.	**Confirmed:** The Trust is compliant with this provision, which is incorporated into its Constitution. Directors and governors are aware of this provision.
B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of Executive and Non-Executive Directors.	**Confirmed:** This provision is set out in the Trust's Board of Directors/Council of Governors' Nominations and Remuneration Committees' Terms of Reference.

B.2.2	Directors on the Board of Directors and governors on the Council should meet the "fit and proper" persons test described in the provider licence.	**Confirmed:** The Trust has undertaken appropriate checks to assure itself that every member of the Board of Directors meets the "fit and proper persons" criteria as described in the provider licence. Governors have confirmed that they meet the requirements of the Fit and Proper Persons criteria and the Council of Governors' Nominations and Remuneration Committee Terms of Reference are clear that candidates must meet the criteria.
B.2.3	The Nominations Committee(s) should regularly review the structure, size and composition of the Board and make recommendations for changes where appropriate.	**Confirmed:** Both the Board of Directors' and Council of Governors' Nominations and Remuneration Committee's 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. The Trust Chair chairs the committee.
B.2.5	The Governors should agree with the Nominations Committee a clear process for the nomination of a new Chairperson and Non-Executive Directors.	**Confirmed:** This is made explicit in the Terms of Reference for the Council of Governors' Nominations and Remuneration Committee.
B.2.6	Where an NHS Foundation Trust has two nominations committees, the nominations committee responsible for the appointment of Non-Executive Directors should consist of a majority of Governors.	**Confirmed:** The Council of Governors' Nominations and Remuneration Committee comprises a majority of Governors as set out in the Terms of Reference.
B.2.7	When considering the appointment of Non-Executive Directors, the Council should take into account the views of the Board and the Nominations Committee on the qualifications, skills and experience required for each position.	**Confirmed:** The Council of Governors' Nominations and Remuneration Committee's Terms of Reference includes this requirement. 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 Chairperson who

		was appointed on 1 April 2019 and the two Non-Executive Directors who were appointed in 2019/20.
B.2.8	The annual report should describe the process followed by the Council in relation to appointments of the Chairperson and Non-Executive Directors.	**Confirmed:** This is set out in the Directors' Report section of the Annual Report.
B.2.9	An independent external adviser should not be a member of or have a vote on the Nominations Committee(s).	**Confirmed:** This provision is complied with via Trust's Nominations and Remuneration Committees' Terms of Reference.
B.3.3	The Board should not agree to a full-time Executive Director taking on more than one Non-Executive Directorship of an NHS Foundation Trust or another organisation of comparable size and complexity.	**Confirmed:** The Trust is compliant with this provision. This is monitored through the declaration of interests' process.
B.5.1	The Board and the Council of Governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.	**Confirmed:** The Board of Directors and Council of Governors receive high quality information appropriate to their functions at their respective meetings and upon request.
B.5.2	The Board, and in particular Non-Executive Directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the Board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.	**Confirmed:** The Board of Directors' minutes provide evidence of executive and Non-Executive Directors' challenge. In addition, the Board of Directors' assurance committees provide the opportunity to test systems and processes in more detail and to confirm a level of assurance. Further, independent advice would be made available if required.
B.5.3	The Board should ensure that Directors, especially Non-Executive Directors, have access to the independent professional	**Confirmed:** The Chief Executive is aware of this provision and will make available independent professional advice as and

	advice, at the NHS Foundation Trust's expense, where they judge it necessary to discharge their responsibilities as Directors.	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 Chair.
B.6.4	The Chairperson, with assistance of the Board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for Non-Executive Directors relevant to their duties as Board members.	**Confirmed:** The Board of Directors regularly discusses whether there are any development needs and these are addressed by the Board of Directors' programme of seminars, away days and external training events. The Chair and the Board Secretary take account of individual NED performance evaluations, as well as feedback from the Directors themselves, in devising development programmes.
B.6.5	Led by the Chairperson, the Council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	**Compliant:** The Chair meets with governors on a one-to-one basis to discuss their performance. The Chair leads the assessment of the collective performance of the Council of Governors annually. Information on discharge of responsibilities is included in the Governors' Annual Report and the Lead Governor also reports on this topic at the Annual Members' Meeting.
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the Council, for the removal from the Council of any Governor who consistently and unjustifiably fails to 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	**Confirmed:** The Trust Chair (Chair of the Board of Directors' Nominations and Remuneration Committee) is aware of this

	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.	requirement.
C.1.2	The Directors should report that the NHS Foundation Trust is a going concern with supporting assumptions or qualifications as necessary.	**Confirmed:** The monthly finance report to the Board of Directors confirms that the Trust is a going concern. A statement confirming the going concern statement is included within this annual report.
C.1.3	At least annually and in a timely manner, the Board should set out clearly its financial, quality and operating objectives for the NHS Foundation Trust and disclose sufficient information, both quantitative and qualitative, of the NHS Foundation Trust's business and operation, including clinical outcome data, to allow members and Governors to evaluate its performance.	**Confirmed:** The Trust's Annual Report 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 NHS Improvement and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS Foundation Trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a	**Confirmed:** The Board of Directors is aware of this requirement.

	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 NHS Improvement and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS Foundation Trust's financial condition; • the performance of its business; and/or the NHS Foundation Trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS Foundation Trust.	
C.3.1	The Board should establish an Audit Committee composed of at least three members who are all independent Non-Executive Directors.	**Confirmed:** The Trust's Audit Committee comprises three independent Non-Executive Directors.
C.3.3	The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors.	**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,	**Confirmed:** The Council of Governors approved the recommendation to re-appoint Deloitte as the Trust's external auditors for the period 1 April 2019 to 31 March 2021 at the meeting held in March

	operations and forward plans of the NHS Foundation Trust.	2019.
C.3.7	When the Council ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHS Improvement informing it of the reasons behind the decision.	**Confirmed:** The Trust Chair is aware of this requirement.
C.3.8	The Audit Committee should review arrangements that allow staff of the NHS Foundation Trust and other individuals, where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial 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 provides assurance to the Board of Directors on the Trust's Raising Concerns Policy. The Senior Independent Director, who is also a member of the Audit Committee, is the Trust non-executive lead on Freedom to Speak Up.
D.1.1	Any performance-related elements of the remuneration of Executive Directors should be designed to align their interests with those of patients, service users and taxpayers and to give these Directors keen incentives.	**Confirmed:** The Board of Directors' Nominations and Remuneration Committee is responsible for determining the eligibility for executive Directors to receive performance-related bonuses after a review of each executive Director's performance.
D.1.2	Levels of remuneration for the Chairperson and other Non-Executive Directors should reflect the time commitment and responsibilities of their roles.	**Confirmed:** The Council of Governors' Nominations and Remuneration Committee determine the remuneration of the Chair and other Non-Executive Directors after taking account of the time commitment and responsibilities of their roles. This is periodically reviewed.
D.1.4	The Remuneration Committee should carefully consider what compensation commitments (including pension contributions and all other elements) their Directors' terms of appointments would give rise to in the event of early termination.	**Confirmed:** This will be undertaken if and when required.
D.2.2	The Remuneration Committee should have delegated responsibility for setting	**Confirmed:** The Terms of Reference of the Board of Directors' Nominations and Remuneration Committee make it clear

	remuneration for all Executive Directors, including pension rights and any compensation payments.	that this responsibility rests with the Committee.
D.2.3	The Council should consult external professional advisers to market-test the remuneration levels of the Chairperson and other Non-Executives at least once every three years and when they intend to make a material change to the remuneration of a Non-Executive.	**Confirmed:** The Council of Governors' Nominations and Remuneration Committee took account of external benchmarking data as part of their work in determining the level of remuneration for the Chair and other Non-Executive Directors. Chair and Non-Executive Director remuneration has not changed since the Trust achieved Foundation Trust status in 2014. The Committee more recently took account of guidance issued in November 2019 on Chair and non-executive remuneration.
E.1.2	The Board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.	**Confirmed:** The Trust has a membership and engagement strategy.
E.1.3	The Chairperson should ensure that the views of governors and members are communicated to the Board as a whole.	**Confirmed:** Governors are encouraged to attend Board meetings as observers and to raise questions received from or based on comment from their constituencies. There is also a joint annual away day at which the views and concerns of members are considered in more detail.
E.2.1	The Board should be clear as to the specific third party bodies in relation to which the NHS Foundation Trust has a duty to co-operate.	**Confirmed:** The Trust meets this requirement. Strong relationships are maintained with principal stakeholders. The Non-Clinical Governance Committee provides assurance on the Trust's approach to external relationships.
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	**Confirmed:** The Trust meets this requirement. Details are set out in the Directors' report section of this annual report.

	appropriate levels of seniority in each.	

NHS Oversight Framework

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

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

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

Segmentation

NHS Improvement had segmented trusts according to the level of support each trust is assessed as requiring across the five themes listed above to enable Trusts to deliver high quality, safe care for patients. Across the 2019/20 financial year, the Trust was placed in segment 2 under the Single Oversight Framework.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from ‘1’ to ‘4’, where ‘1’ reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	**Metric**	**2019/20 Scores**				**2018/19 Scores**	
		Q4	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**
Financial sustainability	Capital Service Capacity	2	2	2	2	1	1
	Liquidity	2	1	1	1	1	1
Financial efficiency	I&E Margin	2	2	1	2	1	1
Financial controls	Distance from Financial Plan	4	4	1	1	1	2

	Agency Spend	3	3	2	2	1	1
Overall scoring		3	3	1	2	1	1

The Trust has received an overall finance score of 3; this is due to the distance from the final plan. This is a deterioration in scoring from 2018/19 where the Trust scored an overall score of 1. The Trust was unable to meet the surplus control total set by NHS England/Improvement; cost pressures were driven by an inability to achieve planned savings, staff cost pressures resulting from covering unfilled vacancies with agency staff and the impact of the Agenda for Change pay award. Failing to meet the control total meant that the Trust was unable to claim the full amount of Provider Sustainability Funding that had been allocated to it.

