Royal United Hospitals Bath
NHS Foundation Trust

Annual Report and Accounts

2020/21

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Contents

Message from the Chair and Chief Executive Page 6

Performance report Page 9

- Overview of performance Page 9

Accountability report Page 30

- Directors' report Page 30
- Remuneration report Page 46
- Staff report Page 65
- NHS Foundation Trust Code of Governance disclosures Page 91
- NHS Improvement's Single Oversight Framework Page 105
- Statement of accounting officer's responsibilities Page 106
- Annual governance statement Page 108

Independent Auditors' Report Page 126

Annual Accounts Page 132

Message from the Chair and Chief Executive

It is Spring at the time of writing and evidence of Nature's resilience and regeneration reflect our own feelings about the Royal United Hospitals Bath NHS Foundation Trust's (RUH) recovery from the challenges of the Coronavirus pandemic. The return to a more normal life seems imminent - COVID-19 set us many challenges in 2020/21, but this report will also acknowledge the many instances of our staff's professionalism and compassion, and the huge support we were given by our community. We also remember the many people who sadly died from the infection and our hearts are with their families and friends and those who took care of them.

The COVID challenge meant we had to make rapid changes in our services, buildings, the ways we work and the partnerships we work with. In normal times many of these innovations would have taken months or years; we made them in days and week. Many have proved to be improvements which outlive the pandemic – and they are here to stay.

For example, in May 2020 we opened an ultra-modern intensive care unit, with 14 beds provided exclusively for COVID-19 patients, created from an orthopaedic ward in just 42 days. In autumn 2020 as coronavirus cases surged we mobilised and reopened our new modular ward as the Respiratory Assessment Unit and, learning from our experiences in the early days of COVID-19, we transformed theatres and redeployed staff to provide urgently-needed coronavirus care.

In early Autumn we were able to assist hospitals from more challenged areas by admitting their patients, but over Christmas and New Year, the RUH saw the highest numbers of COVID-19 patients, many needing intensive care, and many of our staff were also affected directly or indirectly and were unable to work. We juggled and managed our resources to continue to provide high level care and thanks to our dedicated, flexible and professional staff, from cleaners, porters and kitchen staff to frontline doctors and nurses we managed the load.

Collaboration with the two main independent sector hospitals in Bath – Circle Bath Hospital and the BMI Bath Clinic - was vital to enable us to maintain elective and non-elective services throughout and we are grateful for their willingness to help. As the numbers of COVID-19 patients in the hospital reduced during the summer of 2020, we restarted as many of our services as we possibly and safely could but the winter COVID-19 surge meant a return to the postponement of some non-urgent surgery. By Spring 2021 we were in a position to welcome back limited numbers of visitors and to restart elective procedures.

Another important collaboration that helped our COVID-19 work was our continuing and deepening relationship with colleagues in the Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (BSW). Support from BSW community services enabled us to clear beds for incoming COVID patients. We shared mutual aid with our fellows in the BSW Acute Hospital Alliance, Great Western Hospital and Salisbury Hospital during times when we were stretched. We are also supporting each other in recovery such as pooling resources to provide oral

and maxillofacial (OMFS) paediatric day surgery on a number of weekends at the Salisbury site where there is spare capacity. This has not only reduced 7 waiting lists but given staff, from across BSW, valuable opportunities to share learning, skills and training.

In January 2021, again in collaboration with our BSW partners, we also set up and staffed the new large-scale NHS Vaccination Centre at Bath Racecourse, which by March was vaccinating more than a thousand people a day.

Despite the pandemic we have continued to look ahead and move forward with major capital projects that have been transforming the hospital site and making the RUH fit for the future. Work has begun on our biggest project to date, the new Dyson Cancer Centre, which will be located next to the main entrance of the hospital and will bring the majority of our main cancer services under one roof.

One of our most important projects was an upgrade to the Accident and Emergency Department. We received extra funding to carry out the work, enabling us to reduce the amount of time that patients spend waiting to get into the hospital, and also to cut the length of delays that ambulance crews sometimes face in handing patients over to us. The works included creating a new resuscitation area and making improvements to Ambulatory Care and the Trauma Assessment Unit.

We are really proud of our continuing reputation for being part of important national and worldwide research, particularly in COVID-19 studies. In March 2021 our team joined a project looking at whether booster COVID-19 vaccines could be given at the same time as flu vaccines. A large international study has been open since the start of the pandemic, gathering information from positive COVID-19 patients that may help scientists to understand more about the virus. There are also a number of studies going on in our Intensive Care Unit, involving confirmed COVID-19 patients, some to trial treatments and another that aims to identify genes that may make some people more unwell. A clinical trial has also begun across the whole Trust, trying out drugs used for different viruses with the aim of identifying possible treatments to help patients in their recovery and we were part of the study which identified dexamethasone as a very effective treatment option.

Our staff are of course our biggest asset and we’re acutely aware of the impact that the pandemic has had on them, their families and loved ones. We have learned that we all need to look after our physical, emotional and mental health and wellbeing, as well as to look out for our colleagues. Throughout the pandemic we have provided support and resources, such as civility and kindness focus groups, “at your desk” exercise sessions, and advice videos on subjects like relaxation and breathing to combat stress. The health and wellbeing of staff will continue to be a key priority into the future.

We recognise that the restrictions that had to be put in place across the hospital as a result of COVID meant that our patients have had different experiences of using our services than they would otherwise have had. For example, as I alluded to earlier, it became more difficult for carers and family members to visit patients on our wards. We recognise the toll that this had on all concerned including our staff, but we are

grateful for the extra efforts made by our staff to help friends and family retain some sort of contact with patients, mainly through the use of telephones and other technological aids. Technology, also helped us make changes to the way we provided some types of care, particularly outpatient appointments. It is highly likely that many of these innovations will be carried on well beyond the end of the pandemic.

We are, as ever, hugely appreciative of everyone across the local community who supports the Trust – our Board of 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 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, who have, throughout this very difficult period, demonstrated in a variety of ways how much they value the efforts and sacrifices of everyone working in the whole of the health and care sector.

We are particularly grateful to the many individuals and organisations who made donations of money and material throughout the pandemic. In total we received gifts and donations totalling £114,000 during this period. Many of these donations helped to support and encourage our frontline teams when the impact of COVID on the hospital was at its worst.

We are also very grateful to two individuals who responded at the beginning of the pandemic to the challenge of keeping services going. Our former CEO, James Scott, delayed his retirement by two months as the pandemic struck in early 2020, and our Deputy CEO Libby Walters who took the helm in June so willingly and competently until September and the arrival of Cara Charles Barks the new CEO.

We are now looking positively to the future. We've launched our clinical vision and aims for the New Hospitals Programme, which is our opportunity to access funding to invest in our estate, equipment and technology. After such an eventful year there are challenging and exciting times ahead. The RUH is changing.

Overview of performance during 2020/21

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

About the Trust

Statutory background

The 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 unitary Board of Executive and Non-Executive directors working alongside a Council of Governors representing the populations we serve and our key stakeholders.

Our core business is 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 Trust is a key member of the BaNES, Swindon and Wiltshire Integrated Care System (BSW ICS). Integrated Care Systems are formal partnerships between NHS organisations, local authorities and other key local organisations whose role is to take responsibility for managing available resources with a view to improving the health of the local population. The BSW ICS was formally authorised by NHS Improvement/England in December 2020.

The Trust 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. It is recognised as one of the most research-active medium sized acute Trusts in the country.

In common with other areas, our population is evolving:

- We have a growing population of people with more complex needs, in all age groups but in particular in our older population and those with long-term conditions
- There are, rightly, rising public expectations in terms of the quality and availability of public services
- 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 have had to adapt the way that we engage with patients and their families and carers during the pandemic, with more reliance placed on virtual opportunities to receive feedback, such as by telephone, email or via the Trust website.

We aim to provide the highest quality of services in response to the needs of our patients and the communities we serve. Our Trust Strategy 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 2020/21 were:

- Achieve the national target of 33% for discharges by midday
- Improve the recruitment and retention of band 5 nurses (positive starter to leaver ratio)
- Achieve a 10% reduction in hospital onset MSSA, E coli blood stream infections and C-diff infections by the end of 2020/21.

<u>Risks and issues</u>

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

a. Ongoing and future impact of the COVID-19 pandemic

Like the rest of the NHS, the Trust made significant changes to the way it provided its services in order to cope with the different waves of COVID-19 infection. The impact across the South West of the first wave in the spring of 2020 was not as severe as in other parts of the country, and it was possible at that time to carry on with other work (particularly ensuring that cancer care remained on track), albeit with significant restrictions brought on by the requirements for social distancing and the continuous use of personal protective equipment (PPE).

However, the third wave, which started from around Christmas, led to much higher levels of admission, including to the Intensive Care Unit, and serious illness. As a result almost all elective care had to be stopped, and as at the end of March 2021, the number of patients who have been waiting for over 18 weeks for treatment was more than 8000, including more than 1600 who have been waiting for 52 weeks or more. It is acknowledged that it will take a considerable amount of time to clear this backlog, and of course more patients are being referred all the time.

A BSW system-wide approach is being taken to tackling this issue, as both Great Western and Salisbury Hospitals are in similar positions. Steps being taken include the pooling of resources across the three sites, and continued use of independent sector capacity where this is appropriate and available.

b. Staff health and well being

The sheer scale of the additional workload that COVID-19 imposed on the hospital is unprecedented. In spite of the large numbers of volunteers, including retired clinicians, who graciously came forward to assist, many of our frontline staff have worked almost without break since the pandemic was first declared just over a year ago. Many staff have also not previously faced the level of serious illness and, sadly, death that COVID brought. It should also be noted that many staff themselves caught the virus, which of course impacted on their families and loved ones, as well as their colleagues.

As we hopefully enter the last weeks of the pandemic, it is clear that many of our staff are not only physically exhausted, but there are concerns about the longer term impact that this period could have on their mental and psychological wellbeing. The Trust is taking urgent action to increase and broaden the range of staff support services, and a new Health and Wellbeing Strategy is about to be launched. This will initially prioritise staff recovery, providing practical support including enhancing the Employee Assistance Programme, commissioning dedicated support for “long COVID” sufferers and providing team debrief sessions and trauma risk management.

c. Patient experience

Although responses from patients to the Friends and Family Test, and other methods for sharing feedback indicated that overall levels of satisfaction with the quality of care provided by the Trust remains high, there was a significant growth across the year in the number of concerns raised with the Patient Advice and Liaison Service (PALS) and formal complaints recorded. The vast majority of these raised issues around the care and treatment received and how this was coordinated, but many others raised issues around the quality, amount and timeliness of communication between clinicians and patients and their families.

The three clinical divisions continue to work together and with the Director of Nursing and Midwifery and her team to collate, disseminate and demonstrate learning from this important source of feedback. Corporately, the Quality Governance Committee, a sub-committee of the Board scrutinises the extent to which the Trust is able to learn not just from complaints, but also from serious incidents, deaths and the outcomes from legal claims and inquests. The Board itself hears directly from patients and family members at each of its public meetings.

d. Financial sustainability

The COVID-19 pandemic has, unsurprisingly, significantly impacted existing financial models within the NHS. As the crisis unfolded, additional resource was provided by the government to ensure that hospitals were adequately funded to deal with staffing and equipment requirements, much higher levels of Personal Protective Equipment (PPE) use and other steps that were needed to keep hospitals safe.

However, although the immediate demands that the pandemic itself placed on hospitals has now receded, it is clear that the actions that will need to be taken to get services back to on to a sustainable footing will also be resource intensive.

As set out in a. above, specific action will need to be taken to clear the elective backlog, and in addition to continued use of independent sector capacity, this may also include carrying out additional operations and procedures at the weekends and out of hours, and requiring premium payments for the staff involved. Furthermore, there is a risk that the longer term physical and psychological impact of the pandemic on staff could lead to absences and indeed departures, with a consequent reliance, at least in the short term, on expensive agency and locum staff.

The actions articulated in b. should help to mitigate the risk of significant absences. With regard to the other financial risks, it would be essential for all partners in BSW to work collaboratively to maximise whatever funding is made available to the whole system, ensuring, for example, that there is sufficient provision in the community to limit delays in discharging medically fit patients from hospital, and that best use is made of facilities right across the system.

Operational performance

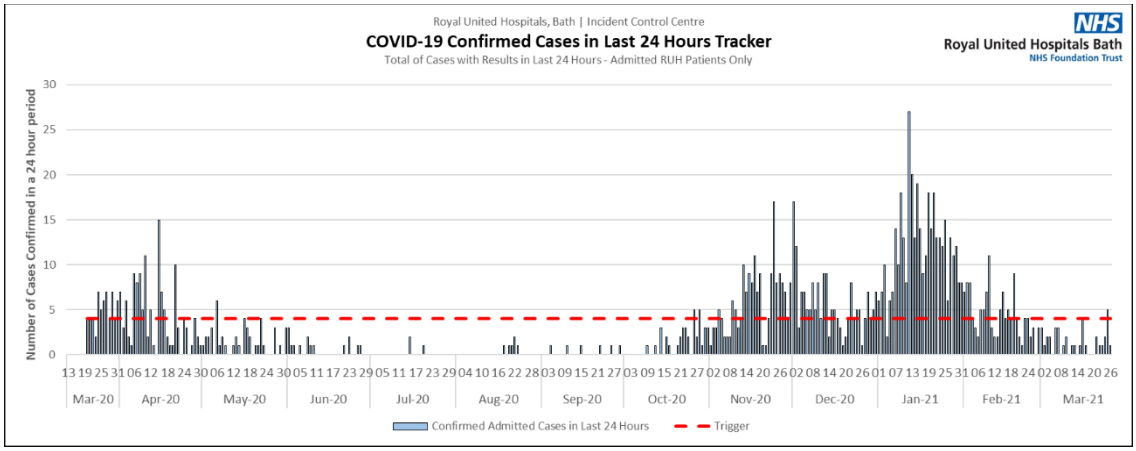
The Trust produces an integrated balanced scorecard which outlines how it is performing under five domains: Caring, Effective, Responsive, Safe and Well-led. The Trust manages performance against the NHS Single Oversight Framework which does not give a performance assessment in its own right; it aims 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.

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.

Covid-19 Summary

The past year has seen a significant impact of the Covid-19 pandemic globally, nationally and for the organisation. The Trust has experienced a number of periods during the year of increased Covid admissions which has impacted operationally. The first was in March / April 2020, with a longer and more sustained period of escalation between October 2020 and March 2021. We saw our highest peaks in admissions at the end of November 2020 and early January 2021.

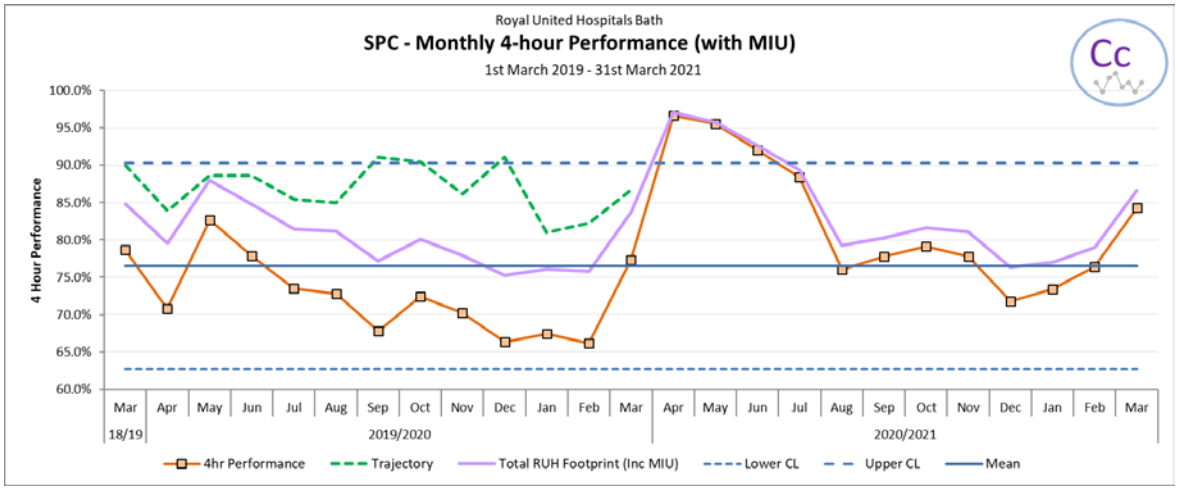


There was a cumulative total of 1,205 confirmed cases of Covid admitted into hospital to the end of March 2021 and sadly 280 deaths since the start of the pandemic to end of this reporting period. During the year, we also experienced a corresponding increase in our Intensive Care and Non-invasive ventilation (NIV) demand, most significantly during January and February 2021.
Throughout the pandemic, we have seen a strong operational response and staff have worked tirelessly to care for COVID-19 patients, while also ensuring that emergency, cancer and elective care provision has continued.

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 continues to find delivery of this target extremely challenging. However, the levels of Emergency presentations and admissions over the past year has been impacted by Covid-19 and the national lockdowns.

The RUH's performance during 2020/21 is outlined below:



Performance improved significantly in March 2020 as a result of the COVID-19 pandemic and a national lockdown which resulted in a dramatic reduction in the number of attendances to the Emergency Department and corresponding achievement of the 95% standard. This level of performance continued in the first four months of this year but as lockdown eased and attendances increased, this had a negative impact on our performance.

During January 2021, we launched our new Improving Patient Flow Together Programme (IPFT) with the aim of improving our emergency pathways across the hospital and the wider system. Whilst we are only at the beginning of our improvement journey, we have seen improved performance during quarter 4 and finished the year at 84.3%, a 8% improvement on the previous month.

Patient feedback about the quality of the care that they receive in our Emergency Department and other access areas continues to be positive.

Looking forward to 2021/22, 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 living with COVID-19.

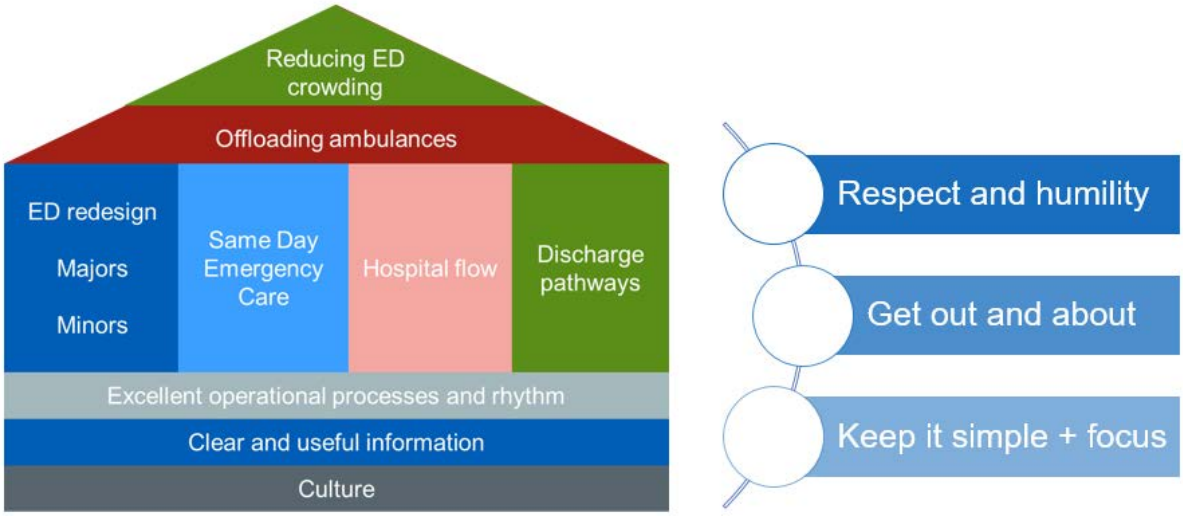
Improving Patient Flow Together Programme (IPFT)

To support improvements in Urgent and Emergency Care, we have developed the Improving Patient Flow Together Programme. The vision for this programme is that *access standards are consistently met and the RUH has established a reputation for*

safe, effective and clinically excellent emergency and elective care. This will be delivered with our partners within an integrated system that is responsive and 'joins the dots' in health and social care so our patients don't have to.

The True North objective is to reducing overcrowding in the Emergency Department to support the achievement of the 4 hour treatment time but it is recognised that emergency flow is a whole hospital and system response so the programme has been designed to reflect this and includes pillars of work in the Emergency Department, Same day assessment, ward processes and discharge from hospital.

Diagram 1: Improving Patient Flow Together Programme



The programme is being supported by our Trust quality improvement methodology "Improving Together". This approach supports the identification of top contributors to poor performance so that actions get to the root cause of the problem. The programme is being supported by our dedicated Coach House, a team of skilled improvement practitioners that provide training and guidance in the various tools and techniques to frontline clinical teams to support them in making improvements.