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

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

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

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

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

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

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

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

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

Signed

Libby Walters,

Interim Chief Executive

24 June 2020

Annual governance statement 2019/20

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Royal United Hospitals Bath NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Royal United Hospitals Bath NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

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

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

The Board of Directors reviews the top operational risks scoring 16 and above on a quarterly basis, alongside the Board Assurance Framework (BAF). The BAF is made up of a relatively small number of high level risks (12 on the current Framework) which could, if not properly managed or mitigated, prevent the Trust from achieving its key objectives. In addition, the monthly operational performance and finance reports that are presented at Board meetings highlight any key areas of risk and the Board of Directors' report template includes a section on risk. The Board of Directors also identifies risks as part of the self-certification documentation submitted to NHS Improvement.

Board Committees

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

Audit Committee

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

Clinical Governance Committee

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

Non-Clinical Governance Committee

- Provides assurance that the non-clinical systems and processes are effective and robust

- Provides specific oversight for the management of health and safety risk
- Reviews allocated risks on the BAF.

People Committee

- Provides assurance that systems for managing people-related risk are sound and robust, including in relation to recruitment and retention
- Provides specific oversight of human resource systems and processes
- Reviews allocated risks on the BAF.

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

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

Charities Committee

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

Divisional Boards

The three clinical Divisions (Medicine, Surgery, and Women and Children's) have each established a Governance Committee, which is responsible for reviewing and managing risks within their respective divisions. There is also a well-established Estates and Facilities Board which has oversight of the various activities undertaken within that division. The Operational Governance Committee, which is a sub-committee of the Trust's 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.
- Designated as Senior Information Risk Officer (SIRO) responsible for maintaining and assuring the framework for managing information governance-related risks.

Director of People

- Designated Director with responsibility for ensuring that there is a framework in place for the management of non-clinical risk across the organisation.

Medical Director

- Director Lead for medical risk for the Trust.

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

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

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

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

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

Staff empowerment and risk management training

Risk management training is provided through the induction programme for all new staff. The corporate training programme ensures that all new staff gain an overview of the Trust's risk management systems and processes and understand their responsibilities for reporting incidents. The corporate induction is supplemented by local induction programmes by managers. The Trust's mandatory training programme includes health and safety, manual handling, fire awareness, infection control, safeguarding patients, resuscitation and information governance. In addition, the Head of Risk and Assurance provides tailored training for individual roles and works closely with staff across the Trust to ensure they

understand their responsibilities and accountabilities for managing risk in their areas. The approach is informed by various sources of information, including incident reports, key quality indicator reports, survey feedback and comments, risk analyses and national guidance and best practice.

The Risk and Control Framework

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

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

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

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

The Board of Directors undertakes a quarterly review and discussion of the Trust risk register, to review the impact upon the BAF and review the organisation's risk appetite. Management Board must approve all risks added to the risk register with a score of 16 or above, and undertakes a monthly review of all current risks on the risk register with a score of 10-15 in order to ensure that lower scoring risks with the potential to have significant impact are not overlooked. Management Board are also

responsible for reviewing and approving any current risks that have been downgraded from a major risk.

The Trust seeks to ensure that lessons learned from incidents, complaints and other investigations are used to update and improve practice. These issues are regularly communicated to the 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. The Director of Nursing and Midwifery also reports key messages emerging from the Operational Governance Committee's deliberations to the Clinical Governance Committee to ensure Board visibility of these emerging themes and how they are being disseminated across the organisation.

Incidents are dealt with in accordance with the Incident Reporting and Management Policy and Procedure. An anonymised summary of all new Serious Incidents is included in the 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 Financial Controls Audit in January 2020. They concluded that the Trust's processes provided "significant assurance" with a few minor recommendations for improvement and stated that: "the Trust has well designed internal control procedures which ensure timely production and review of information with a sufficient degree of segregation of duties." The audit further found that "The Trust has Standing Financial Instructions in place alongside a number of supporting policies and procedures which adequately outline and guide the key financial processes within the Trust".

Board Assurance Framework

The Trust has a Board Assurance Framework (BAF). The BAF 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 these objectives.

The BAF is reviewed quarterly by the Board of Directors with each risk assigned to a lead Executive Director and to the relevant Board committee for oversight. The Board Committees review their respective risks at each meeting and their comments are reported to the Board of Directors, with the responsible Executive Director updating the controls and mitigations regularly. The Committees may also increase or decrease the ratings for their risks to reflect the effectiveness of the mitigations and controls, and /or developments in the external environment. The BAF risks are

also regularly reviewed at the Board of Directors' Away Days which are held quarterly. The Framework is fully refreshed at the start of each financial year.

Risks to data security

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

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

Risks to data security realised in year are detailed under the 'Information Governance' section.

Description of the principal risks facing the Trust

The Management Board identified the Trust's current top clinical and operational risks at its February 2020 meeting as including:

- **ED Performance against the four-hour target:** This risk relates to the Trust's ability to meet the constitutional target to treat, admit or discharge 95% of patients within four hours. As a result of continued increases in the number and acuity of patients attending the department, the Trust has struggled to meet this target. Difficulties in this area have been accentuated by poor flow through the hospital, with the Trust managing relatively high numbers of "stranded" (a patient who has been in hospital for more than seven days) and "super-stranded" (21 days) patients.

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

  To try and reduce the number of vacancies, the Trust is taking actions over and above the usual ongoing recruitment plans and reliance on bank staff, including undertaking a number of local recruitment drives, significant

investment in targeted overseas recruitment activity, and working with NHS Improvement on initiatives to ensure the retention of existing staff.

- **Increasing financial pressures**: for the 2019/20 financial year, the Trust agreed a control total of £7.83 million, with access to a further £5.82 million of Provider Sustainability funding, taking the potential surplus to £13.65 million. However, the Trust was required to reforecast its year-end position £6.5 million away from the £7.83 million target. Factors that have contributed to this shortfall include reduction in elective income, a rise in pay costs and the use of agency staff, and rises in non-pay costs. The Trust is also mindful of the impact that the loss of its surplus would have on future investment plans and opportunities.

These risks will continue to be managed throughout 2020/21.

Emerging and In-year Risks

In December 2019, the emergence of the coronavirus (COVID-19) pandemic, and its impact, particularly among the elderly and those with underlying medical conditions, led to significant pressure on all NHS organisations to alter their operating models to respond to the emergency. In March 2020, this Trust, in compliance with Government direction, cancelled all non-urgent elective activity, and made changes to the way it used its estate in order to accommodate the expected surge in the number of seriously ill patients coming into the hospital. There were concerns about the Trust's ability to effectively manage patients with equally serious but unrelated conditions, as well as the impact that staff shortages caused by clinicians and other staff needing to self-isolate or shield themselves would have on the hospital's ability to cope.

The Trust's senior leadership has continued to work with local, regional and national partners to respond to the crisis, implementing established processes for dealing with such emergencies.

As the rate of COVID-19 infections and admissions decrease, and the Trust re-commences provision of the full range of clinical services, the focus has shifted towards the need to maintain social distancing across the hospital estate. This is proving challenging, and has led to the decision to keep a number of beds closed. Managers are also conscious of the need to ensure that sufficient amounts of personal protective equipment is available both to continue to manage patients who are ill with COVID-19 and also to protect other patients as well as staff.

There is recognition that the number of patients waiting for elective care, and the amount of time that they have been waiting, would have risen during the pandemic. It is also acknowledged that some patients with serious conditions may not have been able to access care during this period. It is therefore likely that there will be a large

number of patients who will be needing care over the coming months within constrained facilities.

Emergency Department performance, capacity and flow

In addition to the COVID-19 crisis, which developed in the fourth quarter of the year, the Trust experienced sustained operational pressures during 2019/20. Factors that contributed to this included significant increases in the number of ambulances arriving at the hospital, extended lengths of stay and delays for patients, particularly those who could have been better cared for within community settings away from the hospital. Although the Trust did not meet the four-hour waiting time standard, within the Emergency Department, it took concerted action to improve the quality of care provided. This included the provision of early clinical triage, ensuring that patients who could be cared for elsewhere were diverted appropriately, and facilitating admissions directly to the Medical Assessment Unit to avoid unnecessary delays.

The Trust has continued to work with the local health and social care system, through the A&E Delivery Board, to develop improvements for patients. The performance of the hospital and the wider system against this important standard is reviewed regularly by the Trust's executive directors, as well as community providers, commissioners and local authority leaders. The Trust's Board of Directors reviews progress against agreed improvement trajectories at each of its meetings, while also taking full account of the quality of care provided in line with the requirements of the CQC's Safe domain.

Governance

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

Communication with stakeholders

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

- **The Council of Governors** has a formal role as a stakeholder body for the wider community, and as part of the Trust's governance structure. The Council holds formal Council of Governor meetings quarterly, and these are open to the public, as well as constituency meetings (for publicly elected governors), regular member newsletters, and the Annual Members' Meeting.

- **Meetings with partner organisations**, including monthly commissioner contract review meetings and other meetings with Clinical Commissioning Groups (including quality and performance meetings and clinical commissioning reference board), Council representatives, voluntary sector and local universities.
- **STP partners,** including monthly meetings that bring together Chairs, Chief Executives, Finance Directors and other key staff.
- **Staff** – staff engagement meetings, staff survey and team briefings.
- **Public and service users** – patient surveys, Patient and Carer Experience Group and Patient Advice and Liaison Service.

Developing workforce safeguards

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

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

At an operational level there is a daily review of staffing in light of demands due to seasonal changes, acuity and activity. This is a dynamic process and is overseen by senior nursing staff. Where skill mix reviews are conducted they are subject to quality impact assessments. The Trust has well established governance arrangements for the development and implementation of short, medium and long-term workforce planning and strategies.