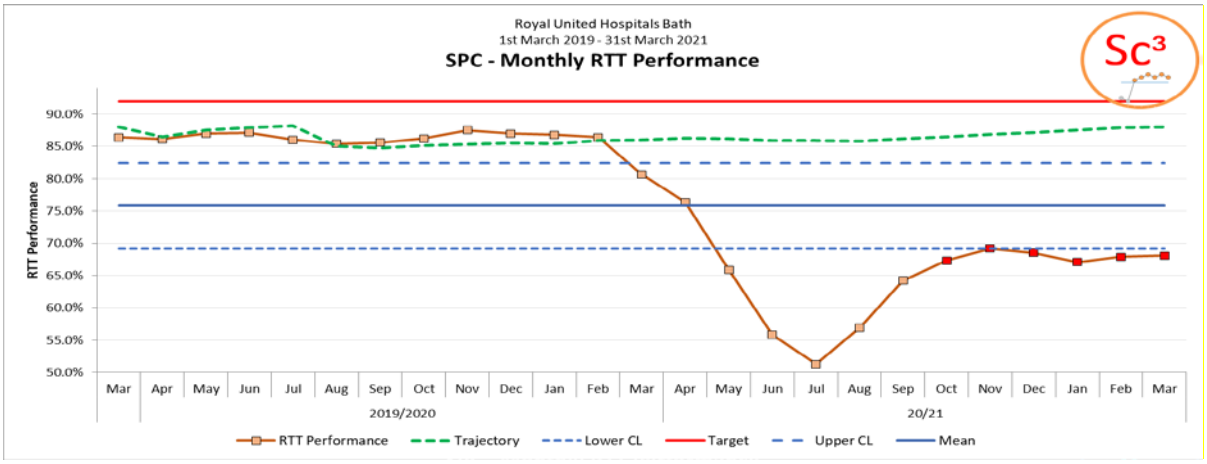
<u>18-week Referral to Treatment Time</u>

Our response to the COVID-19 pandemic has had a significant impact on the waiting times for our elective patients. During the first phase of our Covid-19 response, following national guidance, all routine elective work was suspended to support our emergency response for increased Covid admissions. This included the use of Day theatres as expansion of the Intensive Care bed base.

As the numbers of COVID cases reduced over the summer months, we implemented our Phase 3 Elective Recovery programme to maximise the levels of elective care during quarter 3, whilst continuing to care for COVID patients. During quarter 4, we again suspended some routine elective work to ensure we had sufficient capacity for COVID admissions.

There was a significant deterioration in performance in the first half of the year, due to the suspension of routine elective activity, although from July 2020 we saw a steady improvement in performance and despite increased Covid admissions

between November 2020 and January 2021, we have sustained performance levels, albeit below national target.

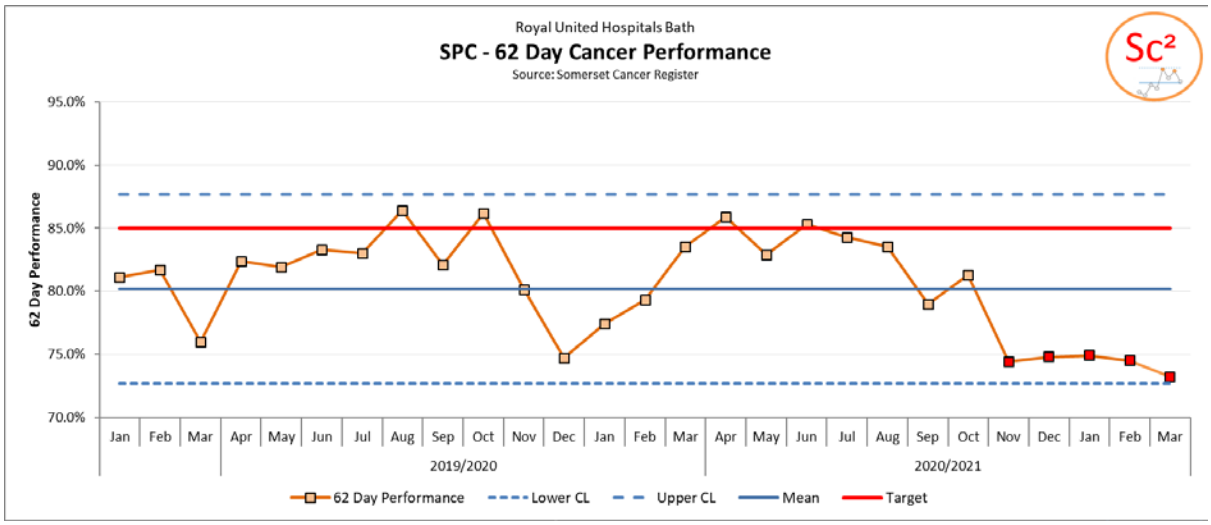


Throughout the year, we have worked closely with lead clinicians to ensure that patients are clinically prioritised to ensure those who need surgery are able to receive treatments and undertaken a full clinical validation of our waiting list to ensure patient safety and we have continued to operate on all urgent and cancer patients throughout the year.

In response to the pandemic, we have also adopted different ways of working, embracing new technologies, such as virtual appointments, to ensure outpatient activity has continued.

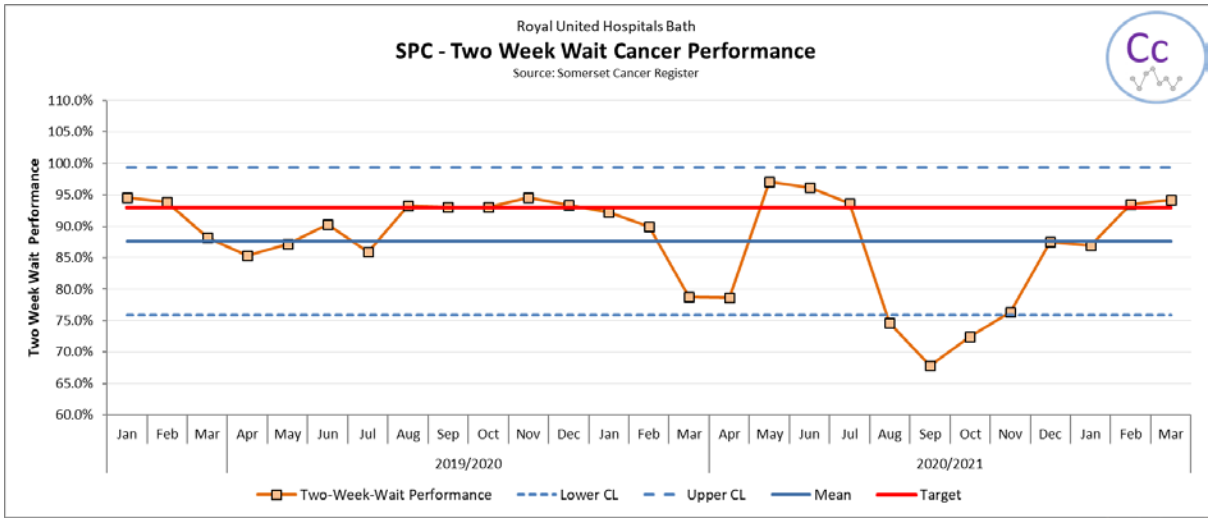
The key focus for 2021/22 will be on our elective recover plan. We are working with clinical teams to ensure we return to pre-covid levels of elective activity and also collaborating with colleagues across BaNES, Swindon & Wiltshire (BSW) and local independent providers to maximise the levels of elective activity to support the reduction in waiting times across all specialties.

<u>Cancer</u>



In 2020/21 Trust performance against the 62 Day GP Referral to Treatment standard has been challenged, with a decline in performance throughout the year, most notably from November 2020. This has been due to higher levels of activity combined with many longer waiting patients receiving treatment during the period.

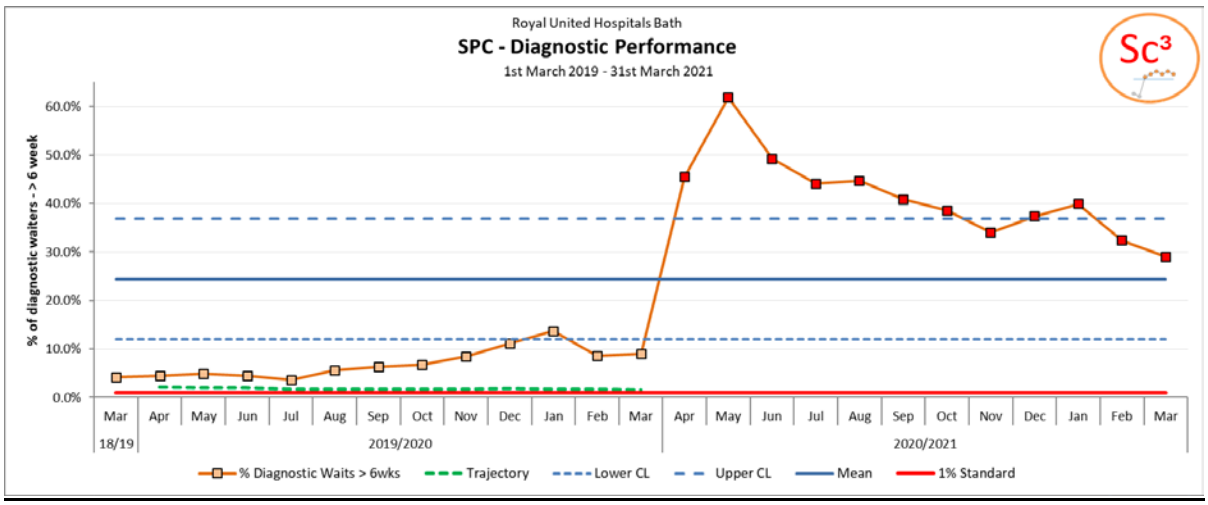
We have actively prioritised cancer activity throughout the pandemic, increasing the number of cases seen but we saw a reduction in patients accessing cancer pathways during lockdowns which has resulted in peaks in demand later the year. Access to diagnostics has also been impacted but considerable work is ongoing to deliver diagnostic capacity over and above pre-covid levels to support a reduction in waiting times.



We saw a similar impact on our two week wait time performance following the first lockdown but teams worked exceptional hard to improve performance in the latter part of the year and achieved the standard of 95% for the last two months.

We will continue to focus on improving cancer waiting times for 2021/22 and are working with the Cancer Alliance to make improvements in our more challenged specialties, with improvement projects underway in Colorectal and Prostate.

<u>Diagnostics</u>



The COVID-19 pandemic led to the cancellation of all routine scanning at the beginning of the year and performance in April 2020 was 45.47%, rising to over 60% in May (against the 1% standard). This position was mirrored both regionally and nationally.

Since the start of the COVID pandemic we have accrued considerable backlogs in diagnostic tests as a result of restrictions caused by the pandemic, including the requirement for staff to use PPE and social distancing in waiting areas. It is anticipated that recovery will take time but a number of steps have already been taken to return diagnostic capacity to pre-covid levels and in some modalities, exceed these.

We have seen a steady increase in activity levels across all modalities over the latter part of the year and an improving performance picture, finishing the year with performance at 30%.

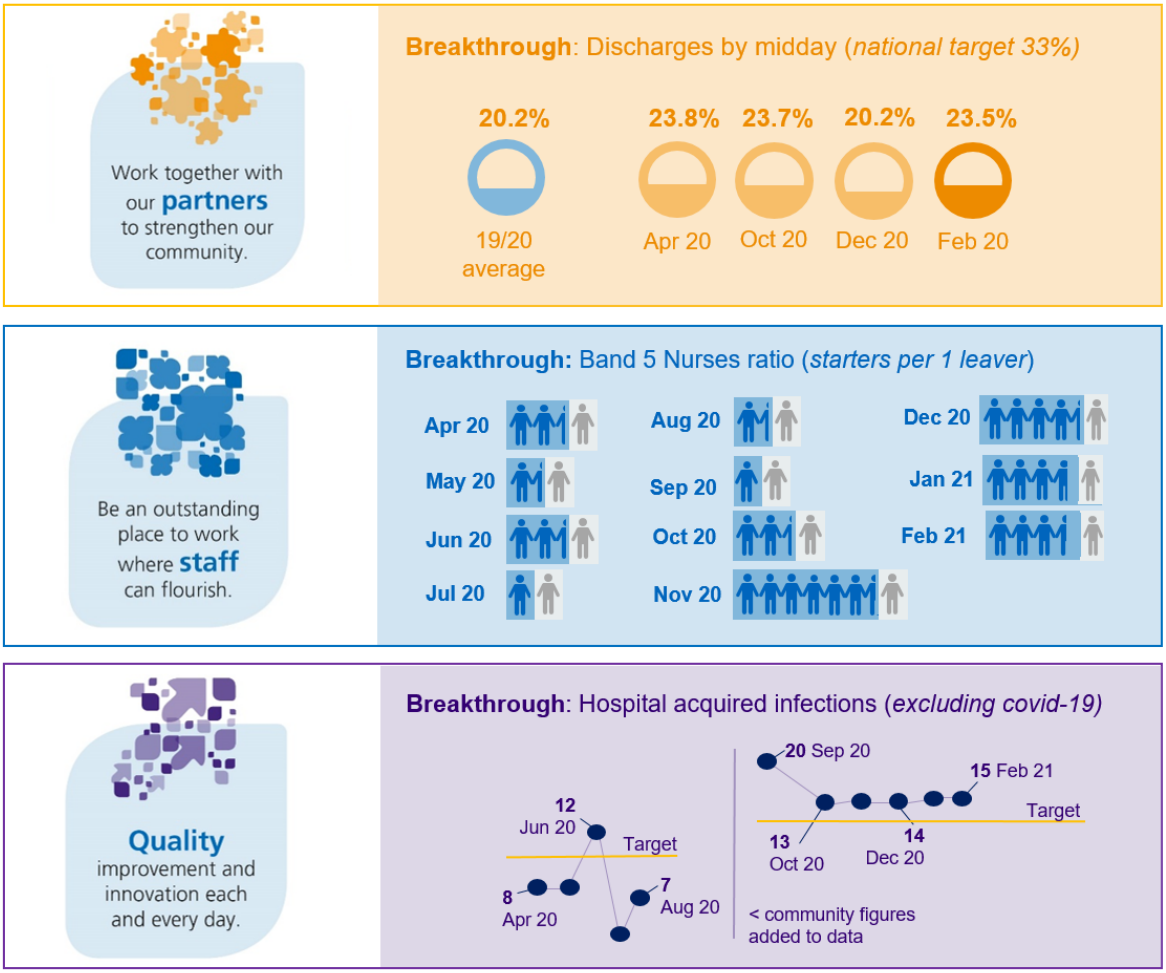
The Trust continues to maximise every opportunity to improve capacity using the Improving Together methodology; monitoring each of the thirteen diagnostic pathways weekly in line with an agreed recovery trajectory.

Improving Together Priorities

To support of our Improving Together Strategic Goals, we identified three Breakthrough Objectives for 2020/21. These were Discharges by Midday, Band 5 Nurse Recruitment and Retention, and Reduction in hospital acquired infections.

Breakthrough Objectives reflect the most pressing quality / performance issues which when addressed will improve performance on our Strategic Goals

A summary of our performance throughout the year against these objectives is illustrated below. We have made good progress in all three areas during the year despite the impact of the pandemic.



Breakthrough Objectives for 2021/22

Following a review of the impact of Covid-19 on our operational and performance targets during 2020/21, we have agreed the following Breakthrough Objectives for 2021/22.

Ambulance handovers replaces discharges before midday as a focus related to the recognistion that our emergency pathways incompass flow through the hospital and the wider system.

Health and wellbeing replaces the workforce focus on band 5 nurse recruitment and retention, and is likely to specifically focus on an improvement in *sickness absence due to stress, anxiety and depression*, which currently represents between a fifth to a quarter of sickness absence.

Infection Prevention and Control is a continuation of one of the 2020/21 Breakthrough Objectives as Hospital Acquired Infections continue to be a key focus for the Trust.

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

Overview of financial performance

In 2020/21 the NHS has been subject to significant challenges as a result of the ongoing COVID-19 pandemic. The impact extended to the financial operations and performance of the organisation, influencing the way the Trust was funded as well its expenditure.

Payments to the Trust for activity on the basis of Payment by Results under standard contracts was suspended and replaced with fixed block funding. This allowed the Trust to continue to strive to provide existing services alongside treating COVID-19 patients. Non-COVID-19 activity dropped significantly across the first half of 2020/21 resulting in a drive after the summer to make inroads into reducing the now significant waiting lists and bring services that had previously suspended back into operation. Going into the winter and most significantly after the New Year, the Trust experienced subsequent surges in COVID-19 activity; this drove up related expenditure and put a halt to elective activity for the second time.

The result of the fluctuating COVID-19 activity levels is reflected in the expenditure across the year. Temporary staff were relied upon to deliver essential services where demand increased and sickness levels increased due to infection, or the requirement to self-isolate or shield. Many employed staff worked additional hours at increased rates to reflect the intensity of the demand and accrued high levels of annual leave that they were unable to take. This all led to large increases in workforce costs in 2020/21.

Income flows from non-patient care services such as catering, car parking and non-clinical services fell dramatically, but the costs of providing these services continued in the most part to be borne by the Trust, as many of the relevant posts are substantive and other overhead costs were maintained. These amounted to additional cost pressures faced by the Trust.

The financial performance of the Trust varied over the period due to the constantly changing financial regime and challenges influencing spend. However, the Trust

closed the year with a surplus of £714,000 as a result of the reversal of a previous impairment on an estate valuation and the net impact of consumables donated from NSHI/E to support the Trust's response to the COVID-19 pandemic. Once the impact of these are removed (as shown in the table below) there was a small deficit of £40,000 due in large part to the need for support funding as outlined above.

	2020/21 £000
Trust surplus for the period as per the Statement of Comprehensive Income	**714**
Reversal of previous impairments as a result of an estate valuation in 2020/21	-397
Capital assets donations and depreciation	-45
Net impact of consumables donated from NHSE/I	-310
Gain on disposal of assets	-2
Adjusted financial deficit for the purpose of system achievement	**-40**

The Trust faces several financial risks going into 2021/22, many of which reflect the national situation within the NHS. The cost of bringing waiting lists back to down to acceptable levels, requirement to recover income levels for non-patient care services to ensure we can cover overheads for such services and ensuring all staff recover the annual leave not taken being the most significant. Plans are in progress to build trajectories and identify where full capacity and performance may not be recovered under new working arrangements, with a big focus on recovering elective capacity to maximise the care we can provide for our communities. National incentive schemes are in place to ensure Trusts deliver as much of this activity as possible.

Capital investment

The Trust invested £32.1m in infrastructure and equipment during 2020/21, (£28.0m in 2019/20). This was funded internally through cash and I&E surpluses, donations and significant additional public dividend capital (PDC) from the Department of Health and Social Care.

Additional PDC funding was provided for COVID-19 related schemes, expansion of critical care provision and investment to address the estate's critical infrastructure risk. Seed funding was provided by the New Hospital Programme both to develop the strategic outline business case and to fund accelerated investment, while winter pressure funding was received for Emergency Medicine. Adoption and adaptation funding was used to increase CT and Endoscopy capacity; Tele-dermatology equipment; Lung Volumetry and Digital Pathology.

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:

- £5.2m on various estates schemes including roof replacement, plant upgrades and emergency lighting to address high and significant risk critical infrastructure backlog.
- £2.7m on the second phase of the RUH Redevelopment programme, including RUH North decant and demolitions and fees for the Cancer Centre (£4.0m in 2019/20)
- £2.6m on other redevelopment schemes including the demolition of John Apley, re-provision of Linen service and office space provision in the main Estates building.
- £1.4m on the development of the strategic outline business case for the New Hospital Programme;
- £2.3m on conversion of Pierce ward to a second intensive care unit (£0.6m in 2019/20);
- £2.8m on schemes related to COVID-19, including medical equipment, IT equipment & Licences and minor works to support new ward configuration for cohort wards (£0.5m in 2019/20);
- £2.5m on reconfiguration of the Emergency Department for same day emergency care, greater access to resuscitation, and trauma assessment unit
- £3.3m on the digital programme, including additional investment in hardware to support changes in working practices, investment in our server infrastructure, telephony, cyber security and clinical systems for Urgent Care and Cardiology;
- £1.0m on implementation of digital Pathology;
- £5.0m on medical equipment, including an additional CT scanner, replacement gamma camera and endoscopy equipment to support expansion of the service.

Going Concern disclosure

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

Environmental matters

Introduction

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

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

In the last year, the Trust published the next 5 year Sustainability Strategy. It focuses on ten themes to make the Trust more sustainable in everything that we do and ensure that we are an organisation that is fit for the future. It also includes a Carbon Reduction Strategy outlining how we plan to contribute to the local and national targets designed to reduce the impact on climate change.

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

Recapping on the last year

Area of focus	Objective	Achievements in the last 12 months	SDAT score 2019/20	SDAT score 2020/21	Trend on last year
Managing our Carbon & Greenhouse Gases	To manage our carbon emissions to remain within safe limits in order to avoid irreversible climate change	• Carbon Reduction Strategy and targets were published • Carbon has become embedded within the Trust's Improving Together Strategy, with the key performance indicators regularly reported to the board	24%	41%	Up
Adapting to Climate Change	Develop sites and services that are resilient to the adverse effects of climate change	• Climate Change has been put on the BAF (Strategic Risk Register) • A piece of work has commenced to evaluate the risk and create adaptation plans to help make the Trust more resilient to climate change	38%	35%	Down
Designing sustainable care models	To improve care whilst maintaining environmental, social and financial	• The Clinical Strategy is evolving as part of the New Hospitals Programme (NHP), and is considering how we	24%	31%	Up

	sustainability	deliver care for the better of our patients and the environment.			

Enabling sustainable travel & logistics	To be a Trust that approaches travel in a way that is innovative and prioritises sustainable modes of transport that are accessible to all	• The Non-Patient Travel Plan was signed off and published
		• Working from home has been encouraged and supported
		• Fleet vehicles have started to transition to electric alternatives
		• Numerous enabling projects have been implemented:
		  • free bikes
		  • loan bike
		  • Wayfinding maps
		  • Voi electric scooter docking stations
			28%	54%	Up

Embedding sustainability	To become a thriving organisation that delivers benefits that extend beyond the traditional organisational boundaries whilst maintaining the highest quality of care.	• The Sustainable Development Management Plan (Strategy) was signed off at board level and shared publically • Working with the Bath, Swindon and Wiltshire Integrated Care System (ICS) to embed and standardise sustainability across the region.	25%	40%	Up
Managing our assets & utilities	To manage the trust's operational assets in a way that continually improves their efficiency and longevity	• Energy & Infrastructure Strategy underway to identify route to net zero for direct emissions. • Energy projects underway including; BMS upgrades; window replacements; and lighting upgrades.	38%	51%	Up
Using resources sustainably	To ensure that we do not extract or pollute at a greater rate than nature regenerates	• An Anytakers trial, which rehomes unwanted furniture in one part of the site to a new home somewhere else on site, was completed avoiding over £3,129 to purchase new items and saving 2148 kg of embodied carbon. • During the RUH North demolition Estates saved a further 15, almost new, items of furniture that would have otherwise been thrown into the skip.	35%	43%	Up
Creating a	To ensure that	• Sustainability principles	40%	30%	Down

sustainable built environment	sustainability underpins the design and construction of our capital projects	are underpinning the Estates solution for the New Hospitals Framework. • Work has commenced to identify what our minimum specification for buildings should be in regards to sustainability and Net Zero Carbon. • We have input to the NHSi/E standard for NZC buildings which is due for publication in November 2021.			
Empowering our people	To create a supportive environment where all our people feel motivated and empowered to consider sustainability in everything they do	• Launched a behaviour change programme called Green Impact to help guide teams in implementing sustainable actionsS • upporting the Coach House to deliver workshops on sustainability to contribute to teams KPIs at a local level.	60%	71%	Up
Enhancing Greenspace	To Protect and enhance the natural systems that we rely on, realising the benefits this brings to the health of our diverse population	• Greenspaces map was created and shared with staff to enjoy the areas on site • Started to work on a Greenspaces and Biodiversity Management Plan	18%	33%	Up

Key areas of Focus

We have a couple of areas that we are prioritising at the moment, as follows:

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

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

A complete review of our carbon footprint has been undertaken to bring it in line with current best practice. References to Scope 1, 2 and 3 emissions relate to the extent to which an organisation has control of or is response for these. Scope 1 are direct emissions from owned or controlled sources, whole Scope 2 cover indirect emissions from the generation of purchased electricity, steam, heating and cooling consumed by the organisation. Scope 3 includes all other indirect emissions that occur in a company's value chain. The Trust came up with three steps to reducing our carbon

footprint that comply with the Climate Change Act, and also support B&NES local plan to become carbon neutral by 2030. These are:

1. Drive down our Scope 1 and 2 emissions to net zero by 2030. These scopes are within our direct control. This will involve reducing our emissions as far as practicable, with the remaining being offset, inset or captured according to relevant guidelines and certified methods.
2. All Scope 3 emissions will be measured and monitored as accurately as possible by 2025, and a target set for reduction of Scope 3 by 2030. Until we measure, we cannot manage, and cannot set a definitive medium target for Scope 3. A target will be quantified in the 2025-2030 SDMP at the latest.
3. By no later than 2050 the Trust will be net zero across all 3 scopes. Our progress will be monitored annually, with a revised strategy each 5 years.

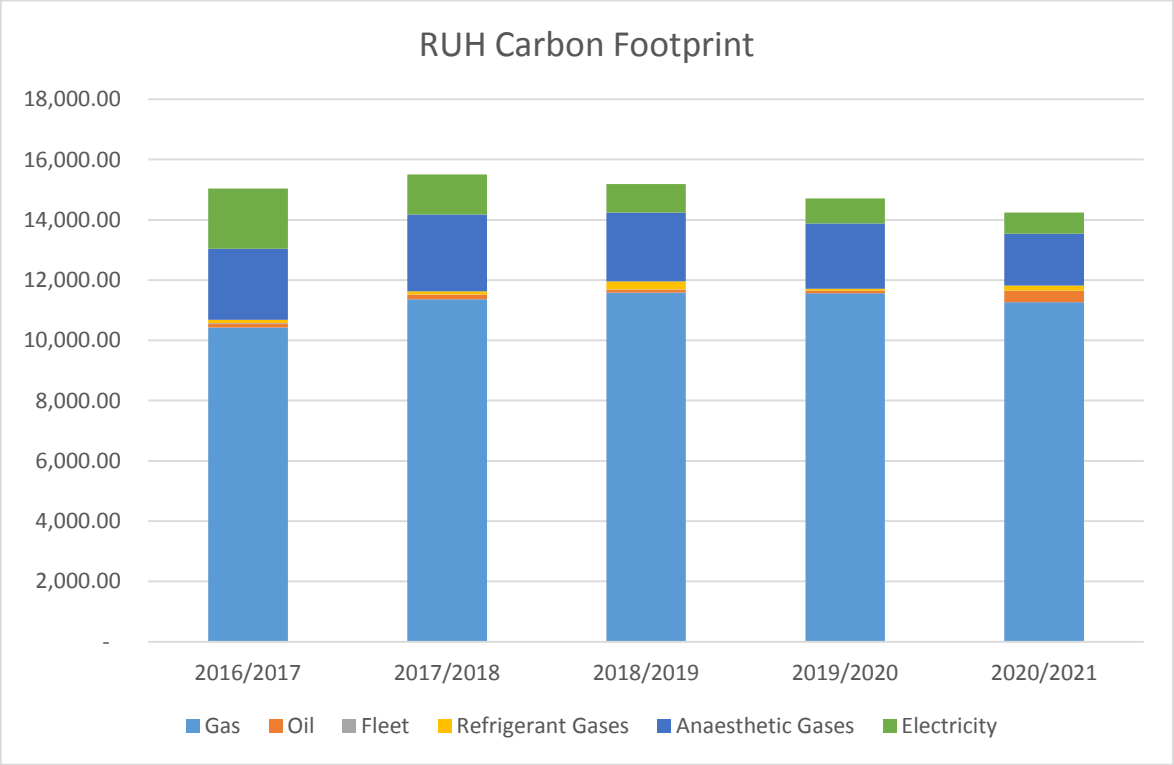


Figure 1 The Trust's Carbon Footprint for Scope 1 and 2 emissions over the last 5 years illustrating a small decline from 2017/2018, but a requirement for ambitious and challenging targets to achieve net zero carbon.

Reducing our impact on Air Quality

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

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

certain respiratory diseases". - Jay Suntharalingam Respiratory Consultant at the RUH

The Trust monitors the Nitrogen Oxide levels onsite in order to understand the air quality in the area. Diffusion tubes are placed across the site and are analysed monthly. During 2020/21 year, the Sustainability Team continued to run initiatives to reduce air pollution on site including:

- Switch off when you drop off campaign in Estates contractors car park and at the main bus stop
- Park & Stride from the Newbridge Park & Ride site, to keep vehicles away from local streets including a digital map and physical wayfinding signs to show the best route
- Procurement of first fast charging plug in electric vehicle and EV charging
- 94 Cyclesheme Certificates issued
- E-Bike Loan scheme – 100% positive feedback from 30 people who took out month-long loans

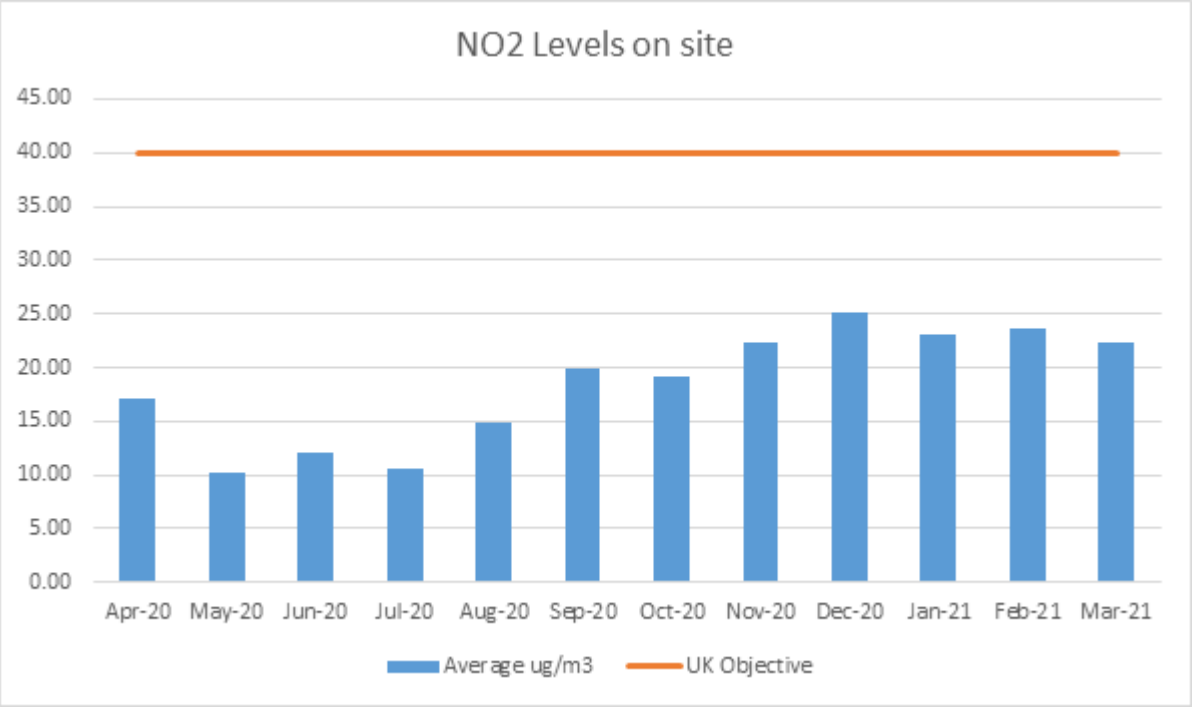


Figure 2 Average Nitrogen Dioxide levels across the site, compared to the UK legal limits

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

The Trust has identified a material and non-adjusting post balance sheet event. On 1 June 2021 the Trust acquired the entire issued share capital of Circle Hospital (Bath) Ltd. The name will be changed to The Sulis Hospital, Bath.

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 and included within the financial performance of the group as set out in the financial statements.

The RUH Charitable Funds is managed by, and operates separately from, the main services provided by the Trust. 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. The financial position of the Charity is reported within the financial performance of the group as set out in the financial statements.

Signed

Cara Charles-Barks

Chief Executive

Accountability report

Directors' report

Directors' responsibility for the annual report and accounts

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

Directors of the Trust

Directors of the Royal United Hospitals Bath NHS Foundation Trust during 2020/21:

Alison Ryan	Chair
Joanna Hole	Non-Executive Director Vice Chair and Senior Independent Director (until 31 October 2020)
Jeremy Boss	Non-Executive Director Vice Chair and Senior Independent Director (from 1 November 2020)
Nigel Stevens	Non-Executive Director
Sumita Hutchison	Non-Executive Director
Anna Mealings	Non-Executive Director
Ian Orpen	Non-Executive Director (from 7 September 2020)
Antony Durbacz	Non-Executive Director (from 1 November 2020)
James Scott	Chief Executive (until 31 May 2020)
Cara Charles-Barks	Chief Executive (from 1 September 2020)
Libby Walters	Deputy Chief Executive & Director of Finance (Acting Chief Executive for the period from 1 June 2020 to 7 September 2020)
Simon Wade	Interim Director of Finance (from 1 April 2020 to 7 September 2020
Bernie Marden	Medical Director
Lisa Cheek	Director of Nursing & Midwifery (until 11 March 2021)
Sarah Merritt	Interim Director of Nursing and Midwifery (from 13 to 31 March 2021)
Simon Sethi	Chief Operating Officer (from 13 January 2021)

Rhiannon Hills	Interim Chief Operating Officer (from 17 August 2020 until 12 January 2021)
Claire Radley	Director for People*
Jocelyn Foster	Director of Strategy*
Brian Johnson	Director of Estates and Facilities*

*Non-voting members

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

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

The Board of Directors

Non-Executive Directors

Alison Ryan, Chair (Appointed: 1 April 2019)

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

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 until 31 October 2020

Joanna chaired the Non-Clinical Governance Committee, was a member of the Audit and Risk Committee, and sat on the Board of Directors' Nominations and Remuneration Committee. She was 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. Joanna left the Board on 31 October 2020 having served with distinction for six years.

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

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

Jeremy served until 4 January 2021 as chair of the Audit and Risk Committee. He also chairs the Charities Committee and from 22 December 2020, became chair of the newly formed Finance and Performance Committee. Jeremy is also a member of the Commercial Transactions Steering Group and the Board of Directors' Nominations and Remuneration Committee. In addition, he is the Board lead on End of Life and Learning from Deaths. He has a BSc (Hons) in Economics from the University of Warwick and is a Fellow of the British Computer Society and a Fellow of the Institute of Chartered Accountants in England and Wales (ICAEW). 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 (now re-named Quality Governance Committee) and is a member of the Board of Directors' Nominations and Remuneration, Finance and Performance, 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 worked as Chief Operating Officer for Keolis UK, a role he combined with wider work in the commercial and public sectors on future transport solutions.

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

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

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

Anna chairs the People Committee, and is a member of the Quality Governance, Finance and Performance and Board of Directors' Nomination and Remuneration Committees. 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.

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

Ian joined the Board in September 2020 as the Trust's first dedicated clinically qualified non-executive director. He previously worked as a General Practitioner in the Bath area and served as Clinical Chair at the Bath and North East Somerset Clinical Commissioning Group from 2013 to 2020. In that capacity, Ian held the role of stakeholder governor on the RUH's Council of Governors right from the Trust's authorisation as a Foundation Trust in 2014. Ian is a member of the Quality Governance, People and Non-Clinical Governance Committees, and he is the Board lead for Children and Young People and Safeguarding.

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

Antony is a chartered accountant by background and an experienced Non-Executive Director. Before he joined the RUH Board in September 2020, he had previously served as a Non-Executive Director and Chair of the Audit Committee at Taunton and Somerset NHS Foundation Trust. He is also Chair of the Audit Committee at LiveWest, one of the largest housing associations in the South West. Antony has held a number of senior finance roles, mainly in the manufacturing sector. On the RUH Board, he chairs the Audit and Risk Committee, and sits on the Finance and Performance and Non-Clinical Governance Committees. He leads on environmental matters, infrastructure and estates.

Executive Directors (voting)

James Scott, Chief Executive (Appointed: June 2007)

James worked at Chief Executive level across the West Country for over 20 years, the last 13 of which were spent at the RUH. He retired from his role at the end of May 2020, having delayed his departure to help the Trust manage through the early stages of the COVID-19 pandemic.

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

Cara has worked at board level within the NHS since 2008, including as Chief Operating Officer and Deputy CEO at Hinchingbrook Healthcare NHS Trust, and more latterly as CEO at Salisbury Foundation Trust between 2017 and 2020. Before that, Cara held senior roles in her native Australia, including as Nursing Director at the Queen Elizabeth Hospital in Adelaide, South Australia. She holds Bachelors and

Master's Degrees in Nursing as well as an MBA from the University of Adelaide. Cara has no declared interests.

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 served as Interim Chief Executive of the Trust between 1 June and 7 September 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. His brother is a Consultant Gastroenterologist at the RUH.

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 left the RUH in March 2021 to take up the role of Chief Nurse at neighbouring Great Western Hospitals NHS Foundation Trust.

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

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

<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, Director of Strategy (Appointed: July 2012)

Joss was previously Director of Business Strategy for Kent County Council, Strategy Director at (Parcelforce) Royal Mail, Strategic and Corporate Development Director at Leicestershire Partnership NHS Trust, and has previous public and private sector experience in business strategy, planning, transformation and new business development. Joss has an MBA, DPhil, and BSc (Hons) in Biological Sciences. Her declared interests for 2020/21 was a financial interest in Veloscient Ltd, a company dedicated to 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. As part of the NHS response to the COVID-19 pandemic in the South-West, Brian took on the additional role of Director of Estates and Facilities for the Bristol Nightingale Hospital.

Contact with the Directors

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

Register of interests

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

Additional Directors' report disclosure

Cost Allocation and Charging Requirements

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

Political Donations

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

Better Payment Practice Code

The Trust is required, by the national "better payment practice code", to aim to pay all valid invoices within 30 days of receipt, or the due date, whichever is the later. Over the 12 months to 31 March 2021, 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	68,121	242,704
Total bills paid within target	65,909	227,774
Percentage of bills paid within target	**96.8%**	**93.8%**
NHS		
Total bills paid in the year	1,526	15,153
Total bills paid within target	982	7,773
Percentage of bills paid within target	**64.4.0%**	**51.3%**
Total		
Total bills paid in the year	**69,647**	**257,857**
Total bills paid within target	**66,891**	**235,547**
Percentage of bills paid within target	**96.0%**	**91.3%**

Total interest paid to suppliers under the Late Payment of Commercial Debts Act 1998 was £1k (£0 in 2019-20).

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. However, the declaration of the COVID-19 pandemic meant that the inspection was suspended and did not take place during 2019/20. The CQC have since consulted on what their future inspection activity might look like and the outcome of this process is that going forward, they will adopt a more risk based approach to the programme, focusing initially on organisations that are rated as inadequate or requiring improvement. The trust will of course continue to ensure that it is meeting both the letter and the spirit of the Well-Led framework.

In January 2021, the CQC carried out short notice a focused inspection of the Trust's Urgent and Emergency Care service as part of their winter pressures programme. The inspection lasted a day and a half. Because of its narrow focus, it did not impact either the Trust's overall rating or that of the service. The main overall finding from the inspection was that the service has good systems in place to ensure that it provided safe care, but there were not always sufficient numbers of nursing staff available, particularly at night. In response to the specific question whether the service is well-led, the inspectors found that its leaders had the skills and abilities to run the service and that they understood and managed the priorities and issues that it faced. They were also found to be visible and approachable both to patients and staff.

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 2021/22, 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

Improving Patient and Carer Experience

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

As a result the Trust is able to focus on projects to improve patient experience, such as:

- Work with Outpatient staff to identify issues for patients about information and communication with outpatients and responding quickly to patient concerns.
- Set up a Patient and Carer Experience Partnership to link with local community organisations, voluntary organisations and social care groups to actively collect patient experience of the RUH from the community, particularly those with protected characteristics and hard to reach groups.
- Set up an RUH Operational Improving Patient Experience Group to drive learning and actions identified through patient experience feedback.

Collecting patient feedback to improve our services

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

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

Friends and Family Test (FFT)

In April 2021 we implemented the new national FFT question using cards as well as an online tool. The RUH chose to also include three additional questions relating to the RUH Patient Goal; to be recognised as a listening organisation, patient-centred and compassionate to enable us to measure our performance in achieving this goal.