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

The Trust works collaboratively with its partner organisations in the BaNES, Swindon and Wiltshire Sustainability and Transformation Partnership (BSW STP) on a range

of joint workforce issues and on plans for the implementation locally of the long-term NHS plan.

Compliance with the Care Quality Commission

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

The Care Quality Commission conducted an announced inspection of the Trust in June 2018. The inspection report was published on 26 September 2018, giving the Trust an overall rating of 'Good'. Further detail on the findings can be found in the Quality Accounts.

The Trust has published an up-to-date register of interests for decision-making staff within the past 12 months, as required by the '*Managing Conflicts of Interest in the NHS'.*

Compliance with NHS pension scheme regulations

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

Compliance with equality, diversity and human rights legislation

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

Compliance with obligations under the Climate Change Act

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

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

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

The Reference Cost Index (RCI) is a percentile of 100, with 100 being the baseline national average. It shows the actual cost of a Trust's case mix compared with the same case mix delivered at national average cost. The RUH's RCI score for

2018/19 (the most recent available) is 91.2, suggesting that as an organisation healthcare is provided at a cost 8.8 below the national average.

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

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

Information governance

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

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

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

- Information governance management;
- Confidentiality and Data Protection Assurance;
- Information Security Assurance;
- Clinical Information Assurance;
- Secondary Use Assurance;
- Corporate Information Assurance.

The Trust has achieved a satisfactory "standards met" level having attained the mandatory 100 evidence items known as assertions for the Data Security & Protection Toolkit (DSP Toolkit) previously known as the Information Governance Toolkit for the submission in 2019/20. The levels for the DSP Toolkit are now "Standards Met or Standards not met" for the new DSP Toolkit rather than recorded as a percentage.

Between 1 April 2019 and 31 March 2020, the Trust reported two serious information governance incidents to the Information Commissioner's Office (ICO). Both of these were satisfactorily investigated and the Trust's Information Governance team was commended by the ICO for the expeditious approach taken in respect of each of the incidents. No further action was taken by the ICO in response to either case.

Issues involving confidentiality or information governance continue to be well reported via the Trust's incident reporting process, Datix. 150 incidents were reported during 2019/20, which compares to 170 in 2018/19. These incidents are considered at meetings of the Information Governance Group to ensure that wider awareness is disseminated across the organisation.

Annual Quality Report

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. NHS Improvement (in exercise of the powers conferred on 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 2019/20 is being developed in line with relevant national guidance, but its publication has been delayed as a result of the COVID-19 pandemic.

Quality Governance Arrangements

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

In recognition of the impact of the COVID-19 pandemic, NHS England/Improvement, in conjunction with the Department for Health and Social Care, temporarily removed the requirement for the 2019/20 Quality Report to be published as part of this Annual Report. Current guidance is that the Quality Report should be published no later than December 2020. The Trust is in the process of resetting its timetable for publication to ensure that all our internal and external groups are able to contribute and comment on the report. The process of identifying the Quality Priorities for 2020/21 will involve staff, governors, members, Healthwatch and Clinical Commissioning Groups. The Trust's external auditor is 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 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. In addition the Quality Board has oversight each month of progress with all the CQUIN schemes.

The Operational Governance Committee, chaired by the Director of Nursing and Midwifery, is the group which delivers risk management at an operational level. This 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, chaired by the Medical Director – 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. James Scott is the Vice-Chair of the West of England Academic Health Science Network. The Trust is also a member of NHS Quest, a member network for NHS Foundation Trusts who wish to focus on improving quality and safety.

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

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. For 2019/20, the external auditors will not be required to report on the arrangements that the Trust has place to secure the data quality of information included in the Quality Accounts.

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

Effective decision-making by the Board of Directors is reliant upon the quality of the data received to inform those decisions. It is therefore imperative that the Board receives regular assurances over the sources of key data underpinning its performance and the integrity of its reporting against national targets. The Trust has an established system for data quality management which includes a team of Senior Business Analysts who provide support to the clinical teams / service lines in

reviewing quality, activity and the patient activity data that contributes to finance information. Analysts support investigation and correction of data errors. The development of user-friendly reporting formats (such as Business Objects, Scorecards and Dashboards and SPC charts) is aimed at displaying information in a format that drives greater engagement from teams. In turn, greater engagement creates more feedback on quality and drives accuracy.

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

Capabilities and culture

The Trust has established the Quality Improvement Centre under the leadership of the 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.

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

Systems and processes

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

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

- Board of Directors' annual mortality review;
- National Patient Safety reports to Board.

Data monitoring and reporting on quality

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

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the Executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework

For this year, the demands of the COVID-19 outbreak have meant that the Quality Report is being prepared separately from this Annual Report and will be published at a later date. However, my review of the effectiveness of the Trust's system of internal control has been informed by other performance information available to me. My review is also informed by comments made by the external auditor in its 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.

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

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

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

Grant Thornton (appointed in April 2019) are the providers of internal audit for the Trust, and in 2019/20, they completed 9 internal audit reports. The areas the reports covered included:

- Financial controls
- Board Assurance Framework and Risk Management
- Data Quality
- STP Partnership Governance

The Head of Internal Audit's opinion for the period based 1 April 2019 to 31 March 2020 is one of significant assurance with some improvements required.

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

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

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

- Internal audits of effectiveness of systems of internal control
- Internal Audit of Committee Governance and Effectiveness
- Well-Led Framework Governance Self-Assessment

Conclusion

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

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

Annual Governance Statement signed 

Libby Walters, Interim Chief Executive (Accounting Officer), 24 June 2020

Accountability report signed 

Libby Walters, Interim Chief Executive (Accounting Officer), 24 June 2020

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST

Report on the audit of the financial statements

1. Opinion

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

- give a true and fair view of the state of the group's and foundation trust's affairs as at 31 March 2020 and of the group's and foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the consolidated statement of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of cash flows;
- the group and foundation trust statements of changes in equity; and
- the related notes 1 to 35.

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

2. Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

3. Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: • Property valuation • Management override of controls  Newly identified  Increased level of risk  Similar level of risk  Decreased level of risk
Materiality	The materiality that we used for the group financial statements was £7.47m which was determined on the basis of 2% of total incoming resources.
Scoping	The focus of our audit work was on the trust. We performed specified audit procedures on the trust's subsidiary, RUH Charitable Fund, where the extent of our testing was based on our assessment of the risks of material misstatement and the materiality of the charity to the Group. Our audit therefore covered all the entities within the Group, which account for 100% of the Group's net assets, total incoming resources and deficit.
Significant changes in our approach	A key audit matter was identified in the prior year in relation to the capitalisation of assets, however this is no longer considered to be a key audit matter as no longer a focus of our most significant audit effort.

4. Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where: • the directors' use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or • the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.	We have nothing to report in respect of these matters.

5. Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

5.1. Property valuations

Key audit matter description	The group holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £166.8m at 31 March 2020 (2019: £143.1m), as shown in Note 15. The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value. The net valuation movement on the foundation trust's estate shown in note 7 is an impairment of £9.7m (2019:£1.8m). As detailed in notes 1.25 and 17, in applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by Covid-19 and therefore less weight can be attached to previous market evidence for comparison purposes, to inform opinions of value. In addition, properties which are priced on their trading potential, including healthcare establishments, may experience a greater impact on pricing in comparison to other asset classes.
How the scope of our audit responded to the key audit matter	We obtained an understanding of the relevant controls around the property valuations performed in the year We worked with our valuation specialists, Deloitte Real Estate, to review and challenge the appropriateness of the assumptions and methodology used in the valuation of the foundation trust's properties including the change in alternative site and Moden Equivalent Asset assumptions. We have used their findings to challenge management assumptions, including the potential impact of Covid-19 and of Brexit on property valuations. We have reviewed the disclosures in notes 1.25 and 17 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation. We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.
Key observations	While we note the increased estimation uncertainty in relation to the property valuation as a result of Covid-19, and as disclosed in notes 1.25 and 17, we consider that the key judgements are within the acceptable range. There were no other matters arising from our work.

5.2. Management override of controls

Key audit matter description	We consider that there is a risk across the NHS that management may override controls to manipulate fraudulently the financial statements or accounting judgements or estimates including completeness of creditors. This is due to the

increasingly tight financial circumstances of the NHS and close scrutiny of the reported financial performance of individual organisations.

The trust reported an overall deficit for the year of £8.6m against a plan of £12.6m, including PSF income of £2.5m against planned PSF funding of £5.8m.

NHS Trusts and Foundation Trusts have previously been requested by NHS Improvement to consider a series of "technical" accounting areas and assess both whether their current accounting approach meets the requirements of International Financial Reporting Standards, and to remove "excess prudence" to support the overall NHS reported financial position. The areas of accounting estimates highlighted included accruals, deferred income, partially completed patient spells, bad debt provisions, property valuations, and useful economic lives of assets.

As part of the overall changes to NHS funding arrangements to respond to the COVID-19 pandemic, NHS England announced in March 2020 that it would reimburse NHS providers for the costs of responding to COVID-19.

How the scope of our audit responded to the key audit matter

Manipulation of accounting estimates

Our work on accounting estimates included considering areas of judgement, including those identified by NHS Improvement. In testing each of the relevant accounting estimates, we considered their findings in the context of the identified fraud risk. Where relevant, the recognition and valuation criteria used were compared to the specific requirements of IFRS.

We tested accounting estimates (including property valuations), focusing on the areas of greatest judgement and value. Our procedures included comparing amounts recorded or inputs to estimates to relevant supporting information from third party sources.

We evaluated the rationale for recognising or not recognising balances in the financial statements and the estimation techniques used in calculations, and considered whether these were in accordance with accounting requirements and were appropriate in the circumstances of the Group.

Manipulation of journal entries

We used data analytic techniques to select journals for testing with characteristics indicative of potential manipulation of reporting focusing in particular upon manual journals.

We traced the journals to supporting documentation and evaluated the accounting rationale for the posting. We evaluated individually and in aggregate whether the journals tested were indicative of fraud or bias.