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 virtual Board meeting to share what has changed as a result of the patient/carer story. Their story is either filmed, voice-recorded or the patient/family member shares their experience in person by attending the virtual Board meeting. 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, for example:

- A male patient shared his experience of the Frailty Assessment Unit (FAU) which at the time was located in the Emergency Department (ED). He was very impressed with the care and treatment that he received there and felt it was an area of calm away from the large numbers of patients in ED. However, he felt that the parking facilities were poor as there were no spaces located near to FAU and there were no immediate toilet facilities in FAU. He explained that patients had to access toilets in ED which were inadequate and unpleasant, and in his opinion a definite contamination problem. As a result of

his experience a review of FAU has been undertaken. The unit is being re-located to ACE ward where there are better and improved toilet facilities close to the assessment area. A review of parking spaces near to the new location has also been undertaken.

- A female patient shared her experience of having elective orthopaedic surgery (hip replacement) during the COVID pandemic and her experience on Philip Yeoman ward. She said she felt well-prepared coming in to hospital and reassured by the measures that the Trust had put in place to protect her from getting COVID – Perspex panels between bed spaces, staff compliance with Personal Protective Equipment (PPE) and regular swabbing. As a result of the pandemic, the Physiotherapy team have had to adapt the 'hip and knee club' face to face meetings and have developed a short film for patients preparing them for surgery. Patients can watch the film at home or on an iPad during their pre-assessment as well as on admission to hospital. The advice booklets have also been updated.

<u>See It My Way</u>

In 2020/21, the Trust suspended 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, due to the pandemic.

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

We plan to reintroduce a virtual programme in 2021/22.

<u>Complaints handling</u>

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 was 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.

This year the Trust received 249 complaints compared to 305 in the previous year. There was a noticeable reduction in the number of complaints received during the first 6 months of the COVID pandemic. The majority of complaints related to communication issues and clinical care and concerns.

On receipt of a complaint, staff are encouraged to seek to resolve concerns at the time either through informal meetings or conversations on the telephone. We have

developed and published guidance on our internal website to help staff effectively manage concerns informally where possible. Staff are also trained in how to manage the formal complaint process, including complaint meetings. This training has been given to junior doctors as well as junior and senior Sisters.

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

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

Hospital questionnaires

During 2020/21 the Patient Experience Team supported 49 RUH services to collect patient and carer feedback and use the information to improve their service, for example:

- **Hospital Multimedia Entertainment System** – A review of TV, radio facilities available to patients, to understand what patients and potential patients, and their carers and families would like available whilst they are in hospital. Feedback from staff was used to inform the system to replace Hospedia at the end of March 2021. Patients can use their mobile phones, tablets and laptops to connect to the NHS Wi-Fi and access services like Netflix, iPlayer and online radio, including Bath Radio, the hospital's own station.

- **Interpreter and Translation Services** – A review was undertaken of the provision of interpreting and translation services to understand what works well and what could be improved. This fed into the STP Service Tender Submission for Interpreting and Translation Services.

- **Outpatient Appointment experience** – as a result of the COVID pandemic, an increasing number of outpatient appointments were made by telephone or by video rather than face to face. The Trust was keen to find out whether this had an impact on their experience or the quality of the consultation. As a result of their feedback, leaflets were developed and

given to patients in how to best prepare for their telephone appointment and also a guide for staff.

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.

Responding to patient experience feedback during the pandemic

The impact of the pandemic on patient experience has been evident with the restrictions on visiting and volunteers on the wards. The patient experience team worked with the Arts Programme Manager to develop a range of **art and craft activities**, 'Boredom Buster' newspapers, crossword puzzles, etc.

The Patient Advice and Liaison Service team also introduced the **Keeping in Touch service.** Families use a generic e-mail address to send messages to their loved ones during their hospital stay. These messages are sent to the wards with a card from the PALS team. From the start of the pandemic to the end of December, the service received approximately 960 messages from family and friends. Families have also been able to bring in items of **food and clothing** to main reception for these to be taken to wards.

To maintain communication between families and patients, each ward was given an iPad and iPhone to enable **virtual visiting** to take place. This has made a real difference to patient and family experience.

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

We have had a number of patients contacting the PALS service enquiring about when their outpatient would be as **waiting times** have increased over the last year. A review of the Trust's external web pages highlighted that the information wasn't easy to understand or kept up to date. This was reviewed and is now updated every month.

Stakeholder relations

West of England Academic Health Science Network (WEAHSN)

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

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

Third Sector

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

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

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

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

Undergraduate and postgraduate medical training

Undergraduate medical students: The RUH hosts Bath Academy as a teaching hub for Bristol University Medical School, supporting the education and training of nearly 400 medical students, equating to 9000 student weeks, per year. Around 25

Consultants act as Coordinators and Tutors providing and organising the teaching of medical students. They work alongside eight Clinical Teaching Fellows (Junior Doctors) as the keystone to providing the teaching both on the wards and in the classroom.

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

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

The General Medical Council and Health Education England are moving forward on a multi-professional education agenda. At the RUH, we continue to explore non-medical workforce options, such as Physician Associates and Advanced Nurse and Physiotherapy Practitioners. 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.

Primary care services

During 2020/21, the Trust continued to work closely with 22 Primary Care Networks across BSW to support them both in their short term aim of making general practice financially sustainable and their longer terms goal of improving access and care.

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.

The COVID-19 pandemic meant that the roll out of training on the Trust's organisational development and improvement methodology, Improving Together, was suspended during most of 2020/21. As the pressures on the hospital and staff eased towards the end of the year, however, the training programme was adapted for online delivery and it has now resumed. The original aim of building the RUH's staff into an army of improvers remains, and concrete steps are being taken to embed Improving Together across the organisation, including using it as the basis for Board and Board Committee reporting.

Consultation with local groups and organisations

Unfortunately, during 2020/21, much of the Trust's routine engagement with local groups and organisations was suspended, both because it became impossible during the peak of the pandemic for anyone to visit the hospital for non-clinical purposes, but also as the vast majority of our staff were engaged, in one way or another in helping to manage the impact of COVID. That said, the support from both our existing and new volunteers, our Foundation Trust members, the Friends of RUH, colleagues from Healthwatch in BaNES and Wiltshire, and other groups and individuals were greatly appreciated.

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

Research

During 2020/21, the RUH responded to the changed focus of research activity towards COVID-19. As one of the most research-active district general hospitals in the county, it was and remains involved in a series of relevant and timely trials and projects, including:

- contribution to a large study around acute respiratory problems linked to infectious diseases
- participation in a trial that considered treatment options for COVID-19, the outcomes of which influenced practice around the world, and

- identification as one of the key sites for a short study considering the safety and immune responses to giving COVID and flu vaccines at the same time.

Statement as to disclosure to the auditor

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

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

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 2020/21 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. However, the Trust has not directly consulted with the wider employee body in setting the remuneration policy for senior managers

Remuneration of Senior Managers

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

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

Individual performance is reviewed through the Trust's appraisal process to evaluate the extent to which the Chief Executive and Executive Directors have met their objectives and contributed to the delivery of the Trust's strategic objectives. The annual review comprises, where applicable, a cost of living uplift 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 organisation's 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 24 February 2021 to consider among other items the Chief Executive and Executive Directors' remuneration and performance bonus for 2020/21. The meeting was chaired by Alison Ryan, Chair, and was attended by Jeremy Boss, Sumita Hutchison, Anna Mealings, Nigel Stevens, Ian Orpen and Antony Durbacz, Non-Executive Directors.

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. On that basis, 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.

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

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

Details of all directors' attendance at Board and Board Committee meetings are set out at pages 62 to 64 of this report.

Annual Report on Remuneration

Service Contracts

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

The Service Contract for Non-Executive Directors is not an employment contract. Non-Executive Directors are appointed for an initial term of up to three years and are eligible for further terms of appointment 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
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 2024	01-April 2021- 31 Mar 2024	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
Ian Orpen **Non-Executive Director**	07-Sept-2020- 31-Aug-2023	07-Sept-2020- 31-Aug-2023	3 months
Antony Durbacz **Non-Executive Director**	07-Sept-2020- 31-Aug-2023	07-Sept-2020- 31-Aug-2023	3 months
Libby Walters **Deputy Chief Executive & Director of Finance**	04-Jun- 2018	N/A	6 months
Bernie Marden **Medical Director**	30-Apr-2018	N/A	6 months
Simon Sethi **Chief Operating Officer**	17-Jan-2021	N/A	6 months
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. The full list of Executive and Non-Executive Directors who served during 2020/21 is set out in pages 54 and 55 below.

Governors' expenses

Governors are not remunerated, but are entitled to claim expenses for costs incurred whilst undertaking duties for the Trust as a Governor (for example, travel expenses to attend Council of Governors' meetings). A total of £117.65 was paid to 2 Governors (out of 21) Governors) in the period 1 April 2020 to 31 March 2021 (£1,395.78 was paid to 10 Governors in the period 1 April 2019 to 31 March 2020).

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

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

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	10-15	-	-	-	10-15
Nigel Sullivan **Non Executive Director** (to 31.07.19)	5-10	-	-	-	5-10
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

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 2021 (bands of £5,000)	Lump Sum at Pension Age, Related to Accrued Pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2020	Real Increase in Cash Equivalent Value Transfer	Cash Equivalent Transfer Value at 31 March 2021	Employer's Contribution to Stakeholder Pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cara Charles-Barks **Chief Executive**	2.5-5	0-2.5	35-40	50-55	477	29	554	16
James Scott **Chief Executive**	0	0	0	0	0	0	0	0
Lisa Cheek **Director of Nursing & Midwifery**	0-2.5	5 - 7.5	45 - 50	140 - 145	1,033	47	1,096	16
Jocelyn Foster **Director of Strategy**	0-2.5	0 - 2.5	20 - 25	20 - 25	295	23	335	17
Bernie Marden **Medical Director**	2.5 - 5	2.5 - 5	65 - 70	140 - 145	1,168	72	1,268	28
Libby Walters **Director of Finance & Deputy Chief Executive**	2.5 - 5	7.5 - 10	55 - 60	120 - 125	856	72	951	23
Simon Wade **Acting Director of Finance**	2.5-5	5-7.5	35-40	75-80	483	43	601	6
Claire Radley **Director for People**	0 - 2.5	0 - 2.5	5 - 10	0 -5	87	12	115	16
Rebecca Carlton **Chief Operating Office**	0 - 2.5	0 - 2.5	35 – 40	65 - 70	566	9	608	7
Rhiannon Hills **Acting Chief**	0-2.5	0-2.5	25-30	50-55	354	22	420	6

Operating Officer								
Simon Sethi **Chief Operating Officer**	0-2.5	0-2.5	25-30	40-45	292	1	318	4
Brian Johnson **Director of Estates and Facilities**	0 - 2.5	0 - 2.5	0-5	0-5	32	11	55	14

No directors received any taxable benefits during 2020/21. The Trust does not pay its directors long-term performance-related bonuses.

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

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

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

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

In considering senior manager pay, the Nominations and Remuneration Committee is mindful of the content of the Trust’s Equality, Diversity and Inclusion Policy which clearly articulates the Trust’s goal of creating a workplace in which all staff feel valued. One of the ways by which the Committee seeks to ensure progress towards realising this goal in the context of senior manager pay is testing the impact that such pay has on the narrowing or widening of the gender pay gap. The Trust

publishes its audit of this gap each year, and the Committee ensures that the setting of senior manager pay does not hamper efforts to narrow the gender pay gap.

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

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

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

Any performance pay is paid retrospectively for the previous annual period of performance. For 2020/21, 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 2020/21 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

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 2021 was £210,000-£215,000 (to 31 March 2020: £215,000-£220,000). This was 6.54 times the median remuneration of the workforce (31 March 2020: 7.1), which was £32,178 (31 March 2020: £30,448).

In 2020-21, three employees received remuneration in excess of the highest paid Director (to 31 March 2020: four). Remuneration for the year ranged from £2,528 to £240,999 (31 March 2020: £10,000 to £223,297).

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 2020-21 or 2019-20 for loss of office. Any compensation payable for loss of office is conducted under the terms and conditions of the appropriate contract of employment.

Payments to past senior managers (on exit payments)

There were no payments to past senior managers during the reporting period. (31 March 2020: one).

	Term of Appointment	Board of Directors	Audit Committee	Non-Clinical Governance Committee	Quality Governance Committee (previously Clinical Governance Committee)	Nominations and Remuneration Committee	Commercial Transactions Steering Group	Charities Committee	Finance and Performance Committee	People Committee
					Attendance/actual/maximum					
Non-Executive Directors										
Alison Ryan, **Chair**	1/04/2019-31/03/2022	9/9	-	-	-	3/3	8/8	3/4	-	-
Joanna Hole, **Vice Chair and Senior Independent Director**	01/04/2011 - 31/10/2020	-	2/2	2/2	-	-	-	-	-	-
Jeremy Boss, **Vice Chair and Senior Independent Director**	06/03/2017-05/03/2023	9/9	3/3	-	-	3/3	8/8	4/4	3/3	2/2
Nigel Stevens	01/04/2018-31/03/2024	8/9	4/4	-	6/6	2/3	7/8	-	3/3	-
Sumita Hutchison	04/09/2019-03/09/2022	6/9	2/2	5/5	-	2/3	-	-	2/3	4/4
Anna Mealings	04/09/2019-03/09/2022	7/9	-	-	6/6	2/3	-	-	3/3	4/4
Ian Orpen	07/09/2020-06/09/2023	5/5	-	4/4	3/4	3/3	-	-	-	3/3
Antony Durbacz	01/11/2020-31/10/2023	3/3	2/2	3/3	-	2/2	5/8	-	2/3	-

	Term of Appointment	Board of Directors	Audit Committee	Non-Clinical Governance Committee	Quality Governance Committee (previously Clinical Governance Committee)	Nominations and Remuneration Committee	Commercial Transactions Steering Group	Charities Committee	Finance and Performance Committee	People Committee
Attendance/actual/maximum										
Executive Directors										
Cara Charles-Barks, **Chief Executive**	01/09/2020-ongoing	5/5	-	-	-	3/3	8/8	-	3/3	3/3
James Scott **Chief Executive**	01/06/2007 - 15/04/2020	2/2	-	-	-	-	-	-	-	-
Libby Walters **Interim Chief Executive** *(from April 2020 – September 2020)*	*15/04/2020 – 01/09/2020)*	2/2	-	-	-	-	-	-	-	1/1
Libby Walters **Deputy Chief Executive & Director of Finance**	01/06/2018 – ongoing	5/5	3/3	4/4	-	-	7/8	3/3	3/3	½
Simon Wade **Interim Director of Finance**	01/04/2020 – 01/09/2020	2/2	1/1	1/1	-	-	-	1/1	-	-
Lisa Cheek, **Director of Nursing & Midwifery**	01/08/2018 – 01/03/2021	8/8	-	-	5/6	-	-	4/4	-	¾

	Term of Appointment	Board of Directors	Audit Committee	Non-Clinical Governance Committee	Quality Governance Committee (previously Clinical Governance Committee)	Nominations and Remuneration Committee	Commercial Transactions Steering Group	Charities Committee	Finance and Performance Committee	People Committee
Attendance/actual/maximum										
Sarah Merritt **Interim Director of Nursing & Midwifery**	01/03/2021 – 01/04/2021	1/1	-	-	-	-	-	-	-	-
Bernie Marden **Medical Director**	01/04/2018 – ongoing	9/9	-	-	4/6	-	-	-	-	¾
Jocelyn Foster **Director of Strategy**	01/07/2012 - ongoing	8/9	-	4/5	-	-	8/8	4/4	-	¾
Simon Sethi **Chief Operating Officer**	15/01/2021 - ongoing	2/2	-	0/2	-	-	-	-	2/2	-
Rhiannon Hills **Interim Chief Operating Officer**	01/07/2020 - 15/01/2021	3/3	-	2/2	-	-	-	-	1/1	½
Rebecca Carlton **Chief Operating Officer** *(until July 2020)*	01/04/2019 – 01/07/2020	4/4	-	1/1	-	-	-	-	-	1/1
Claire Radley **Director for People**	01/04/2018 - ongoing	8/9	-	2/2	-	2/3	-	-	-	4/4
Brian Johnson **Director of Estates & Facilities**	01/04/2019 – ongoing	9/9	-	5/5	-	-	8/8	-	-	4/4

Signed

Cara Charles-Barks

Chief Executive (Accounting Officer)

June 2021

Staff report

Analysis of staff numbers

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

	Permanently Employed	Other	2020/21 Total	2019/20 Total
	Number	Number	Number	Number
Medical and dental	624	16	640	600
Ambulance staff	0	0	0	2
Administration and estates	801	115	916	766
Healthcare assistants and other support staff	1465	111	1576	1,535
Nursing, midwifery and health visiting staff	1334	143	1477	1,373
Scientific, therapeutic and technical staff	450	9	459	424
Healthcare science staff	141	2	143	143
Total average numbers	**4815**	**396**	**5211**	**4,843**

Analysis of staff costs for 2020/21

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

Analysis of staff costs for 2019/20

Employee Expenses 19/20	Permanently Employed	Other	Total
	2020/21 £000	2020/21 £000	2020/21 £000
Salaries and wages	176,690	3,112	179,802
Social security costs	17,716	0	17,716
Apprenticeship levy	1,400	0	1,400
Pension cost - employer contributions to NHS pension scheme	30,907	0	30,907
Temporary staff - agency/contract staff	0	7,276	7,276
NHS charitable funds staff	559	0	559
Total Gross Staff Costs	**227,272**	**10,388**	**237,660**

Gender Analysis

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

- Directors
- Other Senior Manager
- Employees

Position at 31st March 2021			
	Female	Male	Total
Directors*	4	3	7
Other Senior Managers	61	35	96
Other Employees	4300	1294	5594
Total	4365	1332	5697

* As no Permanent Director for Nursing was in post on 31st March, the position is not represented in the figures. (Previous holder left 29th March, successor started 5th April - both female)

Sickness absence data

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

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Staff policies and actions applied during the financial year

The NHS People Plan has been launched and the Trust welcomes and supports the approach and principles set out in the People Plan including the NHS People Promise.

We are a Team

In this financial year we have continued to be a member of the Disability Confident Scheme and have been awarded level 2 Disability confident employer accreditation. In the upcoming year we are looking to expand on this by publishing guidance for staff and managers on supporting staff with reasonable adjustments, in addition to our existing policies and support mechanisms. Training is available either virtually or face to face and support is given to any staff member who may need additional support to complete modules.

The Trust had a very successful Health and Wellbeing week this year which included stands promoting our Equal abilities staff networks which provided staff information on what adjustments were available and education on disabled people in the workforce. Additionally, our catering team produced a variety of food from different countries for our staff to enjoy and taste.

We work flexibly

Agile working has been implemented where we are able, and continues to be embedded across the Trust allowing greater opportunities for our staff to work flexibility. We have provided 1,400 laptops to allow our staff to work from home during the COVID19 pandemic. We additionally have provided the opportunity for staff to feedback via a survey on how they find working from home and continue to actively act on the feedback provided.

We are always learning

Throughout the pandemic we have continued to support individuals professional and personal development needs with access to a variety of apprenticeship schemes allowing our staff to flourish in the work environment and a variety of learning and development opportunities.

We are safe and healthy

This year the Health and Wellbeing of our staff has been our top priority and we have continued to support our staff to access a wide variety of support mechanisms. For example; our EAP programme and Occupational Health Service and an extra day's leave badged as a well-being day. All staff have had access and are encouraged to complete a Covid-19 risk assessment to ensure staff feel comfortable and safe in the work environment and have altered this to reflect any changes in government advice. We have also provided a new compulsory online training on Infection Prevention and Control due to Covid-19.

We each have a voice that counts

The Trust has reviewed how our staff can interact, feedback and be involved in decision making which affects their interests, given the restrictions implemented by covid. As a result we now have more robust two way communication methods with our staff. For example; our workplace app, virtual staff briefs, daily headline updates with a video message from executives and “Ask me anything” sessions which all staff are welcome and encouraged to participate in.

We are compassionate and inclusive

Our Staff Survey has shown that we have made improvements in year with less staff being exposed or experiencing bullying, harassment and/ or violence towards them. We continue to work with staff to ensure everyone adheres to our values and expected behaviours to ensure we have a workplace where we all feel we belong.