Accounting for significant or unusual transactions

We considered whether any transactions identified in the year required specific consideration and did not identify any requiring additional procedures to address this key audit matter.

Completeness of creditors

We performed testing of a sample of payments to suppliers made after the balance sheet date in order to test for unrecorded liabilities. Additionally we tested a sample of invoices added to the ledger in the period from 1 April to 30 May 2020.

Key observations	Based on the work performed, we found no matters that were reportable to those charged with governance.

6. Our application of materiality

6.1. 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 both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group financial statements	Foundation Trust financial statements
Materiality	£7.47m (2019: £7.2m)	£7.36m (2019: £7.1m)
Basis for determining materiality	2% of total incoming resources (2019: 2% of total incoming resources)	2% of total incoming resources (2019: 2% of incoming resources)
Rationale for the benchmark applied	Total incoming resources was chosen as a benchmark as the group is a non-profit organisation, and total incoming resources is a key measure of financial performance for users of the financial statements.	Total incoming resources was chosen as a benchmark as the trust is a non-profit organisation, and total incoming resources is a key measure of financial performance for users of the financial statements.

6.2. Performance materiality

We set performance materiality at a level lower than materiality to reduce the probability that, in aggregate, uncorrected and undetected misstatements exceed the materiality for the financial statements as a whole. Group performance materiality was set at 75% of group materiality for the 2020 audit (2019: 75%). In determining performance materiality, we considered the following factors:

a. the quality of the control environment;
b. The small number of corrected and uncorrected misstatements identified in the previous audit; and
c. Stable finance team during the current and prior periods.

6.3. Error reporting threshold

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £300k (2019: £300k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

7. An overview of the scope of our audit

7.1. Identification and scoping of components

Our group audit was scoped by obtaining an understanding of the Group and its environment, including group-wide controls, and assessing the risks of material misstatement at the Group level.

The focus of our audit work was on the Trust, with work performed directly by the audit engagement team, led by the engagement lead.

We performed specified audit procedures in relation to the Trust's subsidiary, RUH Charitable Fund, where the extent of our testing was based on our assessment of the risks of material misstatement and the component materiality specific for the subsidiary.

Our audit covered all of the entities within the Group, which account for 100% of the Group's net assets, total incoming resources and deficit with no component auditors involved in the audit.

8. Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in respect of these matters.

9. Responsibilities of accounting officer

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

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the group or the foundation trust or to cease operations, or has no realistic alternative but to do so.

10. Auditor's responsibilities for the audit of the financial statements

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

they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

Report on other legal and regulatory requirements

11. Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

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

12. Matters on which we are required to report by exception

12.1. Annual Governance Statement, use of resources, and compilation of financial statements

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

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

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

We have nothing to report in respect of these matters.

12.2. Reports in the public interest or to the regulator

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

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

We have nothing to report in respect of these matters.

13. Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

14. Use of our report

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

Michelle Hopton ACA (Senior statutory auditor)

For and on behalf of Deloitte LLP

Statutory Auditor

Bristol, United Kingdom

24 June 2020

Royal United Hospitals Bath NHS Foundation Trust

Annual accounts for the year ended 31 March 2020

Foreword to the accounts

Royal United Hospitals Bath NHS Foundation Trust

These accounts, for the year ended 31 March 2020, 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 

Libby Walters
Interim Chief Executive
Date **24 June 2020**

Consolidated Statement of Comprehensive Income

		Group	
		2019/20	2018/19
	Note	£000	£000
Operating income from patient care activities	3	330,176	306,433
Other operating income	4	44,087	49,386
Operating expenses	6, 8	(376,212)	(333,677)
Operating surplus/(deficit) from continuing operations		**(1,949)**	**22,142**
Finance income	11	381	364
Finance expenses	11	(264)	(301)
PDC dividends payable		(5,856)	(5,555)
Net finance costs		**(5,739)**	**(5,492)**
Other gains / (losses)	12	2	(77)
(Deficit)/Surplus for the year from continuing operations		**(7,686)**	**16,573**
(Deficit)/Surplus for the year		**(7,686)**	**16,573**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	17	(413)	472
Other reserve movements		(1)	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value (losses)/gains on financial assets mandated at fair value through Other Comprehensive Income	18	(721)	191
Total comprehensive (expense)/income for the period		**(8,821)**	**17,236**
(Deficit)/Surplus for the period attributable to:			
Royal United Hospitals Bath NHS Foundation Trust		(7,686)	16,573
TOTAL		**(7,686)**	**16,573**
Total comprehensive (expense)/income for the period attributable to:			
Royal United Hospitals Bath NHS Foundation Trust		(8,821)	17,236
TOTAL		**(8,821)**	**17,236**

Statements of Financial Position

As at 31 March	Note	Group 31 March 2020 £000	Group 31 March 2019 £000	Trust 31 March 2020 £000	Trust 31 March 2019 £000
Non-current assets					
Intangible assets	14	9,447	9,921	9,447	9,921
Property, plant and equipment	15	206,211	200,147	206,211	200,147
Other investments / financial assets	18	7,932	8,512	-	-
Receivables	22	2,744	1,785	1,567	1,182
Total non-current assets		**226,334**	**220,365**	**217,225**	**211,250**
Current assets					
Inventories	21	4,249	3,000	4,249	3,000
Receivables	22	22,636	30,121	22,566	31,889
Cash and cash equivalents	23	15,512	22,331	13,512	18,946
Total current assets		**42,397**	**55,452**	**40,327**	**53,835**
Current liabilities					
Trade and other payables	24	(31,081)	(28,502)	(30,745)	(28,395)
Borrowings	26	(3,499)	(3,424)	(3,499)	(3,424)
Provisions	28	(213)	(335)	(213)	(335)
Other liabilities	25	(5,270)	(5,691)	(5,270)	(5,691)
Total current liabilities		**(40,063)**	**(37,952)**	**(39,727)**	**(37,845)**
Total assets less current liabilities		**228,668**	**237,865**	**217,825**	**227,240**
Non-current liabilities					
Borrowings	26	(10,924)	(13,771)	(10,924)	(13,771)
Provisions	28	(1,092)	(763)	(1,092)	(763)
Total non-current liabilities		**(12,016)**	**(14,534)**	**(12,016)**	**(14,534)**
Total assets employed		**216,652**	**223,331**	**205,809**	**212,706**
Financed by					
Public dividend capital		161,212	159,070	161,212	159,070
Revaluation reserve		40,350	44,601	40,350	44,601
Income and expenditure reserve		4,247	9,035	4,247	9,035
Charitable fund reserves	20	10,843	10,625	-	-
Total taxpayers' equity		**216,652**	**223,331**	**205,809**	**212,706**

The notes on pages 142 to 188 form part of these accounts.

Libby Walters
Interim Chief Executive

Date 24 June 2020

Statements of Cash Flows

	Note	Group 2019/20 £000	Group 2018/19 £000	Trust 2019/20 £000	Trust 2018/19 £000
Cash flows from operating activities					
Operating (deficit)/ surplus		(1,949)	22,142	(2,685)	21,872
Non-cash income and expense:					
Depreciation and amortisation	6.1	12,264	10,253	12,264	10,253
Net impairments	7	9,703	1,844	9,703	1,844
Income recognised in respect of capital donations	4	-	(1,964)	(1,279)	(1,964)
decrease / (Increase) in receivables and other assets		7,570	(6,123)	9,372	(7,538)
(Increase) / decrease in inventories		(1,249)	1,322	(1,249)	1,322
Increase / (decrease) in payables and other liabilities		5,749	(1,040)	5,749	(1,040)
Increase / (decrease) in provisions		207	(1,843)	200	(1,843)
Movements in charitable fund working capital		(388)	878	-	-
Other movements in operating cash flows		(390)	23	-	(1)
Net cash flows used in operating activities		**31,517**	**25,492**	**32,075**	**22,905**
Cash flows from investing activities					
Interest received		177	159	177	159
Purchase of intangible assets		(586)	(3,112)	(586)	(3,112)
Purchase of PPE		(30,131)	(29,266)	(30,131)	(29,266)
Sales of PPE		23	114	23	114
Receipt of cash donations to purchase assets		(27)	-	800	1,794
Net cash flows used in investing activities		**(30,544)**	**(32,105)**	**(29,717)**	**(30,311)**
Cash flows from financing activities					
Public dividend capital received		2,142	2,224	2,142	2,224
Movement on loans from DHSC		(2,958)	(2,958)	(2,958)	(2,958)
Capital element of finance lease rental payments		(442)	(311)	(442)	(311)
Interest on loans		(248)	(287)	(248)	(287)
Interest paid on finance lease liabilities		(26)	(15)	(26)	(15)
PDC dividend paid		(6,260)	(5,213)	(6,260)	(5,213)
Net cash flows used in financing activities		**(7,792)**	**(6,560)**	**(7,792)**	**(6,560)**
Decrease in cash and cash equivalents		**(6,819)**	**(13,173)**	**(5,434)**	**(13,966)**
Cash and cash equivalents at 1 April - brought forward		**22,331**	**35,504**	**18,946**	**32,912**
Cash and cash equivalents at 1 April - restated		**22,331**	**35,504**	**18,946**	**32,912**
Cash and cash equivalents at 31 March	23.1	**15,512**	**22,331**	**13,512**	**18,946**

Consolidated Statement of Changes in Equity for the year ended 31 March 2020

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**159,070**	**44,601**	**9,035**	**10,625**	**223,331**
Deficit for the year	-	-	(9,901)	2,215	**(7,686)**
Other transfers between reserves	-	(3,838)	3,838	-	**-**
Revaluations	-	(413)	-	-	**(413)**
Fair value losses on financial assets mandated at fair value through Other Comprehensive Income	-	-	-	(721)	**(721)**
Public dividend capital received	2,142	-	-	-	**2,142**
Other reserve movements	-	-	1,275	(1,276)	**(1)**
Taxpayers' and others' equity at 31 March 2020	**161,212**	**40,350**	**4,247**	**10,843**	**216,652**

Consolidated Statement of Changes in Equity for the year ended 31 March 2019

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**156,846**	**42,237**	**(5,171)**	**9,959**	**203,871**
Surplus for the year	**-**	**-**	**16,098**	**475**	**16,573**
Other transfers between reserves	-	1,892	(1,892)	-	**-**
Revaluations	-	472	-	-	**472**
Fair value gains on financial assets mandated at fair value through Other Comprehensive Income	-	-	-	191	**191**
Public dividend capital received	2,224	-	-	-	**2,224**
Taxpayers' and others' equity at 31 March 2019	**159,070**	**44,601**	**9,035**	**10,625**	**223,331**

Statement of Changes in Equity for the year ended 31 March 2020

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**159,070**	**44,601**	**9,035**	**212,706**
Deficit for the year	-	-	(8,625)	**(8,625)**
Other transfers between reserves	-	(3,838)	3,838	**-**
Revaluations	-	(413)	-	**(413)**
Public dividend capital received	2,142	-	-	**2,142**
Other reserve movements	-	-	(1)	**(1)**
Taxpayers' and others' equity at 31 March 2020	**161,212**	**40,350**	**4,247**	**205,809**

Statement of Changes in Equity for the year ended 31 March 2019

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**156,846**	**42,237**	**(5,171)**	**193,912**
Surplus for the year	-	-	16,098	**16,098**
Other transfers between reserves	-	1,892	(1,892)	**-**
Revaluations	-	472	-	**472**
Public dividend capital received	2,224	-	-	**2,224**
Taxpayers' and others' equity at 31 March 2019	**159,070**	**44,601**	**9,035**	**212,706**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS Charitable Funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown of the reserves is provided in note 20.

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.

The Trust continues to operate in a climate of financial uncertainty within the NHS in England and the unprecedented situation that has arisen from the COVID-19 outbreak. Whilst there are known risks over the coming five years, including a substantial capital programme, continuing operational pressures and financial challenges, there is sufficient evidence in the view of the Board to support the view that the Trust will continue to operate over the 12 months from the signing of the opinion.

The Trust is forecasting a breakeven position in 2020/21. The Trust is working on the principal of a breakeven position as part of the interim COVID arrangements. As advised by NHS England/Improvement (NHSE/I) the Trust has been guaranteed minimum level of income for the first four months of the financial year from commissioners in relation to COVID-19. Additional guidance was issued by NHSE/I in May 2020, stating that it was reasonable to assume that the funding would continue to flow for the remaining months of 2020/21 and into 2021/22. Therefore there is no material risk to the cash flow of the Trust.

The Board of Directors has carefully considered the principle of ‘Going Concern’ and the Directors have concluded that whilst there are uncertainties relating to the financial year 2020/21, the going concern basis remains appropriate. This is because the Board of Directors has a reasonable expectation that the Trust will have access to adequate resources to continue to deliver services for the foreseeable future.
The assessment accords with the statutory guidance contained in the NHS Foundation Trust Annual Reporting Manual and the Department of Health and Social Care Group Accounting Manual (GAM).
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Note 1.3 Consolidation

NHS Charitable Funds

The Trust is the corporate trustee to RUH Charitable Fund. The Trust has assessed its relationship to the Charitable Fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the Charitable Fund and has the ability to affect those returns and other benefits through its relationship with the Fund.

The Charitable Fund’s statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity’s assets, liabilities and transactions to:

• recognise and measure them in accordance with the Trust's accounting policies and
• eliminate intra-group transactions, balances, gains and losses.

The key accounting policy for the RUH Charitable Funds relates to its 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.

Joint ventures

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

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

The financial risks of the LLP to the Members are limited to nil as per the signed members agreement, the surpluses are accounted for in the Trust's accounts using the equity method, however as the LLP reports a breakeven position as at 31 March 2020 there is no investment gain to recognise within the Trust's financial position.

Note 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The effect of readmissions is materia,l however is reflected in the contract baseline and therefore in the transaction price.

The Trust receives income from Commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with Commissioners, however the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

The Trust has undertaken an assessment of all revenue streams as required by IFRS 15 - Revenue from contracts with Customers. The Trust was already treating all material revenue streams in line with the requirements set out under the standard, and did not identify any significant amendments to the treatment of revenue for 2019/20.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

Note 1.4 (cont) NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations have been satisfied. In practical terms this means that treatment has been provided to the patient, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Provider sustainability fund (PSF)

The PSF enables providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.5 Other forms of income

Apprenticeship service income

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

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. In 2019/20, the Trust has estimated the impact of cancelled leave due to Covid-19 and included the cost within the accounts.

Pension costs

NHS Pension Scheme

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

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

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

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

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

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

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

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

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

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

Depreciation

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

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

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

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

Gains and losses recognised in the Revaluation Reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

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

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the Revaluation Reserve. Where, at the time of the original impairment, a transfer was made from the Revaluation Reserve to the Income and Expenditure Reserve, an amount is transferred back to the Revaluation Reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation then 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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

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

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

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	8	60
Dwellings	30	35
Plant & machinery	2	25
Transport equipment	5	7
Information technology	2	7
Furniture & fittings	2	15

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

Note 1.9 Intangible assets

Recognition

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

Internally generated intangible assets

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

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

Software

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

Measurement

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

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

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

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

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

	Min life Years	Max life Years
Software licences	2	5
Licences & trademarks	2	9

Note 1.10 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 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by HM Revenue and Customs.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through other comprehensive income.

Financial liabilities are classified as subsequently measured at amortised cost or fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

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

Financial assets measured at fair value through other comprehensive income

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

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

Impairment of financial assets

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

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

In line with NHS guidance, the Trust has not applied an expected credit loss to NHS debts as they are deemed recoverable within the NHS group.

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

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

De-recognition

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

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

Note 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as a lessee

Finance leases

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

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

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

Operating leases

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

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

Leases of land and buildings

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

The Trust as a lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

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

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use HM Treasury's pension discount rate of minus 0.5% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 29 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

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

Note 1.15 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 30 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 30, 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 1.16 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated and grant 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 and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

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

Note 1.18 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March;
• non-monetary assets, and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.19 Third party assets

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

Note 1.20 Losses and special payments

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

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Gifts

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

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

The Trust has reviewed existing contracts in place to 31 March 2020 to identify existing right to use assets. New processes are being developed to ensure all new contracts are assessed during the tender process.

Other standards, amendments and interpretations

IFRS 14 Regulatory Deferral Accounts - This is not EU endorsed and therefore is not applicable to DHSC group bodies.

IFRS 17 Insurance Contracts - Application is required from accounting periods on or after 1 January 2023; this has not yet been adopted by the FReM: therefore early adoption is not therefore permitted.

Note 1.24 Critical judgements in applying accounting policies

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

Leases

New operating leases are considered against the criteria to determine whether substantially all the risks and rewards of ownership have been transferred to the Trust as set out in 1.13.

Capitalisation of staff costs

The Trust makes judgements about which of its staff costs are related to capital improvements that meet the definitions set out in 1.8. These judgements are based on timesheets and the Trust's understanding of what is being achieved by the individuals carrying out the work.

Note 1.25 Sources of estimation uncertainty

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

Depreciation of equipment is based on asset lives, which have been estimated on recognition of assets.

Provisions

Provisions have been made for probable legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using information available at the reporting date. They are estimates of future cash flows which are dependent on future events. Any difference between these estimates and the actual future liability will be accounted for in the period in which such determination is made. Details of the Trust's provisions are set out in note 28.

Property valuations

Property, plant and equipment were valued by Gerald Eve as at 31 March 2020. These valuations are based on the Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health. Property valuation techniques include an inherent element of estimation; in particular specialised assets that have no active market require valuation based on assessing the likely replacement cost of an asset. Future property values will be influenced by factors such as construction costs and developments in healthcare technology and any recognised impairments. Future asset values will inevitably fluctuate but the Trust mitigates against material correcting adjustments by commissioning regular professional asset valuation reviews.

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

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

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

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standard 2020 ('Red Book'), the valuer has declared a material uncertainty in the valuation report. This is on the basis of uncertainties in markets caused by the covid-19 outbreak which was declared by the World Health Organisation as a global pandemic on the 11th March 2020. This has impacted market activity across many sectors and is not specific to the Trust. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. As at the valuation date, the valuer considered they could attach less weight to previous market evidence for comparison purposes, to inform opinion of value, Due to the unprecedented set of circumstances on which this judgement is based, the impact could not be quantified.

Similarly, whilst it is not possible to quantify the impact, it is possible that the ongoing uncertainty in relation to the UK's exit from the EU could have an impact on future property indices which may result in future fluctuations of the Trust's property valuation.

Material uncertainty resulting from market conditions

The Royal Institute of Chartered Surveyors (RICS), the body setting the standards for property valuations, has issued guidance to valuers highlighting that the uncertain impact of COVID-19 on markets might cause the Valuer to conclude that there is a material uncertainty, which the Valuer has declared in their report to the Trust for the valuation as at 31 March 2020. The Valuers are continuing to apply their professional judgement; this is declaring the additional uncertainty attached to current valuations. Further consideration of this is undertaken in note 17.

Contract revenue

The Trust had undertaken an assessment of all revenue streams as required by IFRS 15 - Revenue from contracts with Customers. The Trust was already treating income in line with the requirements set out under the standard, and did not identify any significant amendments to the treatment of revenue for 2019/20.

Note 2 Operating Segments

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

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

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

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

The financial position of the Charity is reported within this set of Financial Statements and as such has not been separately disclosed below.