Staff Turnover

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

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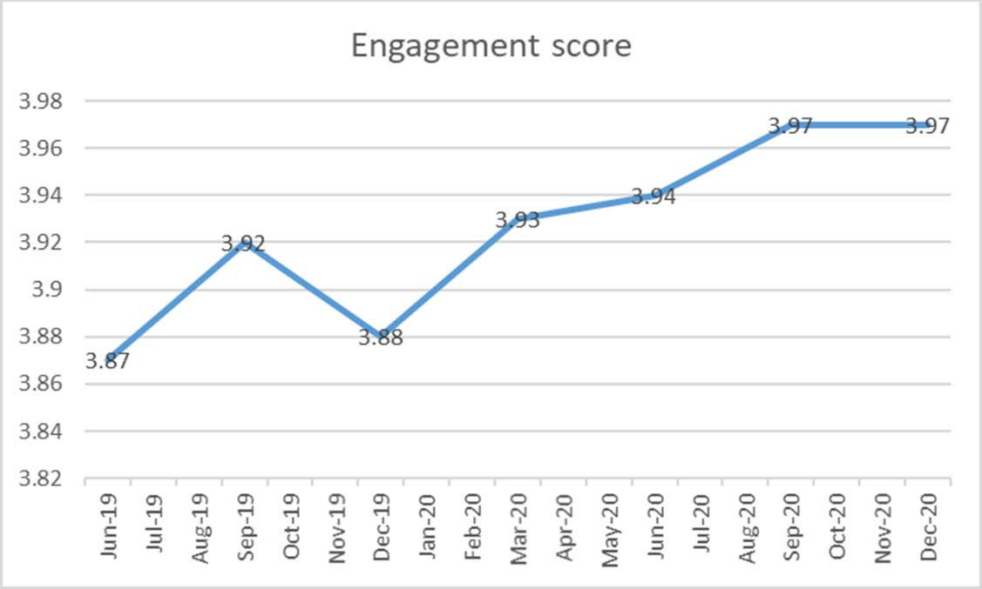
Staff Survey

Staff engagement

The Trust monitors staff engagement using the key indicators in the annual NHS Staff Survey, the Friends and Family Test (FFT) for Staff results and the Go Engage quarterly pulse survey scores. From the NHS Staff Survey the staff engagement score for 2020 was 7.1, and shows a positive increase since 2019 (score 7).

The Trust has been using the quarterly Go Engage pulse surveys to monitor staff engagement levels regularly. This pulse survey is sent to 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.

The Go Engage model gives a staff engagement score out of 5. The table below shows the scores from the surveys.



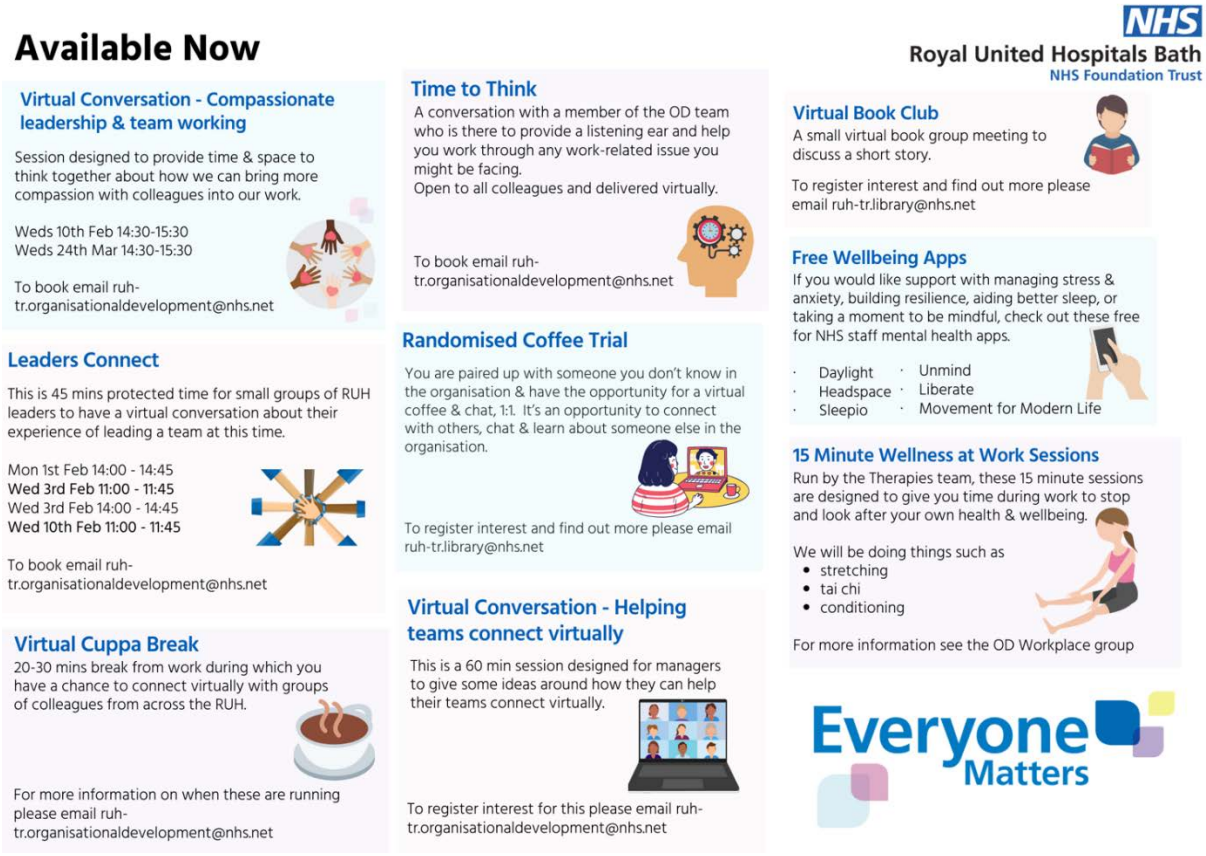
The latest Go Engage survey indicates that the top two scoring enablers of staff engagement are Trust and Work relationships – this has been a consistent trend over the last 12 months.

The two lowest enablers are dedication and energy and this is consistent with the anecdotal feedback from staff and triangulates with anecdotal data from Freedom to Speak Up and Employee Assistance Programme.

The most recent Staff Friends and Family scores (Dec 2020) are below:

	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20
1: How likely are you to recommend the Trust to friends and family as a place to work?	62.46%	70.56%	75%	76.26%	72.9%
2: How likely are you to recommend the Trust to friends and family if they needed care or treatment?	75.07%	79.84%	87.03%	86.76%	80.47%

We have begun to use the values to promote key workstreams – the purpose of this is to raise the profile of the Trust values as well as to link them to high profile activities. For example the #EveryoneMatters campaign has been very successful in the communications about wellbeing at work sessions.



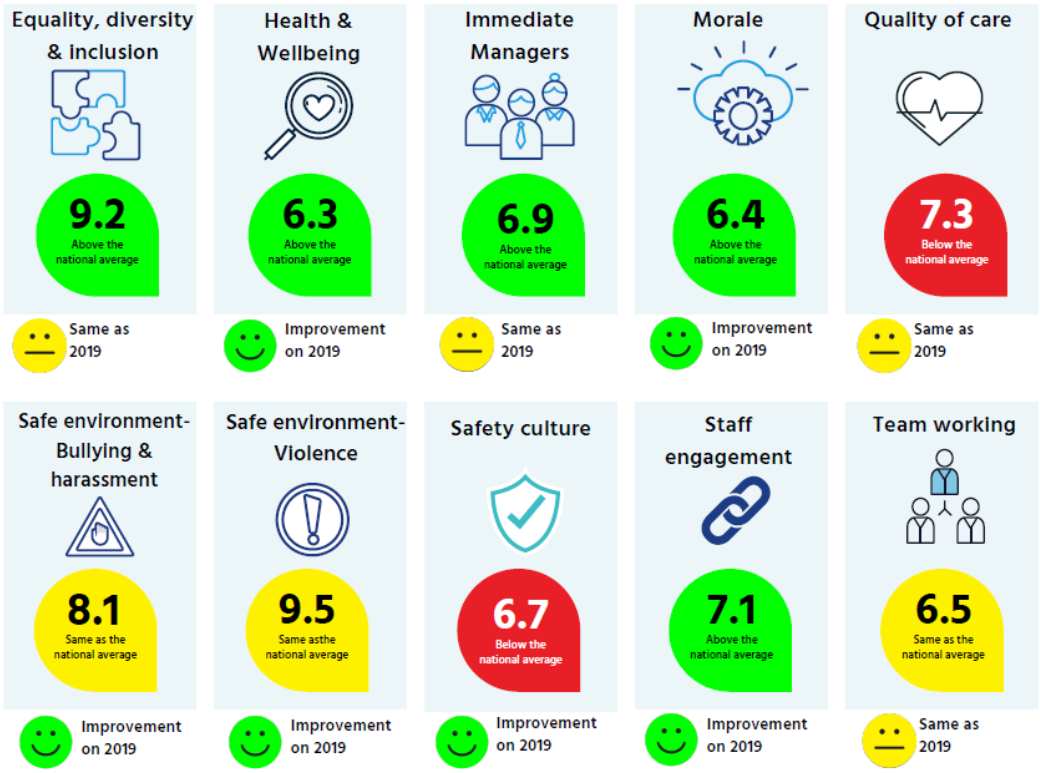
The Organisational Development Team has launched a workstream in March 2021 on Civility and Kindness and is using the #WorkingTogether value to highlight this.

The Organisational Development team has in 2020-21 launched the first wave of the Team Go Engage programme – an engagement programme designed specifically for teams. This went live in September 2020 following a delay due to the CoVid-19 response. The programme launched with initially 6 teams but due to CoVid pressures only three teams have been able to complete the programme currently. Wave 2 has not yet been recruited to, as the capacity of the Organisational Development team has been impacted by the pandemic response.

Recognising and appreciating colleagues remains a key workstream with staff indicating through the Go Engage survey that they do not always feel recognised. The Trust's primary recognition tool is Mo which was given a makeover in February 2021. Staff are encouraged to use Mo to celebrate achievements, acknowledge each other, share good news stories as well as saying thank you and giving praise.

<u>Summary of performance – NHS Staff Survey</u>

All staff across the Trust were invited to complete the annual NHS Staff Survey in Autumn 2020. A total of 2,359 responses were received, equivalent to a response rate of 44%.This is slightly higher than last year's response rate (42%) but falls slightly below the median response rate for our benchmarking group (Acute Trusts in England – 45.4%).



	2020/21		2019/20		2018/19	
	Trust	**Benchmarking Group**	**Trust**	**Benchmarking Group**	**Trust**	**Benchmarking Group**
Equality, diversity and inclusion	9.2	9.1	9.1	9.0	9.2	9.1
Health and Wellbeing	6.3	6.1	5.9	5.9	6.0	5.9
Immediate Managers	6.9	6.8	6.8	6.8	6.8	6.7
Morale	6.4	6.2	6.2	6.1	6.1	6.1
Quality of Appraisals	*No longer measured*		5.7	5.6	5.6	5.4
Quality of Care	7.3	7.5	7.2	7.5	7.1	7.4
Safe environment – B&H	8.1	8.1	7.9	7.9	8.0	7.9
Safe environment – violence	9.5	9.5	9.4	9.4	9.5	9.4
Safety culture	6.7	6.8	6.5	6.7	6.4	6.6
Staff engagement	7.1	7.0	7.0	7.0	7.1	7.0
Team Working	6.5	6.5	6.5	6.6	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 has identified 4 key areas for work during 2020/21 and these will be the focus for action and improvement this year. These include:

- A continued focus on health and wellbeing of staff (building on the progress made in 2020/21)
- A closer look at Quality of Care and an understanding of which areas are scoring lower and what action can be taken to support staff to feel they are able to deliver the level of care they aspire to
- An understanding of Safety Culture – which areas of the hospital are scoring lower and supporting staff and responding to any concerns
- An ambition to increase the response rate for 2021 survey.

The progress against these actions will be monitored by the Staff Engagement Group which has been running for over 12 months and meets quarterly to monitor all aspects of the Trust's staff engagement work. The group is chaired by the Associate Director for Learning and Culture. The group also monitors the survey results from the Go Engage quarterly surveys, as well as monitoring staff engagement activities including Mo, Workplace and the agenda includes updates from Freedom to Speak Up and the network groups.

Monitoring arrangements for the Trust's staff engagement work is through the Trust's governance committees, Strategic Workforce Committee, People Committee, Improving Together Capability and Capacity Group, Management Board and the Board of Directors.

Trade Union Facility Time

The total number of employees who were relevant union officials during 2020/21 was:

Number of employees who were relevant union officials 20/21	**Full-time equivalent employee number**
54	4704

Percentage of time spent on facility time during 2020/21

Percentage of time	**Number of employees**
0%	0

1-50%	52
51%-99%	1
100%	1

Percentage of time spent on facility time during 2020/21

Total cost of facility time	£65,585
Total Trust pay bill	£259,217,000
% of total pay bill spent on facility time	0.025%

Paid trade union activities during 20/21

Time spent on paid trade union activities as a percentage of total paid facility time hours	0.025%

Off payroll engagements

In accordance with the HM Treasury annual reporting guidance the Trust is required to report the number of off-payroll engagements for more than £245 per day that were in place as at 31st March 2021 (Table 1), all off-payroll workers engaged at any point during the year ended 31 March 2021 (Table 2) and, any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021 (Table 3).

From April 2017, the Government has reformed the legislation associated with off-payroll payments so that public sector bodies are responsible for deducting and paying all employment taxes and national insurance contributions from the individuals concerned. As a result of this all off-payroll arrangements, irrespective of value, are assessed and steps taken to ensure that tax and national insurance is deducted correctly.

Table 1

Off-payroll worker engagements as at 31 March 2021

Number of existing engagements as of 31 March 2021	
Of which	
Number that have existed for less than one year at time of reporting	6
Number that have existed for between one and two years at time of reporting.	1
Number that have existed for between two and three years at time of reporting	nil
Number that have existed for between three and four years at time of reporting	nil
Number that have existed for four or more years at time of reporting.	nil

Table 2

All off-payroll workers engaged at any point during the year ended 31 March 2021

Number of off-payroll workers engaged during the year ended 31 March 2021	
Of which	
Number assessed as within the scope of IR35	nil
Number assessed as not within the scope of IR35	16
Number of engagements reassessed for consistency/assurance purposes during the year	nil
Of which: number of engagements that saw a change to IR35 status following review	nil
Number of engagements where the status was disputed under provisions in the off-payroll legislation	nil
Of which: number of engagements that saw a change to IR35 status following review	nil

Table 3

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	nil
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	23

There were no new off-payroll engagements for more than £245 per day for longer than 6 months entered into or in respect of Board members or senior officials with significant financial responsibility during the year ended 31 March 2020.

Expenditure on consultancy

Expenditure on consultancy, as defined in the Department of Health's Group Accounting Manual during 2020/21 was £379k (£1,327k in 2019/20).

Exit Packages 2020-2021

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	14	14
£10,000 - £25,000	-	2	2
£25,001 - £50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
>£150,000	-	-	-
Total number of exit packages by type	**0**	**16**	**16**
Total resource cost (£'000)	**0**	**81**	**81**

	2020-2021	
	Agreements	Total Value of Agreements
		£0
	Number	
Voluntary redundancies including early retirement contractual costs.	-	-
Mutually agreed resignations (MARS) contractual costs.	-	-
Early retirements in the efficiency of the service contractual costs.	-	-
Contractual payments in lieu of notice.	16	81
Exit payments following Employment Tribunals or court orders.	-	-
Non-contractual payments requiring MHT approval.	-	-
Total	**16**	**81**

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

Expenses 2020 - 2021

Year	Staff group	Amount	No of individuals
2020/2021	Directors	£ 838.50	5
2020/2021	NED's	£ -	0

Equality Report including Gender Pay Gap

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. As part of our ongoing commitment as a Disability Confident Employer we encourage people with disabilities to apply to work for us; as well as

support existing staff with disabilities or those who develop disabilities during employment. Providing appropriate training, career development and promotional opportunities for staff with disabilities.

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

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

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

The Trust has three established staff networks, Fusion, (representing staff from 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.

In response to COVID-19 risk assessments and one to one conversations to support staff and ensure a safe working environment. This enabled us to identify those staff who were vulnerable to the virus and needed to work from home, be redeployed or shield during the pandemic.

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

We are focused on improving the opportunities for staff from all backgrounds whilst recognising that we have some targeted work to do. In recognition of this, two Inclusion Ambassadors, recruited from our existing staff were appointed in November 2020 to assist with the delivery of this agenda.

Governance of the Trust

Role of the Board of Directors

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

The Board of Directors is responsible for:

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

For most of 2020/21, the Board of Directors met monthly in public, but with effect from January 2021, this has changed to bi-monthly, but there is the provision to hold extraordinary meetings as required. The Board has a formal schedule of matters specifically reserved for its decision, including approving strategy, business plans and budgets, approving high value expenditure and contracts, regulations and control, 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 through Board Seminars and Away Days and individual training needs are assessed through the appraisal process. All Directors are able to attend regional and national events.

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

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 that robust governance and accountability arrangements are in place, as well as evaluating the performance of the Board of Directors, its committees and individual Non-Executive Directors.

Role of the Non-Executive Directors

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

Non-Executive Directors are appointed on a three-year term of office. A Non-Executive Director can be reappointed for a second three-year term subject to the recommendation of the Council of Governors' Nominations and Remuneration

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

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

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

Board of Directors Completeness

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

All of the Non-Executive Directors of the Trust are considered to be independent in accordance with the NHS Foundation Trust Code of Governance as published by NHS Improvement. The Board considers that the Non-Executive Directors bring a wide range of business, commercial 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. During 2020/21, in order to enhance the skill-set within the Board, the decision was made to appoint an additional Non-Executive Director with a clinical background.

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 March 2020, the Council of Governor's Nominations Committee agreed to commence the process of appointing to a newly created Non-Executive Director role, specifically seeking candidates with a clinical background. Unlike in previous exercises of this nature, the Trust decided not to use the services of a recruitment consultant, instead advertising the role via NHS Jobs and the local media. The COVID-19 pandemic led to a pausing of the process and the post was eventually advertised in May. 33 candidates applied for the role, and following longlisting and shortlisting, 5 candidates were invited for interview on 28 July.

The Interview Panel comprised of:

- The Trust Chair

- Charlotte Hitchings, Chair, Avon and Wiltshire Mental Health Partnership NHS Trust
- Amanda Buss, Lead Governor
- Mike Welton, Public Governor
- Anne Martin, 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 Ian Orpen be appointed to the Board. This recommendation was approved Ian Orpen agreed to join the RUH Board of Directors in September 2020.

The third term of office of Joanna Hole, who had originally joined the Board in April 2011 came to an end on 31 October 2020. The Council of Governors had agreed that for her replacement, the focus should be on finding a candidate with a professional background or qualification in financial management, and experience of risk management and internal control. The advertisement was published in July 2020, again via NHS Jobs and the local media, and it attracted 47 applications. Following long and shortlisting, 5 candidates were interviewed on 28 September, by a panel comprising of:

- The Trust Chair
- Liam Coleman, Chair, Great Western Hospitals NHS Foundation Trust
- Amanda Buss, Public Governor
- Mike Welton, Public Governor
- Anne Martin, Public Governor.

Again, the process also involved focus group meetings with key stakeholders, following which the Nomination Committee recommended that Antony Durbacz be appointed to the Board. This recommendation was accepted and Antony became a Non-Executive Director of the Trust on 1 November 2020.

Board evaluation and development

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

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

programme of Board Seminars that are held after public Board meetings as well as on months when no public meetings are scheduled. These cover a range of topical issues and are often facilitated or attended by external colleagues. Individual Directors attend a range of formal and informal training and networking events as part of their ongoing development.

Board Committees

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

Management Board

The Management Board is chaired by the Chief Executive, and has delegated powers from the Board of Directors to oversee the day-to-day management of an effective system of integrated governance, risk management and internal control across the whole 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, service developments and capital projects up to a specified limit. The Management Board has also continued in its role of monitoring progress in the rolling out of training on Improving Together, and the completion of projects in line with this methodology.

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 meetings are held twice monthly.

Audit and Risk Committee

The Audit and Risk Committee is chaired since January 2021 by Antony Durbacz who took over from Jeremy Boss. 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.

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

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

The current external auditor, Deloitte, was reappointed on 10 March 2021 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 2020/21.

Non-Clinical Governance Committee (NCGC)

The Non-Clinical Governance Committee is chaired by Sumita Hutchison. The NCGC focuses primarily on providing assurance to the Board that the Trust has a robust framework for the management of risks arising from or associated with: estates and facilities; environment and equipment; health and safety; information governance; business continuity; business development and other non-clinical areas as may be identified.

Quality Governance Committee

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

People Committee

The People Committee was established in 2019/20. It is chaired by Anna Mealings, and its role is to provide assurance to the Board that all people-related risks are being appropriately managed, and that the Trust's employment processes are fit for purpose and legally compliant. In 2020/21 the Committee has been particularly focused on gaining assurance as to the effectiveness of the Trust's staff health and wellbeing provision as the organisation emerges from the pandemic. It is also paying close attention to the development of the equality, diversity and inclusion agenda.

Finance and Performance Committee

The Finance and Performance Committee is the newest Board Committee and it held its first meeting in December 2020. It is chaired by Jeremy Boss, and its key role is to provide assurance to the Board on the Trust's operational and financial performance. Specifically, it assesses the effectiveness of the Trust's business planning and financial management systems, and the extent to which the organisation is operating in line with its annual business plan objectives. Going forward, one of the committee's key areas of focus will be on the Trust's relationship with its BSW partners, and the changing approaches to commissioning, contracting, joint working and the allocation of resources.

Board of Directors' Nominations and Remuneration Committee

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

The Charities Committee

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

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

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

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

Commercial Transactions Steering Group

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

Members and Governors

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

The Council of Governors

The Council of Governors is made up of 21 governors:

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

The Council of Governors is chaired by the Trust Chair, Alison Ryan. Governors at the Royal United Hospitals Bath provide a direct link between the Foundation Trust and its members. The Council of Governors' 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.

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

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

The Working Groups continue to meet regularly to take forward tasks assigned by the Council and provide a full report at each of the Council of Governors meetings. All governors are invited to participate in their working groups. Working Group meetings were attended by executive directors and senior managers to support information sharing and engagement with governors.

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

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

2020/21 Governor Elections

During 2020/21 the Trust held elections to elect three staff governors and seven public governors across five constituencies. This was the third constituency-wide election for new governors since the Trust gained Foundation Trust status in 2014.

Each constituency, with the exception of the Rest of England and Wales and the Mendip constituencies had a contested election and participation was reasonable, ranging from 12.89% to 17.03%. The full election report is available from the Membership Office at ruhmembership@nhs.net.

Lead Governor

Amanda Buss, Public Governor held the position of Lead Governor until her term ended in October 2020. Gill Little, Public Governor for South Wiltshire was appointed by the Council of Governors as the new Lead Governor.

Council of Governor Meetings

The Council of Governors has met on the following occasions:

- 3 June 2020
- 7 September 2020
- 18 January 2021
- 10 March 2021

The following table sets out Governor Attendance at Council of Governor meetings in the period from 1 April 2020 to 31 March 2021, as well as governors' terms of appointment:

Name	**Constituency**	**Term of Appointment**	**Council of Governors Meeting Attendance**
Public Governors			
Amanda Buss	City of Bath	02/11/2012 - 31/10/2020 (shadow Governor from 2012-2014)	2/2
Mike Midgley	City of Bath	01/11/2016 - 31/10/2022	2/4
Nesta Collingridge-Padbury	City of Bath	02/11/2020 - 31/10/2023	2/2
Helen Rogers	North East Somerset	02/11/2012 - 31/10/ 2020 (shadow Governor from 2012-2014)	2/2
Melanie Hilton	North East Somerset	01/11/2019 - 31/10/2022	4/4

Name	Constituency	Term of Appointment	Council of Governors Meeting Attendance
Suzanne Harris	North East Somerset	02/11/2020 - 31/10/2023	2/2
Michael Welton	Somerset (Mendip)	02/11/2012 - 31/10/ 2020 (shadow Governor from 2012-2014)	2/2
Anne Martin	Somerset (Mendip)	01/11/2016 - 31/10/2022	4/4
John Osman	Somerset (Mendip)	02/11/2020 - 31/10/2023	2/2
Jacek Kownacki	North Wiltshire	01/11/2017 - 31/10/2020	0/2
Peter McCowen	North Wiltshire	02/11/2020 - 31/10/2023	2/2
Anna Shantry	North Wiltshire	02/11/2020 - 31/10/2023 (stood down in March 2021)	1/1
Gill Little	South Wiltshire	01/11/2019 - 31/10/2022	4/4
Chris Hardy	South Wiltshire	01/11/2017 - 31/10/2020	2/2
Jill Scott	South Wiltshire	02/11/2020 - 31/10/2023	2/2
Andrew Simkins	Rest of England & Wales	21/12/2017 - 31/10/2020	2/2
Virginia McNab	Rest of England & Wales	02/11/2020 - 31/10/2023	2/2
Staff Governors			
Darrin King	Staff	01/11/2017 - 31/10/2020	1/2
Michael Coupe	Staff	01/11/2017 - 31/10/2020	2/2
Narinder Tegally	Staff	01/11/2019 - 31/10/2022	2/4
Sarah Bond	Staff	01/11/2019 - 31/10/2022	4/4
Sophie Legg	Staff	01/11/2019 - 31/10/2023	4/4
Julie Stone	Staff	02/11/2020 - 31/10/2023	2/2
Baz Harding-Clark	Staff	02/11/2020 - 31/10/2023	2/2
Stakeholder Governors (appointed)			

Name	Constituency	Term of Appointment	Council of Governors Meeting Attendance
Dr Ian Orpen	BaNES CCG	01/11/2014 - 31/10/2020 (stood down March 2020)	0/0
Dr Andrew Girdher	Wiltshire CCG	07/01/2016 - 31/10/2020	0/2
Cllr Johnny Kidney	Wiltshire Council	01/10/2017 - 30/09/2020	3/4
Dr Bryn Bird	BSW CCG	01/04/2020 - 31/03/2023	1/4
Cllr Rob Appleyard	BaNES Council	28/05/2019 - 30/04/2022	3/4
Dr Vivien Gibbs	University of the West of England	01/04/2019 - 31/03/2021 (stood down June 2020)	0/1
Prof. Dave Clarke	University of the West of England	15/06/2020 - 31/03/2021	0/2

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

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.

The Trust currently has 16,916 members, made up of 11,358 public members (patients, carers and the public) and 5,558 staff members. The Trust has a number of channels for engaging and communicating with its members, including:

- Members' quarterly newsletter and Insight magazine
- Staff monthly magazine and weekly newsletter
- E-communications
- Caring for You events
- Governor Constituency meetings
- Online surveys
- The Annual Members' Meeting

The aim of the *Caring for you* events and Governor Constituency meetings is to help members understand more about the work of the hospital. However, the COVID-19

pandemic, has meant that the Trust has been limited in the scale and scope of its engagement activities during 2020/21. The most recent Annual General Meeting was held virtually in October 2020, and more than 100 members of the public were able to join. Recruitment of new members has been constrained by the inability to hold live events such as university freshers' fairs. However, a small number of members have been recruited via the Bath Racecourse vaccination centre.

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	Directors' Report

Ref No	Code Provision	Annual Report and Accounts Section
	they were elected or appointed, and the 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 should be communicated to the Board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Governance of the Trust
FT ARM	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on	This power has not been exercised.

Ref No	Code Provision	Annual Report and Accounts Section
	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)	
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 Statement (within the annual report).	Annual Governance Statement
C.2.1	The annual report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	Annual Governance Statement
C.2.2	A trust should disclose in the annual report: a) If it has an internal audit function, how the function is structured and what role it performs; or b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Annual Governance Statement

Ref No	Code Provision	Annual Report and Accounts Section
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 and Risk Committee
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

Ref No	Code Provision	Annual Report and Accounts Section
E.1.6	The Board of Directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Governance of the Trust
FT ARM	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Governance of the Trust
FT ARM	The annual report should disclose details of company Directorships or other material interests in companies held by governors and/or Directors where those companies or related parties are likely to do business, 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	Summary of requirement	RUH Compliance

A.1.4	The Board should ensure that adequate systems and processes are maintained to measure and monitor the NHS Foundation Trust's effectiveness, efficiency and economy as well as the quality of its health care delivery.	**Confirmed:** the Board of Directors receives detailed monthly reports on operational performance, quality and finance. There is a Board Assurance Framework and a system of internal controls in place as detailed in the Annual Governance Statement.
A.1.5	The Board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance.	**Confirmed:** the Board of Directors receives 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's & Children's) 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 Quality Account 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	**Confirmed:** the Chief Executive is aware of this provision in the Accounting Officer Memorandum.

	decisions.	
A.1.8	The Board should establish the constitution and standards of conduct for the NHS Foundation Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life.	**Confirmed:** the Trust has a Constitution, which was last updated in October 2019. Staff are required to sign the Trust's Code of Conduct. The Board of Directors annually confirms its adherence to the Nolan standards of public life and the Fit and Proper Person Requirements.
A.1.9	The Board should operate a code of conduct that builds on the values of the NHS Foundation Trust and reflect high standards of probity and responsibility.	**Confirmed:** The Trust has a Code of Conduct based on the Trust's values. There are separate codes of conduct for the members of the Board of Directors and Council of Governors. The Board of Directors' Code of Conduct reflects the requirements of the Fit and Proper Persons Test.
A.1.10	The NHS Foundation Trust should arrange appropriate insurance to cover the risk of legal action against its Directors.	**Confirmed:** the Trust is a member of NHS Resolution and is covered by its indemnity scheme. The Trust's NHS Foundation Trust Constitution states that providing Directors act honestly and in good faith, any legal costs incurred in the execution of their functions will be met by the Trust.
A.3.1	The Chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A Chief Executive should not go on to be the Chairperson of the same NHS Foundation Trust.	**Confirmed:** The Trust Chair and Chief Executive are compliant with this provision. The Trust's Chair meets the independence criteria.
A.4.1	In consultation with the Council, the Board should appoint one of the independent Directors to be the Senior Independent Director.	**Confirmed:** The Vice Chair is the Senior Independent Director. The current Vice-Chair and Senior Independent Director, Jeremy Boss, took up office on 1 November 2020.
A.4.2	The Chairperson should hold meetings with the Non-Executive Directors.	**Confirmed:** The Trust Chair holds regular meetings with Non-Executive Directors.
A.4.3	Where Directors have concerns that cannot be resolved about the running of the NHS Foundation Trust or a proposed action, they should ensure that their concerns are recorded in the Board minutes.	**Confirmed:** All discussions at the Board of Directors' meetings are contained in the minutes of each meeting.
A.5.1	The Council of Governors should meet sufficiently regularly to discharge its	**Confirmed:** The Council of Governors meets quarterly which accords with other NHS

	duties.	Foundation Trusts. There is provision to hold additional meetings if required.
A.5.2	The Council of Governors should not be so large as to be unwieldy.	**Confirmed:** The size of the Council of Governors is considered to be appropriate and is regularly reviewed.
A.5.4	The roles and responsibilities of the Council of Governors should be set out in a written document.	**Confirmed:** A document setting out the roles and responsibilities of the Council of Governors is available from the Trust's public website and is also set out in the NHS Foundation Trust's Constitution.
A.5.5	The Chairperson is responsible for leadership of both the Board and the Council but the Governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive to their meetings and inviting attendance by other Executives and Non-Executives, as appropriate.	**Confirmed:** Members of the Board of Directors (both Executive and Non-Executive) are in attendance at Council of Governor meetings. 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 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.
A.5.8	The Council should only exercise its power to remove the Chairperson or any Non-Executive Directors after exhausting all means of engagement with the Board.	**Confirmed:** The process for removing the Chair and Non-Executive Directors is set out in the Trust's Constitution. Governors are aware of this provision and of the consequences of exercising this power.
A.5.9	The Council should receive and consider other appropriate information required to enable it to discharge its duties.	**Confirmed:** The Trust is compliant with this provision and provides extensive information to the Council of Governors via regular reports and through the Council's various working groups and at its formal meetings.
B.1.2	At least half the Board, excluding the Chairperson, should comprise Non-Executive Directors determined by the Board to be independent.	**Confirmed:** The Trust is compliant with this provision. All Non-Executives are considered to be independent. Other than the Chair and Chief Executive, the Board consists of six non-executive and four voting executive directors.
B.1.3	No individual should hold, at the same time, positions of Director and governor	**Confirmed:** The Trust is compliant with this provision, which is incorporated into its Constitution. Directors and governors are

	of any NHS Foundation Trust.	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 two Non-Executive

		Directors who were appointed in 2020/21.
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 Committees provide the opportunity to test systems and processes in more detail and to provide assurance to the Board.
B.5.3	The Board should ensure that Directors, especially Non- Executive Directors, have access to the independent professional advice, at the NHS Foundation Trust's expense, where they judge it necessary to discharge their responsibilities as Directors.	**Confirmed:** The Chief Executive is aware of this provision and will make available independent professional advice as required.
B.5.4	Committees should be provided with sufficient resources to undertake their duties.	**Confirmed:** This is considered as part of the Committees' annual reviews of their effectiveness.
B.6.3	The senior Independent Director should lead the performance evaluation of the Chairperson.	**Confirmed:** The Senior Independent Director leads the performance evaluation of the Trust's Chair.

B.6.4	The Chairperson, with assistance of the Board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for Non-Executive Directors relevant to their duties as Board members.	**Confirmed:** The Board of Directors regularly discusses whether there are any development needs and these are addressed by the Board of Directors' programme of seminars, away days and external training events. The Chair and the Head of Corporate Governance take account of individual NED performance evaluations, as well as feedback from the Directors themselves, in devising development programmes.
B.6.5	Led by the Chairperson, the Council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	**Compliant:** The Chair meets with governors on a one-to-one basis to discuss their performance. The Chair leads the assessment of the collective performance of the Council of Governors annually. Information on discharge of responsibilities is included in the Governors' Annual Report and the Lead Governor also reports on this topic at the Annual Members' Meeting.
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the Council, for the removal from the Council of any Governor who consistently and unjustifiably fails to 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 Constitution sets out the criteria and process for removing a Governor.
B.8.1	The Remuneration Committee should not agree to an Executive member of the Board leaving the employment of an NHS Foundation Trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the Board first having completed and approved a full risk assessment.	**Confirmed:** The Trust Chair (Chair of the Board of Directors' Nominations and Remuneration Committee) is aware of this requirement.
C.1.2	The Directors should report that the NHS Foundation Trust is a going concern with supporting assumptions or qualifications as necessary.	**Confirmed:** The monthly finance report to the Board of Directors confirms that the Trust is a going concern. A statement confirming the going concern statement is included within this annual report.
C.1.3	At least annually and in a timely manner, the Board should set out	**Confirmed:** The Trust's Annual Report and Annual Quality Accounts Reports are

	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.	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 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.	**Confirmed:** The Board of Directors is aware of this requirement.
C.3.1	The Board should establish an Audit Committee composed of at least three	**Confirmed:** The Trust's Audit Committee comprises three independent Non-Executive

	members who are all independent Non-Executive Directors.	Directors.
C.3.3	The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors.	**Confirmed:** The Council of Governors agreed the tender process for appointing new external auditors in consultation with the Audit Committee.
C.3.6	The NHS Foundation Trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS Foundation Trust.	**Confirmed:** The Council of Governors approved the 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 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 People Committee provides assurance to the Board of Directors on the Trust's Raising Concerns Policy. Sumita Hutchison is the Trust non-executive lead on Freedom to Speak Up.
D.1.1	Any performance-related elements of the remuneration of Executive Directors should be designed to align their interests with those of patients, service users and taxpayers and to give these Directors keen incentives.	**Confirmed:** The Board of Directors' Nominations and Remuneration Committee is responsible for determining the eligibility for executive Directors to receive performance-related bonuses after a review of each executive Director's performance.
D.1.2	Levels of remuneration for the Chairperson and other Non- Executive Directors should reflect the time commitment and responsibilities of their roles.	**Confirmed:** The Council of Governors' Nominations and Remuneration Committee determine the remuneration of the Chair and other Non-Executive Directors after taking account of the time commitment and responsibilities of their roles. This is periodically reviewed.
D.1.4	The Remuneration Committee should carefully consider what compensation commitments (including pension contributions and all other elements) their Directors' terms of appointments would give rise to in the event of early termination.	**Confirmed:** This will be undertaken if and when required.

D.2.2	The Remuneration Committee should have delegated responsibility for setting remuneration for all Executive Directors, including pension rights and any compensation payments.	**Confirmed:** The Terms of Reference of the Board of Directors' Nominations and Remuneration Committee make it clear that this responsibility rests with the Committee.
D.2.3	The Council should consult external professional advisers to market-test the remuneration levels of the Chairperson and other Non-Executives at least once every three years and when they intend to make a material change to the remuneration of a Non-Executive.	**Confirmed:** The Council of Governors' Nominations and Remuneration Committee 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 changed as a result of more recent benchmarking and in taking account of guidance issued in November 2019 on Chair and non-executive remuneration.
E.1.2	The Board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.	**Confirmed:** The Trust has a membership and engagement strategy.
E.1.3	The Chairperson should ensure that the views of governors and members are communicated to the Board as a whole.	**Confirmed:** Governors are encouraged to attend Board and Board committee meetings as observers and to raise questions received from or based on comment from their constituencies. 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 appropriate levels of seniority in each.	**Confirmed:** The Trust meets this requirement. Details are set out in the Directors' report section of this annual report.

NHS Improvement Single 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 2020/21 financial year (and during 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.

As a result of the changes that have been made to the funding regimes in the NHS as a result of the COVID-19 pandemic, the metric set out above has been deemed irrelevant for the 2020/21 financial year and is not being assessed.

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

Cara Charles-Barks,

Chief Executive

June 2021

Annual governance statement 2020/21

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 2021 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 (13 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 five Assurance Committees, each chaired by a Non-Executive Director together with other Non-Executive Director members that ensure that there are effective monitoring and assurance arrangements in place to support the system of internal control. The Board is also able to delegate specific topics to the Committees for detailed consideration. The key responsibilities of each Committee in relation to risk management are set out below:

<u>Audit and Risk Committee</u>

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

<u>Quality Governance Committee</u>

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

<u>Non-Clinical Governance Committee</u>

- Provides assurance that the non-clinical systems and processes are effective and robust
- Provides specific oversight for the management of health and safety risk, business continuity and information technology
- 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.

Finance and Performance Committee

- Provides assurance that the Trust's financial and operational performance is in line with the Trust's operational targets and business plan objectives
- Scrutinises the effectiveness of the Trust's financial management systems
- Assesses the impact of the COVID-19 pandemic, and extent to which the recovery of elective care delivery is in line with agreed targets.

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. During 2020/21, the Trust's Quality Board and Operational Governance Committee merged. The revamped Quality Board is jointly chaired by the Chief Nurse and the Medical Director, and it acts as the operational group

responsible for supporting the management of clinical risk issues. The Health and Safety Committee acts as the operational committee for supporting the management of health and safety risks.

Leadership of the Risk Management Process

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

Chief Nurse (previously known as 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. Also acts as Chief Clinical Information Officer and Caldicott Guardian.

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

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

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

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

These responsibilities are managed operationally through the Head of Risk and Assurance who has responsibility for ensuring that staff are trained and equipped to manage risk effectively and in accordance with the Strategic Framework for Risk

Management. This is achieved through risk training programmes and the provision of practical support to divisional teams.

Staff empowerment and risk management training

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

The Risk and Control Framework

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

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

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

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

The Board of Directors undertakes a quarterly review and discussion of the Trust risk register, to 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 on the organisation are not overlooked. Management Board are also responsible for reviewing and approving any current risks that have been downgraded from a major risk.

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

Incidents are dealt with in accordance with the Incident Reporting and Management Policy and Procedure. An anonymised summary of all new Serious Incidents is included in the Quality Report which is presented at each Board of Directors' meeting and is published on the Trust's website. The Board of Directors also receives a quarterly Incidents, Claims and Inquests report which contains more detailed analysis of trends and learning and is considered in the private Board of Directors' meeting. During 2020/21, a Serious Incident Panel was set up as a sub-group of Quality Board specifically to ensure that such incidents are appropriately investigated and that learning from them is derived and shared across the Trust.

The Trust's Internal Auditors conducted a Financial Controls Audit in January 2021. They concluded that the Trust's processes provided "significant assurance" with a few mainly 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".

Board Assurance Framework

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

The BAF is reviewed at each public meeting of the Board of Directors. Each risk is assigned to a lead Executive Director and to the relevant Board committee for oversight. The Board Committees review their respective risks at each meeting and their comments are reported to the Board of Directors, with the responsible Executive Director updating the controls and mitigations regularly. The Committees may also increase or decrease the ratings for their risks to reflect the effectiveness of the mitigations and controls, and /or developments in the external environment. The BAF risks are also regularly reviewed at the Board of Directors' Away Days which are held quarterly. The Framework is fully refreshed at the start of each financial year.

Risks to data security

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

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

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

Description of the principal risks facing the Trust

The Management Board identified the Trust's current top clinical and operational risks at its March 2021 meeting as including:

- **Recovery of elective performance:** As at March 2021, there were over 1600 Trust patients who had been waiting more than 52 weeks for their procedures, and another 2300 over 40 weeks. This is due to a combination

of the priority that the hospital has understandably given to the treatment of COVID patients, and the lack dedicated capacity for this form of care.

Steps being taken to manage the situation include maintaining local independent sector capacity on an ongoing basis, maximising theatre capacity and working with partners across BSW providers. In the meantime, the clinical teams continue to conduct reviews of long waiting patients to ensure that they do not suffer harm as a result of these delays.

- **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.