Note 3 Operating income from patient care activities (Group)

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

Note 3.1 Income from patient care activities (by nature)	2019/20 £000	2018/19 £000
Acute services		
Elective income	40,288	39,905
Non elective income	124,984	115,818
First outpatient income	36,542	36,092
Follow up outpatient income	32,635	30,826
A & E income	14,362	12,385
High cost drugs income from commissioners (excluding pass-through costs)	37,458	34,165
Other NHS clinical income	25,715	27,879
All services		
Private patient income	882	645
Agenda for Change pay award central funding*	-	3,248
Additional pension contribution central funding**	9,377	-
Other clinical income	7,933	5,470
Total income from activities	**330,176**	**306,433**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

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

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2019/20 £000	2018/19 £000
NHS England	61,319	52,497
Clinical commissioning groups	260,196	243,350
Department of Health and Social Care	28	3,261
Other NHS providers	458	176
NHS other	1,382	1,349
Local authorities	1,226	1,251
Non-NHS: private patients	882	645
Non-NHS: overseas patients (chargeable to patient)	405	295
Injury cost recovery scheme	453	603
Non-NHS: other	3,827	3,006
Total income from activities	**330,176**	**306,433**
Of which:		
Related to continuing operations	330,176	306,433
Related to discontinued operations	-	-

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

	2019/20	2018/19
	£000	£000
Income recognised this year	405	295
Cash payments received in-year	102	185

Note 4 Other operating income (Group)

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	3,608	-	**3,608**	1,064	-	**1,064**
Education and training	12,641	492	**13,133**	14,212	-	**14,212**
Non-patient care services to other bodies	7,890	-	**7,890**	7,992	-	**7,992**
Provider sustainability fund (PSF)	2,539	-	**2,539**	14,851	-	**14,851**
Marginal rate emergency tariff funding (MRET)	6,304	-	**6,304**	-	-	-
Income in respect of employee benefits accounted on a gross basis	2,466	-	**2,466**	2,478	-	**2,478**
Receipt of capital grants and donations	-	-	**-**	-	1,964	**1,964**
Rental revenue from operating leases	-	363	**363**	-	270	**270**
Charitable fund incoming resources	-	3,292	**3,292**	-	1,555	**1,555**
Other income	4,492	-	**4,492**	5,000	-	**5,000**
Total other operating income	**39,940**	**4,147**	**44,087**	**45,597**	**3,789**	**49,386**
Of which:						
Related to continuing operations	**39,940**	**4,147**	**44,087**	**45,597**	**3,789**	**49,386**
Related to discontinued operations	**-**	**-**	**-**	**-**	**-**	**-**

Note 5 Additional Information on contract revenue and commissioner requested services

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

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period-end	1,297	4,756

Note 5.2 Income from activities arising from commissioner requested services

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

	2019/20	2018/19
	£000	£000
Income from services designated as commissioner requested services	330,176	297,070
Income from services not designated as commissioner requested services	44,087	58,749
Total	**374,263**	**355,819**

Note 6 Operating expenses

Note 6.1 Operating expenses (Group)

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	-	17
Purchase of healthcare from non-NHS and non-DHSC bodies	1,699	1,272
Staff and executive directors costs	231,755	207,750
Remuneration of non-executive directors	146	149
Supplies and services - clinical (excluding drugs costs)	35,842	33,313
Supplies and services - general	3,872	3,890
Drug costs	43,571	42,997
Consultancy costs	1,327	921
Establishment	3,925	3,455
Premises	11,590	10,339
Transport (including patient travel)	874	1,012
Depreciation of property, plant and equipment	10,286	8,517
Amortisation of intangible assets	1,978	1,736
Net impairments	9,703	1,844
Movement in credit loss allowance: contract receivables / contract assets	(15)	(180)
Increase/(decrease) in other provisions	(175)	(1,248)
Audit fees payable to the external auditor		
audit services - statutory audit	59	54
other auditor remuneration (external auditor only)	10	11
Internal audit costs	66	110
Clinical negligence	10,227	10,000
Legal fees	334	209
Insurance	385	333
Research and development	3,765	2,697
Education and training	3,691	3,057
Rentals under operating leases	416	18
Hospitality	176	245
Losses, ex gratia and special payments	22	13
Other NHS charitable fund resources expended	717	744
Other	(34)	402
Total	**376,212**	**333,677**
Of which:		
Related to continuing operations	376,212	333,677
Related to discontinued operations	-	-

Note 6.2 Other auditor remuneration (Group)

	2019/20	2018/19
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	10	11
Total	**10**	**11**

Note 6.3 Limitation on auditor's liability (Group)

The auditor's liability for external audit work carried out for the financial years 2019/20 and 2018/19 is £1.0m.

Note 7 Impairment of assets (Group)

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus /(deficit) resulting from:		
Changes in market price	9,703	1,844
Total net impairments charged to operating surplus / (deficit)	**9,703**	**1,844**

Of the £9.7m impairment charged in the accounts, £4.1m related to the valuation of the new Therapies building following completion in 2019-20.

The remaining impairment is a result of the Trust undertaking a full valuation of the land, buildings and dwellings on the RUH site as at 31 March 2020.

The land and buildings were valued, in line with the Trust's policy, by an independent Valuer. The valuation was carried out by Gerald Eve as at 31 March 2020.

Where no revaluation reserve was held for an asset the full impairment was charged to the Statement Of Comprehensive Income.

Note 8 Employee benefits (Group)

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	179,802	170,529
Social security costs	17,716	16,608
Apprenticeship levy	1,400	839
Employer's contributions to NHS pensions*	30,907	20,329
Temporary staff (including agency)	7,276	4,487
NHS charitable funds staff	559	536
Total gross staff costs	**237,660**	**213,328**
Recoveries in respect of seconded staff	-	-
Total staff costs	**237,660**	**213,328**
Of which		
Costs capitalised as part of assets	1,117	785

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost off £9.3m has been recognised within employer's contribution to NHS pensions.

Note 8.1 Retirements due to ill-health (Group)

During 2019/20 there were no early retirements from the Trust agreed on the grounds of ill-health (there was a total of 5 in 2018-19). The estimated additional pension liabilities of these ill-health retirements are £0.0m (£0.3m in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

The Trust Directors are eligible for a performance related incentive scheme. The total cost of this in 2019/20 was £0.06m (£0.04m in 2018/19).

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020 is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 10 Royal United Hospitals Bath NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Royal United Hospitals Bath NHS Foundation Trust is the lessee.

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	416	18
Total	**416**	**18**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	416	67
- later than one year and not later than five years;	2,960	201
Total	**3,376**	**268**
Future minimum sublease payments to be received	-	-

Note 11 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2019/20	2018/19
	£000	£000
Interest on bank accounts	177	159
NHS charitable fund investment income	204	205
Total finance income	**381**	**364**

Note 11.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	237	278
Finance leases	27	15
Total interest expense	**264**	**293**
Unwinding of discount on provisions	-	8
Total finance costs	**264**	**301**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

	2019/20	2018/19
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	3

Note 12 Other gains / (losses) (Group)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	19	3
Losses on disposal of assets	(17)	(80)
Total gains / (losses) on disposal of assets	**2**	**(77)**
Total other gains / (losses)	**2**	**(77)**

Note 13 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own Income Statement and Statement of Comprehensive Income. The Trust's deficit for the period was £8.6m (2018/19 surplus £16.1m). The Trust's total comprehensive income/(expense) for the period was (£9.2m) (2018/19: £18.8 m).

Note 14 Intangible assets

Note 14.1 Intangible assets - 2019/20

Group	Software licences £000	Licences & trademarks £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2019 - brought forward	**1,755**	**12,036**	**1,146**	**14,937**
Additions	2	1,094	408	**1,504**
Reclassifications	-	273	(273)	**-**
Valuation / gross cost at 31 March 2020	**1,757**	**13,403**	**1,281**	**16,441**
Amortisation at 1 April 2019 - brought forward	**1,395**	**3,621**	**-**	**5,016**
Provided during the year	145	1,833	-	**1,978**
Amortisation at 31 March 2020	**1,540**	**5,454**	**-**	**6,994**
Net book value at 31 March 2020	**217**	**7,949**	**1,281**	**9,447**
Net book value at 1 April 2019	**360**	**8,415**	**1,146**	**9,921**

Note 14.2 Intangible assets - 2018/19

Group	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**1,783**	**11,306**	**-**	**13,089**
Additions	53	824	1,146	**2,023**
Disposals / derecognition	(81)	(94)	-	**(175)**
Valuation / gross cost at 31 March 2019	**1,755**	**12,036**	**1,146**	**14,937**
Amortisation at 1 April 2018 - as previously stated	**1,317**	**2,066**	**-**	**3,383**
Provided during the year	159	1,577	-	**1,736**
Disposals / derecognition	(81)	(22)	-	**(103)**
Amortisation at 31 March 2019	**1,395**	**3,621**	**-**	**5,016**
Net book value at 31 March 2019	**360**	**8,415**	**1,146**	**9,921**
Net book value at 1 April 2018	**466**	**9,240**	**-**	**9,706**

Note 15 Property, plant and equipment

Note 15.1 Property, plant and equipment - 2019/20

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 2019 - brought forward	**10,862**	**127,547**	**4,959**	**26,567**	**55,170**	**34**	**10,713**	**924**	**236,776**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	5,287	16	14,087	5,279	-	1,105	707	**26,481**
Impairments	(822)	(8,881)	-	-	-	-	-	-	**(9,703)**
Revaluations	(32)	(3,751)	(876)	-	-	-	-	-	**(4,659)**
Reclassifications	-	32,866	-	(32,866)	-	-	-	-	**-**
Disposals / derecognition	-	-	(4)	-	(2,876)	-	(57)	(6)	**(2,943)**
Valuation/gross cost at 31 March 2020	**10,008**	**153,068**	**4,095**	**7,788**	**57,573**	**34**	**11,761**	**1,625**	**245,952**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**303**	**-**	**-**	**29,020**	**34**	**6,853**	**419**	**36,629**
Provided during the year	-	4,199	131	-	4,371	-	1,425	160	**10,286**
Revaluations	-	(4,117)	(129)	-	-	-	-	-	**(4,246)**
Disposals / derecognition	-	-	(2)	-	(2,863)	-	(57)	(6)	**(2,928)**
Accumulated depreciation at 31 March 2020	**-**	**385**	**-**	**-**	**30,528**	**34**	**8,221**	**573**	**39,741**
Net book value at 31 March 2020	**10,008**	**152,683**	**4,095**	**7,788**	**27,045**	**-**	**3,540**	**1,052**	**206,211**
Net book value at 1 April 2019	**10,862**	**127,244**	**4,959**	**26,567**	**26,150**	**-**	**3,860**	**505**	**200,147**