- **Patient safety in an overcrowded Emergency Department**: As the immediate COVID-19 pressures have eased, the numbers of patients attending the Trust's Emergency Department have risen back up to pre-pandemic levels. However, social distancing measures and the requirement to test patients on arrival at the Department have often led to overcrowding, which in turn places both patients and staff at risk of infection.

  Actions being taken to address this include better communication with patients, some urgent capital work in the Department to provide a dedicated direct admit area for expected patients as well as more general improvements to the flow of patients through the hospital to avoid bottlenecks in the ED.

- **Uncertain financial position**: The COVID-19 pandemic and the changes that needed to be made to the way the NHS works to deal with it, has meant that the normal financial planning arrangements have been suspended. For the whole of 2020/21, NHS England/Improvement (NHSEI) provided fixed funding to cover all COVID costs. The funding regime for Trusts also changed from October 2020 from "payment by results" to a "block" arrangement, whereby the whole of the BSW system was allocated a fixed amount based on forecasts which had already estimated a £3.03 million deficit. For the purposes of funding in 2021/22, the year has been divided

into two halves, but it is unclear what criteria will be used for decided on allocations in the second half, and whether this will compensate for lost income during the pandemic such as through catering and car parking.

To help mitigate the impacts of any shortfalls, the clinical and corporate divisions are being supported to find additional efficiencies and savings.

These and other key risks will continue to be managed throughout 2021/22.

Emerging and In-year Risks

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 an inspection by the Health and Safety Executive in January 2021 led to Improvement Notices being issued, in part because the inspectors observed breaches of the social distancing requirements. An improvement plan was put in place to address the issues that were picked up in the inspection, and the vast majority of these had been dealt with by the end of the financial year.

In addition to the rise in the elective backlog, there is recognition that patients with serious conditions, such as cancer and heart problems may not have been able to access care during this period. It is therefore likely that there will be a large number of patients with complex presentations who will be needing care over the coming months within constrained facilities.

Governance

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

Communication with stakeholders

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

- **The Council of Governors** has a formal role as a stakeholder body for the wider community, and as part of the Trust's governance structure. The Council holds formal Council of Governor meetings quarterly, and these are

open to the public, as well as constituency meetings (for publicly elected governors), regular member newsletters, and the Annual Members' Meeting.

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

Developing workforce safeguards

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

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

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

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

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

Compliance with the Care Quality Commission

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

The Care Quality Commission conducted an announced inspection of the Trust in June 2018. The inspection report was published on 26 September 2018, giving the Trust an overall rating of 'Good'. A short notice inspection of the Emergency Department was carried out in January 2021. This had no impact on either the Trust's overall ratings or those of the ED itself. Further details of its findings are set out elsewhere in this report.

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

Compliance with NHS pension scheme regulations

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

Compliance with equality, diversity and human rights legislation

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

Compliance with obligations under the Climate Change Act

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

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

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

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

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

Information governance

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

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

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

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

The Trust 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 2020/21. 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 2020 and 31 March 2021, the Trust reported two potentially serious information governance incidents to the Information Commissioner's Office (ICO).

However, it was later discovered that neither incident required such escalation, and they were instead included on Trust's DSPT reported incidents log.

Issues involving confidentiality or information governance continue to be well reported via the Trust's incident reporting process, Datix. 115 incidents were reported during 2020/21, which compares to 150 in 2019/20. The fall in the number of reported incidents could be attributable to fewer staff being on site, and therefore less generation of printed documents containing information. Also, there was less clinical activity besides COVID-19 treatment for large parts of the year. Most incidents related to emails being sent to the wrong patients, and patient information being incorrectly included within the records of other patients. These incidents are considered at meetings of the Information Governance Group to ensure that awareness of the issues raised and the lessons learnt from them are shared across the organisation.

Annual Quality Report

The *NHS Foundation Trust Annual Reporting Manual* for 2020/21 indicated that the preparation of a quality report is now optional and that if one is prepared, it does not need to be published as part of a trust's annual report. The requirement for the trust's external audit to review the quality account and to test a sample of the quality indicators disclosed in them has also been removed, The RUH has nevertheless decided that it will prepare and publish a streamlined quality report, as an opportunity for engagement with external stakeholders. This is being done to a slightly different timetable to the annual report, and publication is expected to take place in September 2021.

Quality Governance Arrangements

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

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

The Trust's participation in national and regional patient safety initiatives sets the tone for the rest of the organisation and demonstrates that quality improvement is a top priority. The Trust hosts and has a close working relationship with the West of England Academic Health Science Network. The Trust is also a member of NHS Quest, a member network for NHS Foundation Trusts who wish to focus on improving quality and safety.

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

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

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

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

Capabilities and culture

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

Complaints are seen as an opportunity to learn and the Trust is keen to ensure that this remains the focus. The Trust has adopted a more personal approach to

resolving concerns which involves meeting with complainants to discuss their concerns as a preferred alternative to or in conjunction with responding in writing.

Systems and processes

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

- The monthly Quality Report 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 and Risk Committee, Quality Governance Committee, Non-Clinical Governance Committee and the Management Board. When issues are identified, plans are put in place to address any weaknesses and ensure that any learning is embedded in the organisation. This ensures that the system is subject to continuous improvement.

The Trust's Assurance Framework provides me with evidence of the effectiveness of controls that manage the risks to the organisation achieving its strategic objectives, have been reviewed and are being actively managed. Internal Audit provides me with an opinion about the effectiveness of the assurance framework and the internal controls reviewed as part of the Internal Audit plan. Work undertaken by Internal Audit is reviewed by the Assurance Committees (Audit and Risk, Non-Clinical and Clinical Governance 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 2020/21, they completed 8 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 2020 to 31 March 2021 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

Cara Charles-Barks, Chief Executive (Accounting Officer), June 2021

Accountability report signed

Cara Charles-Barks, Chief Executive (Accounting Officer), June 2021

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

Report on the audit of the financial statements

Opinion

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

- give a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2021 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 36.

We have also audited the information in the Remuneration Report and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes on page 53;
- the table of pension benefits of senior managers and related narrative notes on page 55;
- the table of pay multiples and related narrative notes on page 59; and
- the table of exit packages and related narrative notes on page 59.

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

Basis for opinion

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

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and

the foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the group and the foundation trust is adopted in consideration of the requirements set out in the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts , which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other information

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

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

We have nothing to report in this regard.

Responsibilities of accounting officer

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

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

We discussed among the audit engagement team regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following area, and our specific procedures performed to address it are described below:

- determination of whether an expenditure is capital in nature: we teted capitalised expenditure on a sample basis to assess whether they meet the relevant accounting requirements to be recognised as capial in nature.

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

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

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management, internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced;
- reading minutes of meetings of those charged with governance; and
- reviewing internal audit reports.

Report on other legal and regulatory requirements

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

In our opinion:

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

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice, we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

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

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

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

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

We undertake our work in accordance with the Code of Audit Practice, having regard to the guidance, published by the Comptroller & Auditor General in April 2021, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

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

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

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

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

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

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

We have nothing to report in respect of these matters.

Delay in certification of completion of the audit

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

Use of our report

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

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

9 June 2021

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements

In our audit report for the year ended 31 March 2021 issued on 9 June 2021 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2021 and of the group's and foundation trust's income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

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

In our audit report for the year ended 31 March 2021 issued on 9 June 2021, we were required to report to you if we had not been able to satisfy ourselves that the foundation trust had made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We had nothing to report in respect of this matter.

Certificate of completion of the audit

In our audit report for the year ended 31 March 2021 issued on 9 June 2021, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources and. We have now completed our work in this area.

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

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

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

Michelle Hopton (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Bristol, United Kingdom
1 September 2021

Royal United Hospitals Bath NHS Foundation Trust

Annual accounts for the year ended 31 March 2021

Foreword to the accounts

Royal United Hospitals Bath NHS Foundation Trust

These accounts, for the year ended 31 March 2021, 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  .....

Cara Charles-Barks
Chief Executive
Date **9 June 2021**

Consolidated Statement of Comprehensive Income

For the year ended 31 March 2021

		Group	
		2020/21	2019/20
	Note	£000	£000
Operating income from patient care activities	3.1	362,848	330,176
Other operating income	4	53,194	44,087
Operating expenses	6.1	(409,108)	(376,212)
Operating surplus/(deficit) from continuing operations		**6,934**	**(1,949)**
Finance income	11	183	381
Finance expenses	12	(229)	(264)
PDC dividends payable		(5,584)	(5,856)
Net finance costs		**(5,630)**	**(5,739)**
Other (losses)/ gains	13	(33)	2
Surplus / (deficit) for the year		**1,271**	**(7,686)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(2,126)	-
Revaluations	18	384	(413)
Other reserve movements		-	(1)
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on financial assets mandated at fair value through OCI	20	1,249	(721)
Total comprehensive income / (expense) for the period		**778**	**(8,821)**
Surplus/ (deficit) for the period attributable to:			
Royal United Hospitals Bath NHS Foundation Trust		1,271	(7,686)
TOTAL		**1,271**	**(7,686)**
Total comprehensive income/ (expense) for the period attributable to:			
Royal United Hospitals Bath NHS Foundation Trust		778	(8,821)
TOTAL		**778**	**(8,821)**

Statements of Financial Position

As at 31 March 2021	Note	Group 31 March 2021 £000	Group 31 March 2020 £000	Trust 31 March 2021 £000	Trust 31 March 2020 £000
Non-current assets					
Intangible assets	15	8,665	9,447	8,665	9,447
Property, plant and equipment	16	225,664	206,211	225,664	206,211
Other investments / financial assets	20	9,324	7,932	-	-
Receivables	24	2,701	2,744	2,301	1,567
Total non-current assets		**246,354**	**226,334**	**236,630**	**217,225**
Current assets					
Inventories	23	4,236	4,249	4,236	4,249
Receivables	24	18,748	22,636	17,519	22,566
Cash and cash equivalents	25	30,297	15,512	28,275	13,512
Total current assets		**53,281**	**42,397**	**50,030**	**40,327**
Current liabilities					
Trade and other payables	26	(41,134)	(31,081)	(40,824)	(30,745)
Borrowings	28	(3,504)	(3,499)	(3,504)	(3,499)
Provisions	30	(185)	(213)	(185)	(213)
Other liabilities	27	(5,056)	(5,270)	(5,056)	(5,270)
Total current liabilities		**(49,879)**	**(40,063)**	**(49,569)**	**(39,727)**
Total assets less current liabilities		**249,756**	**228,668**	**237,091**	**217,825**
Non-current liabilities					
Borrowings	28	(7,469)	(10,924)	(7,469)	(10,924)
Provisions	30	(1,618)	(1,092)	(1,618)	(1,092)
Total non-current liabilities		**(9,087)**	**(12,016)**	**(9,087)**	**(12,016)**
Total assets employed		**240,669**	**216,652**	**228,004**	**205,809**
Financed by					
Public dividend capital		184,435	161,212	184,435	161,212
Revaluation reserve		37,350	40,350	37,350	40,350
Income and expenditure reserve		6,219	4,247	6,219	4,247
Charitable fund reserves	22	12,665	10,843	-	-
Total taxpayers' equity		**240,669**	**216,652**	**228,004**	**205,809**

The notes on pages 1 to 47 form part of these accounts.

Cara Charles-Barks
Chief Executive
Date **9 June 2021**

Statements of Cash Flows

For the year ended 31 March 2021	Note	Group 2020/21 £000	Group 2019/20 £000	Trust 2020/21 £000	Trust 2019/20 £000
Cash flows from operating activities					
Operating surplus / (deficit)		6,934	(1,949)	6,555	(2,685)
Non-cash income and expense:					
Depreciation and amortisation	6.1	13,429	12,264	13,429	12,264
Net impairments	7	(397)	9,703	(397)	9,703
Income recognised in respect of capital donations	4	(682)	-	(833)	(1,279)
Decrease in receivables and other assets		3,965	7,570	3,916	9,372
Decrease/(increase) in inventories		13	(1,249)	13	(1,249)
Increase / (decrease) in payables and other liabilities		5,217	5,749	5,217	5,749
Increase / (decrease) in provisions		498	207	498	200
Movements in charitable fund working capital		(457)	(388)	-	-
Other movements in operating cash flows		(77)	(390)	-	-
Net cash flows generated from operating activities		**28,443**	**31,517**	**28,398**	**32,075**
Cash flows used in investing activities					
Interest received		5	177	5	177
Purchase of intangible assets		(1,548)	(586)	(1,548)	(586)
Purchase of PPE		(26,889)	(30,131)	(26,889)	(30,131)
Sales of PPE		2	23	2	23
Receipt of cash donations to purchase assets		401	(27)	424	800
Net cash flows used in investing activities		**(28,029)**	**(30,544)**	**(28,006)**	**(29,717)**
Cash flows generated from / (used in) financing activities					
Public dividend capital received		23,223	2,142	23,223	2,142
Movement on loans from DHSC		(2,958)	(2,958)	(2,958)	(2,958)
Capital element of finance lease rental payments		(483)	(442)	(483)	(442)
Interest on loans		(208)	(248)	(208)	(248)
Other interest		(1)	-	(1)	-
Interest paid on finance lease liabilities		(31)	(26)	(31)	(26)
PDC dividend paid		(5,171)	(6,260)	(5,171)	(6,260)
Net cash flows generated from / (used in) financing activities		**14,371**	**(7,792)**	**14,371**	**(7,792)**
Increase / (decrease) in cash and cash equivalents		**14,785**	**(6,819)**	**14,763**	**(5,434)**
Cash and cash equivalents at 1 April - brought forward		**15,512**	**22,331**	**13,512**	**18,946**
Cash and cash equivalents at 31 March	25.1	**30,297**	**15,512**	**28,275**	**13,512**

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

Group	Note	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 2020 - brought forward		**161,212**	**40,350**	**4,247**	**10,843**	**216,652**
Adjustment for Charity investments following 2019/20 audit		-	-	-	16	16
Taxpayers' and others' equity at 1 April 2020 - restated		**161,212**	**40,350**	**4,247**	**10,859**	**216,668**
Surplus for the year		-	-	539	732	**1,271**
Other transfers between reserves		-	(1,258)	1,258	-	**-**
Impairments	7	-	(2,126)	-	-	**(2,126)**
Revaluations	18	-	384	-	-	**384**
Fair value gains on financial assets mandated at fair value through OCI	20	-	-	-	1,249	**1,249**
Public dividend capital received	Cashflow	23,223	-	-	-	**23,223**
Other reserve movements		-	-	175	(175)	**-**
Taxpayers' and others' equity at 31 March 2021		**184,435**	**37,350**	**6,219**	**12,665**	**240,669**

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

Group	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
		£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 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	18	-	(413)	-	-	**(413)**
Fair value losses on financial assets mandated at fair value through OCI		-	-	-	(721)	**(721)**
Public dividend capital received	Cashflow	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**

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

Trust	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward		**161,212**	**40,350**	**4,247**	**205,809**
Surplus/(deficit) for the year		-	-	539	**539**
Other transfers between reserves		-	(1,258)	1,258	**-**
Impairments	7	-	(2,126)	-	**(2,126)**
Revaluations	18	-	384	-	**384**
Public dividend capital received	Cashflow	23,223	-	-	**23,223**
Other reserve movements		-	-	175	**175**
Taxpayers' and others' equity at 31 March 2021		**184,435**	**37,350**	**6,219**	**228,004**

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

Trust	Note	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**
Surplus/(deficit) for the year		-	-	(9,901)	**(9,901)**
Other transfers between reserves		-	(3,838)	3,838	**-**
Revaluations	18	-	(413)	-	**(413)**
Public dividend capital received	Cashflow	2,142	-	-	**2,142**
Other reserve movements		-	-	1,275	**1,275**
Taxpayers' and others' equity at 31 March 2020		**161,212**	**40,350**	**4,247**	**205,809**

Information on reserves

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

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

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

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 22.

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 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, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

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

Note 1.3 Consolidation

NHS Charitable Funds

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

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

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

The key accounting policies are as follows:

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.

Income recognition for donated goods – All donated goods will be measured at their fair value at the time of their receipt.

Joint ventures

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

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

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

Note 1.4 Revenue from contracts with customers

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

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

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

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled 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 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.6 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 1.7 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.8 Other forms of income

Grants and donations

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

Apprenticeship service income

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

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 1.9 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 1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

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

Measurement

Valuation

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

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

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

- Land and non-specialised buildings – market value for existing use; and
- 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 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 and, where capitalised in accordance with IAS 23, borrowings costs. 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 the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.
Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated and grant funded assets

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

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

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	5	62
Dwellings	41	46
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 1.11 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 are shown in the table below:

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

Note 1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

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

Note 1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

Note 1.14 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.
Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income, depending upon type.

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

Financial assets and financial liabilities at amortised cost

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

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

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

Financial assets measured at fair value through other comprehensive income

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

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

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

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

Impairment of financial assets

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

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

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

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

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

Derecognition

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

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

Note 1.15 Leases

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

The Trust as a lessee

Finance leases

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

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

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

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 1.16 Provisions

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

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.18%
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 2021:

Note 1.16 Provisions continued

	Inflation rate
Year 1	1.20%
Year 2	1.60%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms. The Compensation Recovery Unit (CRU) advises a percentage probability of not receiving the income for injury benefits. For 2020/21 this figure is 22.43% (2019/20 this figure is 21.79%)

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 30.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 31 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 31, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:
• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.18 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

Note 1.19 Value added tax

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

Note 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March;
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.22 Third party assets

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

Note 1.23 Losses and special payments

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

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.24 Gifts

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

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

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

IFRS 16 Leases

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

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

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

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

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

The DHSC GAM does not require the following standards and interpretations to be applied in 2020/21. These standards are still subject to HM Treasury FReM adoption;

IFRS 14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016 and is not applicable to DHSC group bodies.
IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

Note 1.27 Critical judgements & esitmates 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.

Critical judgements

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

Property Valuations

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

Note 1.27 Critical judgements and accounting estimates in applying accounting policies continued

Property, plant and equipment were valued using an index from Gerald Eve as at 31 March 2021. 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

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 and Amortisation

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

Useful economic life

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

Valuation of property

When arriving at the valuation for property, Trust management engages a qualified surveyor to assist them in forming estimates.

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. The only balance that is considered material to the Trust is the investments which are disclosed in note 20.

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)	2020/21 £000	2019/20 £000 reclassified
Acute services		
Block contract / system envelope income*	332,434	248,811
High cost drugs income from commissioners (excluding pass-through costs)**	3,218	37,458
Other NHS clinical income	2,459	25,715
All services		
Private patient income	585	882
Additional pension contribution central funding***	10,351	9,377
Other clinical income	13,801	7,933
Total income from activities	**362,848**	**330,176**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**In 20-21 the majority of high cost drug income was included within the block contracts and therefore not identfied to be split out. The value identified separately is the value that was paid outside the block

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

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2020/21 £000	2019/20 £000
NHS England	80,017	61,319
Clinical commissioning groups	276,913	260,196
Department of Health and Social Care	-	28
Other NHS providers	309	458
NHS other	816	1,382
Local authorities	1,208	1,226
Non-NHS: private patients	585	882
Non-NHS: overseas patients (chargeable to patient)	131	405
Injury cost recovery scheme	650	453
Non NHS: other	2,219	3,827
Total income from activities	**362,848**	**330,176**
Of which:		
Related to continuing operations	362,848	330,176
Related to discontinued operations	-	-

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

	2020/21	2019/20
	£000	£000
Income recognised this year	131	405
Cash payments received in-year	98	102
Amounts added to provision for impairment of receivables	48	-

Note 4 Other operating income (Group)

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	3,503	-	**3,503**	3,608	-	**3,608**
Education and training	13,057	558	**13,615**	12,641	492	**13,133**
Non-patient care services to other bodies	7,442		**7,442**	7,890	-	**7,890**
Provider sustainability fund (2019/20 only)	-	-	**-**	2,539	-	**2,539**
Marginal rate emergency tariff funding (2019/20 only)	-	-	**-**	6,304	-	**6,304**
Reimbursement and top up funding	16,219	-	**16,219**	-	-	**-**
Income in respect of employee benefits accounted on a gross basis	1,795		**1,795**	2,466	-	**2,466**
Receipt of capital grants and donations	-	682	**682**	-	-	**-**
Charitable and other contributions to expenditure	-	6,245	**6,245**	-	-	**-**
Rental revenue from operating leases	-	281	**281**	-	363	**363**
Charitable fund incoming resources	-	1,749	**1,749**	-	3,292	**3,292**
Other income	1,733	(70)	**1,663**	4,492	-	**4,492**
Total other operating income	**43,749**	**9,445**	**53,194**	**39,940**	**4,147**	**44,087**
Of which:						
Related to continuing operations			53,194			44,087
Related to discontinued operations			-			-

Note 5 Additional income disclosures

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

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,625	1,297

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:

	2020/21	2019/20
	£000	£000
Income from services designated as commissioner requested services	362,848	330,176
Income from services not designated as commissioner requested services	53,194	44,087
Total	**416,042**	**374,263**

Note 5.3 Fees and charges (Group)

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

	2020/21	2019/20
	£000	£000
Income	1,258	3,629
Full cost	(1,576)	(1,945)
Surplus / (deficit)	**(318)**	**1,684**

Fees and charges relate to car parking and retail catering

Note 6 operating expenses

Note 6.1 Operating expenses (Group)

	2020/21	2019/20
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	1,625	1,699
Staff and executive directors costs	264,581	231,755
Remuneration of non-executive directors	153	146
Supplies and services - clinical (excluding drugs costs)	39,333	35,842
Supplies and services - general	3,265	3,872
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	44,394	43,571
Inventories written down	106	-
Consultancy costs	379	1,327
Establishment	3,200	3,925
Premises	14,891	11,590
Transport (including patient travel)	826	874
Depreciation of property, plant and equipment	11,241	10,286
Amortisation of intangible assets	2,188	1,978
Net impairments	(397)	9,703
Movement in credit loss allowance: contract receivables / contract assets	873	(15)
Increase/(decrease) in other provisions	1,157	(175)
audit services- statutory audit	78	59
other auditor remuneration (external auditor only)	-	10
Internal audit costs	60	66
Clinical negligence	12,801	10,227
Legal fees	297	334
Insurance	533	385
Research and development	2,956	3,765
Education and training	3,208	3,691
Rentals under operating leases	720	416
Hospitality	15	176
Losses, ex gratia & special payments	8	22
Other NHS charitable fund resources expended	663	717
Other	(46)	(34)
Total	**409,108**	**376,212**
Of which:		
Related to continuing operations	409,108	376,212

Note 6.2 Other auditor remuneration (Group)

	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
2. Audit-related assurance services	-	10
Total	**-**	**10**

Note 6.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1 million (2019/20: £1 million).