Note 15.2 Property, plant and equipment - 2018/19

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2018 - as previously stated	**9,972**	**129,790**	**5,184**	**9,525**	**50,276**	**34**	**9,806**	**819**	**215,406**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	4,031	40	20,591	8,266	-	997	121	**34,046**
Impairments	-	(2,734)	-	-	-	-	-	-	**(2,734)**
Reversals of impairments	890	-	-	-	-	-	-	-	**890**
Revaluations	-	(7,089)	(265)	-	-	-	-	-	**(7,354)**
Reclassifications	-	3,549	-	(3,549)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(3,372)	-	(90)	(16)	**(3,478)**
Valuation/gross cost at 31 March 2019	**10,862**	**127,547**	**4,959**	**26,567**	**55,170**	**34**	**10,713**	**924**	**236,776**
Accumulated depreciation at 1 April 2018 - as previously stated	**-**	**5,010**	**182**	**-**	**28,409**	**34**	**5,319**	**343**	**39,297**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	2,842	95	-	3,869	-	1,622	89	**8,517**
Revaluations	-	(7,549)	(277)	-	-	-	-	-	**(7,826)**
Disposals / derecognition	-	-	-	-	(3,258)	-	(88)	(13)	**(3,359)**
Accumulated depreciation at 31 March 2019	**-**	**303**	**-**	**-**	**29,020**	**34**	**6,853**	**419**	**36,629**
Net book value at 31 March 2019	**10,862**	**127,244**	**4,959**	**26,567**	**26,150**	**-**	**3,860**	**505**	**200,147**
Net book value at 1 April 2018	**9,972**	**124,780**	**5,002**	**9,525**	**21,867**	**-**	**4,487**	**476**	**176,109**

Note 15.3 Property, plant and equipment financing - 2019/20

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	10,008	147,063	4,095	6,210	21,833	3,540	995	-	**193,744**
Finance leased	-	-	-	-	2,691	-	-	-	**2,691**
Owned - donated	-	5,620	-	1,578	2,521	-	57	-	**9,776**
NBV total at 31 March 2020	**10,008**	**152,683**	**4,095**	**7,788**	**27,045**	**3,540**	**1,052**	**-**	**206,211**

Note 15.4 Property, plant and equipment financing - 2018/19

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	10,862	123,215	4,959	23,463	20,706	3,860	434	-	**187,499**
Finance leased	-	-	-	-	2,767	-	-	-	**2,767**
Owned - donated	-	4,029	-	3,104	2,677	-	71	-	**9,881**
NBV total at 31 March 2019	**10,862**	**127,244**	**4,959**	**26,567**	**26,150**	**3,860**	**505**	**-**	**200,147**

Note 16 Donations of property, plant and equipment

During the year ended 31 March 2020 the Trust received donations from which assets were purchased to the value of £1.3m (£1.9m 2018-19).

The donations were made up as follows:
- £0.8m cash donation from the Royal United Hospital Bath Charitable Fund to fund project costs for RNHRD & Therapies Centre; and
- £0.5m from Royal United Hospital Bath Charitable Fund to fund various medical equipment.

The cash donation from Royal United Hospital Bath Charitable Fund was restricted to ensure funds were only used for project costs towards the RNHRD & Therapies Centre.

Note 17 Revaluations of property, plant and equipment

The Trust's policy is to complete a full revaluation at least every five years, with a desktop review every three years. Gerald Eve, who are members of the Royal Institute of Chartered Surveyors and are independent of the Trust, undertook a full valuation of the Trust's land and buildings as at 31 March 2020. The last full revaluation was undertaken as at 31 March 2016. The valuations were carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1).

The total movement in the revaluation reserve is £4.2m. £0.4m has been charged to other comprehensive income, where the valuation has arisen from a consumption of economic benefit. There has also been a movement between the Revaluation Reserve and Income and Expenditure Reserve of £3.8m to reflect the updated valuation and in-year depreciation of the Trust's Revaluation Reserve.

The valuation exercise was carried out in February 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the Valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on 11 March 2020, has impacted global financial markets. Travel restrictions have been implemented by many countries.

In the UK, market activity is being impacted in all sectors. As at the valuation date, Gerald Eve considers that it can attach less weight to previous market evidence for comparison purposes to inform opinions of value. Indeed, the current response to COVID-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement.

The valuation is therefore reported on the basis of 'material valuation uncertainty' per VPGA 10 of the RICS Valuation – Global Standards. Consequently, less certainty – and a higher degree of caution – should be attached to their valuation than would normally be the case.

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the Valuer having declared this material valuation uncertainty, the Valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

Of the £167m net book value of land and buildings subject to valuation, £167m relates to specialised assets valued on a depreciated replacement cost basis. Here the Valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service. Any change would be less significant than if the valuation was based on purely transactional or rental evidence.

It is possible that the COVID-19 pandemic will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient evidence to affect the assumptions used in the valuation.

Note 18 Other investments / financial assets (non-current)

	Group	
	2019/20	**2018/19**
	£000	**£000**
Carrying value at 1 April - brought forward	**8,512**	**7,128**
Prior period adjustments		-
Carrying value at 1 April - restated	**8,512**	**7,128**
Acquisitions in year	141	1,193
Movement in fair value through OCI	(721)	191
Carrying value at 31 March	**7,932**	**8,512**

Note 19 Disclosure of interests in other entities

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

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

Wiltshire Health and Care LLP has a full year annual turnover of over £57 million. The clinical services provided to Wiltshire are procured mainly from Great Western Hospitals NHS Foundation Trust, with other small service provision, both clinical and corporate, received from Salisbury NHS Foundation Trust and the Royal United Hospitals Bath NHS Foundation Trust on a contract basis.

The financial risks of the LLP to the Members are limited to nil as per the signed members' agreement, the surpluses are accounted for in the Trust's accounts using the equity method, however the LLP reports a breakeven position as at the 31 March 2020, therefore there is no investment gain to recognise.

Note 20 Analysis of charitable fund reserves

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.

	31 March 2020 £000	31 March 2019 £000
Unrestricted funds:		
Unrestricted income funds	1,639	1,786
Restricted funds:		
Other restricted income funds	9,204	8,839
	10,843	**10,625**

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 Inventories

	Trust	
	31 March 2020 £000	31 March 2019 £000
Drugs	867	422
Consumables	3,315	2,507
Energy	67	64
Other	-	7
Total inventories	**4,249**	**3,000**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £58.8m (2018/19: £53.8m). Write-down of inventories recognised as expenses for the year were nil (2018/19 nil).

Note 22 Receivables

Note 22.1 Receivables

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Current				
Contract receivables	17,806	30,386	17,806	32,180
Capital receivables	26	-	26	-
Allowance for impaired contract receivables / assets	(277)	(365)	(277)	(365)
Allowance for other impaired receivables	-	-	-	
Deposits and advances	25	-	25	-
Prepayments (non-PFI)	3,475	-	3,475	-
PDC dividend receivable	478	74	478	74
VAT receivable	940	-	940	-
Other receivables	93	-	93	-
NHS charitable funds receivables	70	26	-	-
Total current receivables	**22,636**	**30,121**	**22,566**	**31,889**
Non-current				
Contract receivables	1,460	1,443	1,460	1,443
Allowance for impaired contract receivables / assets	(264)	(261)	(264)	(261)
NHS charitable funds receivables	1,177	603	-	-
Total non-current receivables	**2,744**	**1,785**	**1,567**	**1,182**
Of which receivable from NHS and DHSC group bodies:				
Current	11,161	20,627	14,406	20,627
Non-current	371	-	371	-

Note 22.2 Allowances for credit losses - 2019/20

	Trust
	Contract receivables and contract assets
	£000
Allowances as at 1 April 2019 - brought forward	**626**
Changes in existing allowances	(15)
Utilisation of allowances (write -offs)	(70)
Allowances as at 31 March 2020	**541**

Note 22.3 Allowances for credit losses - 2018/19

	Trust	
	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 April 2018 - as previously stated	**-**	**776**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	776	(776)
Changes in existing allowances	(180)	-
Utilisation of allowances (write- offs)	30	-
Allowances as at 31 March 2019	**626**	**-**

Note 23 Cash and cash equivalents

Note 23.1 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	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
At 1 April	**22,331**	**35,504**	**18,946**	**32,912**
Net change in year	(6,819)	(13,173)	(5,434)	(13,966)
At 31 March	**15,512**	**22,331**	**13,512**	**18,946**
Broken down into:				
Cash at commercial banks and in hand	279	38	7	14
Cash with the Government Banking Service	15,233	22,293	13,505	18,932
Total cash and cash equivalents as in SoFP	**15,512**	**22,331**	**13,512**	**18,946**
Total cash and cash equivalents as in SoCF	**15,512**	**22,331**	**13,512**	**18,946**

Note 23.2 Third party assets held by the Trust

Royal United Hospitals Bath NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2020	31 March 2019
	£000	£000
Bank balances	8	-
Total third party assets	**8**	**-**

Note 24 Trade and other payables

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Current				
Trade payables	8,373	5,592	8,373	5,592
Capital payables	1,985	5,805	1,985	5,805
Accruals	6,602	9,873	6,602	9,873
Social security costs	4,522	-	4,522	-
VAT payables	-	85	-	85
Other taxes payable	-	4,192	-	4,192
Other payables	9,263	2,848	9,263	2,848
NHS charitable funds: trade and other payables	336	107	-	-
Total current trade and other payables	**31,081**	**28,502**	**30,745**	**28,395**
Of which payables from NHS and DHSC group bodies:				
Current	6,062	4,126	6,062	4,126
Non-current	-	-	-	-

Note 24.1 Early retirements in NHS payables above

There were no early retirements included in the payables note above in relation to the current or prior year.

Note 25 Other liabilities

	Group	
	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	5,270	5,691
Total other current liabilities	**5,270**	**5,691**

Note 26 Borrowings

	Group	
	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	3,016	3,026
Obligations under finance leases	483	398
Total current borrowings	**3,499**	**3,424**
Non-current		
Loans from DHSC	8,755	11,714
Obligations under finance leases	2,169	2,057
Total non-current borrowings	**10,924**	**13,771**

Note 26.1 Reconciliation of liabilities arising from financing activities (Group)

2019/20	Loans from DHSC £000	Finance leases £000	Total £000
Carrying value at 1 April 2019	**14,740**	**2,455**	**17,195**
Cash movements:			
Financing cash flows - payments and receipts of principal	(2,958)	(442)	**(3,400)**
Financing cash flows - payments of interest	(248)	(26)	**(274)**
Non-cash movements:			
Additions	-	636	**636**
Application of effective interest rate	237	29	**266**
Carrying value at 31 March 2020	**11,771**	**2,652**	**14,423**

All financing activities relate to the Trust only.

2018/19	Loans from DHSC £000	Finance leases £000	Total £000
Carrying value at 1 April 2018	**17,630**	**549**	**18,179**
Prior period adjustment	**-**	**-**	**-**
Carrying value at 1 April 2018 - restated	**17,630**	**549**	**18,179**
Cash movements:			
Financing cash flows - payments and receipts of principal	(2,958)	(311)	**(3,269)**
Financing cash flows - payments of interest	(287)	(16)	**(303)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	77	-	**77**
Additions	-	2,218	**2,218**
Application of effective interest rate	278	15	**293**
Carrying value at 31 March 2019	**14,740**	**2,455**	**17,195**

All financing activities relate to the Trust only.

Note 27 Finance leases

Note 27.1 Royal United Hospitals Bath NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	Trust	
	31 March 2020 £000	31 March 2019 £000
Gross lease liabilities	**2,745**	**2,518**
of which liabilities are due:		
- not later than one year;	513	416
- later than one year and not later than five years;	1,985	1,655
- later than five years.	247	447
Finance charges allocated to future periods	(93)	(63)
Net lease liabilities	**2,652**	**2,455**
of which payable:		
- not later than one year;	483	398
- later than one year and not later than five years;	1,925	1,613
- later than five years.	244	444

All lease liabilities relate to the Trust only.

Note 28 Provisions for liabilities and charges analysis

Group	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2019	**842**	**37**	**219**	**1,098**
Arising during the year	**99**	**7**	**748**	**854**
Utilised during the year	(71)	-	(56)	**(127)**
Reversed unused	**(73)**	**-**	**(447)**	**(520)**
At 31 March 2020	**797**	**44**	**464**	**1,305**
Expected timing of cash flows:				
- not later than one year;	76	44	**93**	**213**
- later than one year and not later than five years;	295	-	**-**	**295**
- later than five years.	426	0	**371**	**797**
Total	**797**	**44**	**464**	**1,305**

Pensions - early departure costs
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.

Other
Other provisions have been made in relation to employment issues. These amounts are estimates based on known risks and salaries. £371k has been included in long term provisions and relates to claims pension entitlements, which is not expected to be settled wiithin 5 years.

All provisions relate to the Trust only.

Note 29 Clinical negligence liabilities

At 31 March 2020, £135.9m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal United Hospitals Bath NHS Foundation Trust (31 March 2019: £157.3m).

Note 30 Contingent assets and liabilities

	Trust	
	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	18	37
Gross value of contingent liabilities	**18**	**37**
Net value of contingent liabilities	**18**	**37**

Contingent liabilities are the legal claims under the liability to third parties and property expenses administered by the NHS Resolution (formerly NHS Litigation Authority). The Trust has not identified any contingent assets in 2019/20 (nil in 2018/19).

Note 31 Contractual capital commitments

	Trust	
	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	6,476	14,149
Intangible assets	474	697
Total	**6,950**	**14,846**

Contractual capital commitments relate to the Trust only.

Note 32 Financial instruments

Note 32.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with NHS England and Clinical Commissioning Groups and the way those bodies are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. Although the Trust has operations overseas, it has no establishment in other territories. The Foundation Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. Additionally the Trust's cash balances are held with the Government Banking Service. The Trust, therefore, has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's income comes from contracts with other public sector bodies, it has low exposure to credit risk. The maximum exposures as at 31 March 2020 are in receivables from customers, as disclosed in the trade and other receivables note. These funding arrangements ensure that the Trust is not exposed to any material credit risk.

Liquidity risk
The Trust's operating costs are incurred under contracts with Commissioners, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated funds. The Trust is not, therefore, exposed to significant liquidity risks.

Note 32.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non -financial assets	19,215	-	**19,215**
Cash and cash equivalents	13,512	-	**13,512**
Consolidated NHS Charitable fund financial assets	3,247	7,932	**11,179**
Total at 31 March 2020	**35,974**	**7,932**	**43,906**

The Charitable Fund elected to classify equity instruments as fair value through OCI on initial recognition; the carrying value of these designated assets are £7.9m, (£8.5m in 2018/19).

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non -financial assets	30,574	-	**30,574**
Cash and cash equivalents	18,946	-	**18,946**
Consolidated NHS Charitable fund financial assets	4,014	8,512	**12,526**
Total at 31 March 2019	**53,534**	**8,512**	**62,046**

Note 32.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non-financial assets	19,215	-	**19,215**
Cash and cash equivalents	13,512	-	**13,512**
Total at 31 March 2020	**32,727**	**-**	**32,727**

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non-financial assets	30,548	-	**30,548**
Cash and cash equivalents	18,946	-	**18,946**
Total at 31 March 2019	**49,494**	**-**	**49,494**

Note 32.4 Carrying values of financial liabilities

Group	Held at amortised cost	Total book value
	£000	
Carrying values of financial liabilities as at 31 March 2020		
Loans from the Department of Health and Social Care	11,771	11,771
Obligations under finance leases	2,652	2,652
Trade and other payables excluding non financial liabilities	26,223	26,223
Total at 31 March 2020	**40,646**	**40,646**

Group	Held at amortised cost	Total book value
	£000	
Carrying values of financial liabilities as at 31 March 2019		
Loans from the Department of Health and Social Care	14,740	14,740
Obligations under finance leases	2,455	2,455
Trade and other payables excluding non financial liabilities	24,118	24,118
Total at 31 March 2019	**41,313**	**41,313**

Trust	Held at amortised cost	Total book value
	£000	
Carrying values of financial liabilities as at 31 March 2020		
Loans from the Department of Health and Social Care	11,771	11,771
Obligations under finance leases	2,652	2,652
Trade and other payables excluding non financial liabilities	26,223	26,223
Total at 31 March 2020	**40,646**	**40,646**

Trust	Held at amortised cost	Total book value
	£000	
Carrying values of financial liabilities as at 31 March 2019		
Loans from the Department of Health and Social Care	14,740	14,740
Obligations under finance leases	2,455	2,455
Trade and other payables excluding non financial liabilities	22,217	22,217
Total at 31 March 2019	**39,412**	**39,412**

32.5 Maturity of financial liabilities

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
In one year or less	29,722	27,542	29,722	27,542
In more than one year but not more than two years	3,456	3,356	3,456	3,356
In more than two years but not more than five years	2,374	4,808	2,374	4,808
In more than five years	5,094	5,607	5,094	5,607
Total	**40,646**	**41,313**	**40,646**	**41,313**

Liabilities relate to the Trust only.

33 Losses and special payments

	2019/20		2018/19	
Group and Trust	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Special payments				
Compensation under court order or legally binding arbitration award	-	-	5	0
Ex-gratia payments	43	19	32	351
Total special payments	**43**	**19**	**37**	**351**
Total losses and special payments	**43**	**19**	**37**	**351**

The Trust had no cases above £0.3m in 2019/20 (one case in 2018/19 above £0.3m, this related to a Health & Safety Executive ruling (£0.3m).

34 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 2020, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

CCGs
NHS Wiltshire CCG
NHS Bath and North East Somerset CCG
NHS Somerset CCG
NHS Bristol, North Somerset and South Gloucestershire CCG
NHS Gloucestershire CCG

NHS England Organisations
NHS England - Core (including Provider Sustainability Funding)
NHS England South West Local Office
NHS England - South West Commissioning Hub
NHS England South Central Local Office
NHS England - Wessex Specialised Commissioning Hub

NHS Trusts and Foundation Trusts
University Hospitals Bristol NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
North Bristol NHS Trust
Salisbury NHS Foundation Trust
Avon and Wiltshire Mental Health Partnership NHS Trust
Somerset Partnership NHS Foundation Trust
Yeovil District hospital NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust

Other Agencies
Health Education England
Department Of Health
Bath and North East Somerset Council
Wiltshire Unitary Authority
Welsh Assembly Government (including all other Welsh Health Bodies)
Public Health England
NHS Litigation Authority
NHS Blood and Transplant (excluding Bio products Laboratory)

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Her Majesty's Revenue and Customs in relation to Value Added Tax, National Insurance Contributions and Income Taxes.

The Trust has also received revenue and capital payments from the Royal United Hospital Bath NHS Trust Charitable Funds, for which the Trust Board acts as Corporate Trustee. The audited accounts of the Charitable Funds are available at www.ruh.nhs.uk.

The Trust is an equal partner in Wiltshire Health and Care LLP, the Trust received payment of £0.1m in respect to the provision of Financial Services to the partnership.

35 Events after the reporting date

The Trust has not identified any post balance sheet events for 2019/20.