Note 7 Impairment of assets (Group)

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / (deficit) resulting from:		
Changes in market price	(397)	9,703
Total net impairments charged to operating surplus / (deficit)	**(397)**	**9,703**
Impairments charged to the revaluation reserve	2,126	-
Total net impairments	**1,729**	**9,703**

Of the £1.7m impairment charged in the accounts, the largest impairments related to the conversion of a ward to an ITU and remedial work.

The remaining impairment is a result of the Trust undertaking an interim desktop valuation of the land, buildings and dwellings on the RUH site as at 31 March 2021.

The reversal of the impairment was a result of increased market prices relating to land where the land had previously been impaired.

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 2021.

Note 8 Employee benefits (Group)

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	207,188	179,802
Social security costs	19,813	17,716
Apprenticeship levy	977	1,400
Employer's contributions to NHS pensions	23,736	21,530
Employer's contributions paid by NHSE to NHS pensions	10,351	9,377
Temporary staff (including agency)	7,070	7,276
NHS charitable funds staff	527	559
Total staff costs	**269,662**	**237,660**
Of which		
Costs capitalised as part of assets	1,526	1,117

Note 8.1 Retirements due to ill-health (Group)

During 2020/21 there were 3 early retirements from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £180k (0k in 2019/20).

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 2020/21 was £0.09m (£0.06m in 2019/20).

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

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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Note 10 Operating leases (Group)

Note 10.1 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.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	720	416
Total	**720**	**416**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year; and	720	416
- later than one year and not later than five years.	2,880	2,960
Total	**3,600**	**3,376**
Future minimum sublease payments to be received	-	-

Note 11 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2020/21	2019/20
	£000	£000
Interest on bank accounts	5	177
NHS charitable fund investment income	178	204
Total finance income	**183**	**381**

Note 12 Finance Expenditure

Note 12.1 Finance expenditure (Group)

financing.

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	197	237
Finance leases	31	27
Interest on late payment of commercial debt	1	-
Total finance costs	**229**	**264**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

	2020/21	2019/20
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	1	-

Note 13 Other (losses)/gains (Group)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	2	19
Losses on disposal of assets	(35)	(17)
Total (losses)/gains on disposal of assets	**(33)**	**2**

Note 14 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own Income Statement and Statement of Comprehensive Income. The Trust's surplus for the period was £0.7m (2019/20 deficit £8.6m). The Trust's total comprehensive income/(expense) for the period was £22.3m (2019/20: £6.9m).

Note 15 Intangible Assets

Note 15.1 Intangible assets - 2020/21

Group	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**1,757**	**13,403**	**1,281**	**16,441**
Additions	-	934	472	**1,406**
Disposals / derecognition	-	(17)	-	**(17)**
Valuation / gross cost at 31 March 2021	**1,757**	**14,320**	**1,753**	**17,830**
Amortisation at 1 April 2020 - brought forward	**1,540**	**5,454**	**-**	**6,994**
Provided during the year	94	2,094	-	**2,188**
Disposals / derecognition	-	(17)	-	**(17)**
Amortisation at 31 March 2021	**1,634**	**7,531**	**-**	**9,165**
Net book value at 31 March 2021	**123**	**6,789**	**1,753**	**8,665**
Net book value at 31 March 2020	**217**	**7,949**	**1,281**	**9,447**

Note 15.2 Intangible assets - 2019/20

Group	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**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 - as previously stated	**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 31 March 2019	**360**	**8,415**	**1,146**	**9,921**

Note 16 Property, plant and equipment

Note 16.1 Property, plant and equipment - 2020/21

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**10,008**	**153,068**	**4,095**	**7,788**	**57,573**	**34**	**11,761**	**1,625**	**245,952**
Additions	-	8,293	12	11,671	7,990	-	3,795	327	**32,088**
Impairments	-	(4,185)	(2)	-	-	-	-	-	**(4,187)**
Reversals of impairments	1,034	1,424	-	-	-	-	-	-	**2,458**
Revaluations	-	(4,133)	(105)	-	-	-	-	-	**(4,238)**
Reclassifications	-	2,629	-	(2,629)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(869)	-	(239)	(22)	**(1,130)**
Valuation/gross cost at 31 March 2021	**11,042**	**157,096**	**4,000**	**16,830**	**64,694**	**34**	**15,317**	**1,930**	**270,943**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**385**	**-**	**-**	**30,528**	**34**	**8,221**	**573**	**39,741**
Provided during the year	-	4,578	125	-	4,898	-	1,423	217	**11,241**
Revaluations	-	(4,497)	(125)	-	-	-	-	-	**(4,622)**
Disposals / derecognition	-	-	-	-	(822)	-	(237)	(22)	**(1,081)**
Accumulated depreciation at 31 March 2021	**-**	**466**	**-**	**-**	**34,604**	**34**	**9,407**	**768**	**45,279**
Net book value at 31 March 2021	**11,042**	**156,630**	**4,000**	**16,830**	**30,090**	**-**	**5,910**	**1,162**	**225,664**
Net book value at 31 March 2020	**10,008**	**152,683**	**4,095**	**7,788**	**27,045**	**-**	**3,540**	**1,052**	**206,211**

Note 16.2 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 - as previously stated	**10,862**	**127,547**	**4,959**	**26,567**	**55,170**	**34**	**10,713**	**924**	**236,776**
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 - as previously stated	**-**	**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 16.3 Property, plant and equipment financing - 2020/21

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
2021								
Owned - purchased	11,042	151,113	4,000	15,228	25,217	5,905	1,118	**213,623**
Finance leased	-	-	-	-	2,198	-	-	**2,198**
Owned - donated/granted	-	5,517	-	1,602	2,675	5	44	**9,843**
NBV total at 31 March 2021	**11,042**	**156,630**	**4,000**	**16,830**	**30,090**	**5,910**	**1,162**	**225,664**

Note 16.4 Property, plant and equipment financing - 2019/20

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
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/granted	-	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 17 Donations of property, plant and equipment

During the year ended 31 March 2021 the SOCI shows the Group received donations to purchase assets of £0.7m (£0m in 2019/20).

Excluding Group eliminations the Trust received donations from which assets were purchased to the value of £0.8m (£1.3m 2019/20).

The donations were made up as follows:
- £0.4m cash donation from an external charity (Bath Cancer Unit Support Group) towards the purchase of a new Gamma Camera.
- £0.1m from Royal United Hospital Bath Charitable Fund to fund various medical equipment.
- £0.3m relates to the donation of COVID Loan equipment by the DHSC.

The cash donation from the Bath Cancer Unit Support Group charity was restricted to ensure funds were only used for the purchase of the Gamma Camera.

Note 18 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 desktop valuation using indices of the Trust's land and buildings as at 31 March 2021. The last full revaluation was undertaken as at 31 March 2020. The valuations were carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1).

The total movement in the revaluation reserve is £3.0m. Impairments of (£2.1m) and revaluations of £0.4m have 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 (£1.3m) to reflect the updated valuation and in-year depreciation of the Trust’s Revaluation Reserve.

Note 19 Heritage Assets

The Trust hold a number of art works. The art is across a variety of mediums and have either been donated or transferred from the acquisition of The Royal National Hospital for Rheumatic Diseases in 2015.

These assets are not operational and are not held to deliver front line services or back office functions. Therefore the assets will not be recognised in the statement of financial position.

The assets were last valued in 2015 for insurance purposes. The Trust has not obtained up to date valuations, as the cost will not be commensurate with the benefits to users of the financial statements.

The art works are held at various locations across the Trust site and a small number have been loaned to the Bath Medical Museum. The art collection is managed by the Art & Design Manager.

Note 20 Other investments / financial assets (non-current)

	Group	
	2020/21	**2019/20**
	£000	**£000**
Carrying value at 1 April - brought forward	**7,932**	**8,512**
Adjustment for Charity investments following 2019/20 audit	16	-
Carrying value at 1 April - restated	**7,948**	**8,512**
Acquisitions in year	127	141
Movement in fair value through OCI	1,249	(721)
Carrying value at 31 March	**9,324**	**7,932**

Note 21 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, and are accounted for in the Trust's accounts using the equity method.

Note 22 Analysis of charitable fund reserves

	31 March 2021 £000	31 March 2020 £000
Unrestricted funds:		
Unrestricted income funds	1,948	1,639
Restricted funds:		
Other restricted income funds	10,717	9,204
	12,665	**10,843**

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 23 Inventories

	Group	
	31 March 2021 £000	31 March 2020 £000
Drugs	540	867
Consumables	3,595	3,315
Energy	101	67
Total inventories	**4,236**	**4,249**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £65,460k (2019/20: £58,779k). Write-down of inventories recognised as expenses for the year were £106k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £6,245k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 24 Receivables

Note 24.1 Receivables

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
Current				
Contract receivables	14,963	17,806	14,963	17,806
Contract assets	-	26	-	-
Capital receivables	-	-	49	26
Allowance for impaired contract receivables / assets	(988)	(277)	(988)	(277)
Deposits and advances	23	25	23	25
Prepayments (non-PFI)	2,750	3,475	2,750	3,475
PDC dividend receivable	65	478	65	478
VAT receivable	604	940	604	940
Other receivables	53	93	53	93
NHS charitable funds receivables	1,278	70	-	-
Total current receivables	**18,748**	**22,636**	**17,519**	**22,566**
Non-current				
Contract assets	1,600	1,460	1,600	1,460
Allowance for other impaired receivables	(296)	(264)	(296)	(264)
Other receivables	997	371	997	371
NHS charitable funds receivables	400	1,177	-	-
Total non-current receivables	**2,701**	**2,744**	**2,301**	**1,567**
Of which receivable from NHS and DHSC group bodies:				
Current	12,532	11,161	12,532	14,406
Non-current	997	371	997	371

The contract receivables balance as at 1st April 2019 was £30.3 million (Group) and £32.2 million (Trust).

Note 24.2 Allowances for credit losses - 2020/21

	Trust
	Contract receivables and contract assets
	£000
Allowances as at 1 Apr 2020 - brought forward	**541**
New allowances arising	966
Changes in existing allowances	9
Reversals of allowances	(102)
Utilisation of allowances (write offs)	(130)
Allowances as at 31 Mar 2021	**1,284**

Note 24.3 Allowances for credit losses - 2019/20

	Trust
	Contract receivables and contract assets
	£000
Allowances as at 1 Apr 2019 - as previously stated	**626**
Changes in existing allowances	(15)
Utilisation of allowances (write offs)	(70)
Allowances as at 31 Mar 2020	**541**

Note 25 Cash and cash equivalents

Note 25.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2020/21	2019/20	2020/21	2019/20
	£000	£000	£000	£000
At 1 April	**15,512**	**22,331**	**13,512**	**18,946**
Net change in year	14,785	(6,819)	14,763	(5,434)
At 31 March	**30,297**	**15,512**	**28,275**	**13,512**
Broken down into:				
Cash at commercial banks and in hand	80	279	2	7
Cash with the Government Banking Service	30,217	15,233	28,273	13,505
Total cash and cash equivalents as in SoFP	**30,297**	**15,512**	**28,275**	**13,512**
Total cash and cash equivalents as in SoCF	**30,297**	**15,512**	**28,275**	**13,512**

Note 25.2 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 2021	31 March 2020
	£000	£000
Bank balances	9	8
Total third party assets	**9**	**8**

Note 26 Trade and other payables

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000 reclassified	31 March 2021 £000	31 March 2020 £000 reclassified
Current				
Trade payables*	415	546	415	546
Capital payables	6,633	1,985	6,633	1,985
Accruals*	22,294	15,060	22,294	14,975
Social security costs	5,233	4,522	5,233	4,522
VAT payables	49	-	49	-
Other payables	6,200	8,632	6,200	8,717
NHS charitable funds: trade and other payables	310	336	-	-
Total current trade and other payables	**41,134**	**31,081**	**40,824**	**30,745**
Of which payables from NHS and DHSC group bodies:				
Current	3,569	6,062	3,569	6,062
Non-current	-	-	-	-

*The registered invoice accrual of £8.3m has been reclassfied in 2019-20 from trade payables to accruals

Note 26.1 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.

The deferred income ba;lance

Note 27 Other liabilities

	Group	
	31 March 2021	31 March 2020
	£000	£000
Current		
Deferred income: contract liabilities	5,056	5,270
Total other current liabilities	**5,056**	**5,270**

The deferred income balance at 1st April 2019 was £5.6 million.

Note 28 Borrowings

	Group	
	31 March 2021	31 March 2020
	£000	£000
Current		
Loans from DHSC	3,016	3,016
Obligations under finance leases	488	483
Total current borrowings	**3,504**	**3,499**
Non-current		
Loans from DHSC	5,789	8,755
Obligations under finance leases	1,680	2,169
Total non-current borrowings	**7,469**	**10,924**

Note 28 Reconciliation of liabilities arising from financing activities (Group)

Group - 2020/21	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2020	**11,771**	**2,652**	**14,423**
Cash movements:			
Financing cash flows - payments and receipts of principal	(2,958)	(483)	**(3,441)**
Financing cash flows - payments of interest	(208)	(31)	**(239)**
Non-cash movements:			
Application of effective interest rate	200	30	**230**
Carrying value at 31 March 2021	**8,805**	**2,168**	**10,973**

Group - 2019/20	Loans from DHSC	Finance leases	Total
	£000	£000	£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.

Note 29 Finance leases

Note 29.1 Royal United Hospitals Bath NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	Trust	
	31 March 2021 £000	31 March 2020 £000
Gross lease liabilities	**2,232**	**2,745**
of which liabilities are due:		
- not later than one year;	513	513
- later than one year and not later than five years; and	1,670	1,985
- later than five years.	49	247
Finance charges allocated to future periods	(64)	(93)
Net lease liabilities	**2,168**	**2,652**
of which payable:		
- not later than one year;	488	483
- later than one year and not later than five years; and	1,631	1,925
- later than five years.	49	244

All lease liabilities relate to the Trust only.

Note 30 Provisions

Note 30.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2020	**797**	**44**	**464**	**1,305**
Arising during the year	136	19	626	**781**
Utilised during the year	(88)	(19)	(32)	**(139)**
Reversed unused	(144)	-	-	**(144)**
At 31 March 2021	**701**	**44**	**1,058**	**1,803**
Expected timing of cash flows:				
- not later than one year;	80	44	61	**185**
- later than one year and not later than five years;	319	-	-	**319**
- later than five years.	302	-	997	**1,299**
Total	**701**	**44**	**1,058**	**1,803**

Pensions - early departure costs
Early retirement costs and injury benefit payments for staff, based on the information provided by NHS Pensions. The amounts and timings of the cash flows are accurate for the life of the claimant. Timings of payment are due over the life of the claimants.

Other legal claims
Litigation claims against the Trust that are being handled by NHS Litigation Authority. The provision is based on the information provided by NHS Litigation Authority. The timing of future and actual amounts remain uncertain until the claims are settled.

Other
Other provisions have been made in relation to employment issues. These amounts are estimates based on known risks and salaries. £0.9m has been included in long term provisions and relates to clinicans pension tax reimbursements, which is not expected to be settled within 5 years. The amounts are estimates based on known risks and saleries and are therefore inherently uncertain.

Note 30.2 Clinical negligence liabilities

At 31 March 2021, £151,682k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal United Hospitals Bath NHS Foundation Trust (31 March 2020: £135,964k).

Note 31 Contingent assets and liabilities

	Trust	
	31 March 2021	31 March 2020
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	17	18
Gross value of contingent liabilities	**17**	**18**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**17**	**18**
Net value of contingent assets	**-**	**-**

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 2020/21 (nil in 2019/20).

Note 32 Contractual capital commitments

	Trust	
	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	8,484	6,476
Intangible assets	328	474
Total	**8,812**	**6,950**

Note 33 Financial instruments

Note 33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with NHS England and Clinical Commissioning Groups and the way those bodies are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no establishment in other territories. The Foundation Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. Additionally the Trust's cash balances are held with the Government Banking Service. The Trust, therefore, has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's income comes from other public sector bodies, it has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in receivables from customers, as disclosed in the trade and other receivables note. These funding arrangements ensure that the Trust is not exposed to any material credit risk.

Liquidity risk
The Trust's operating costs are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated funds. The Trust is not, therefore, exposed to significant liquidity risks.

Note 33.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	16,191	-	**16,191**
Cash and cash equivalents	28,275	-	**28,275**
Consolidated NHS Charitable fund financial assets	3,700	9,324	**13,024**
Total at 31 March 2021	**48,166**	**9,324**	**57,490**

The Charitable Fund elected to classify equity instruments as fair value through OCI on initial recognition; the carrying value of these designated assets are £9.3m, (£7.9m in 2019/20).

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**

Note 33.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	16,191	-	**16,191**
Cash and cash equivalents	28,275	-	**28,275**
Total at 31 March 2021	**44,466**	**-**	**44,466**

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**

Note 33.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	8,805	**8,805**
Obligations under finance leases	2,168	**2,168**
Trade and other payables excluding non financial liabilities	35,542	**35,542**
Total at 31 March 2021	**46,515**	**46,515**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
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**

Note 33.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	8,805	**8,805**
Obligations under finance leases	2,168	**2,168**
Trade and other payables excluding non financial liabilities	35,852	**35,852**
Total at 31 March 2021	**46,825**	**46,825**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
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**

Note 33.6 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2021 £000	31 March 2020 restated* £000	31 March 2021 £000	31 March 2020 restated* £000
In one year or less	39,190	29,902	39,190	29,902
In more than one year but not more than five years	3,417	6,442	3,417	6,442
In more than five years	5,394	6,018	5,394	6,018
Total	**48,002**	**42,362**	**48,002**	**42,362**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 34 Losses and special payments

	2020/21		2019/20	
Group and Trust	**Total number of cases Number**	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Losses				
Cash losses	1	1	-	-
Total losses	**1**	**1**	**-**	**-**
Special payments				
Compensation under court order or legally binding arbitration award	1	-	-	-
Ex-gratia payments	27	7	43	19
Total special payments	**28**	**7**	**43**	**19**
Total losses and special payments	**29**	**8**	**43**	**19**
Compensation payments received		-		-

Note 35 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 2021, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

CCGs
NHS Bath and North East Somerset, Swindon and Wiltshire CCG
NHS Somerset CCG
NHS Bristol, North Somerset and South Gloucestershire CCG
NHS Gloucestershire CCG

NHS England Organisations
NHS England - Central Specialised Commissioning Hub
NHS England - South West Regional Office
NHS England - South West Specialised Commissioning Hub
NHS England - South East Regional Office
NHS England - Wessex Specialised Commissioning Hub
NHS England - Midlands Regional Office

NHS Trusts and Foundation Trusts
University Hospitals Bristol and Weston NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
North Bristol NHS Trust
Salisbury NHS Foundation Trust
Avon and Wiltshire Mental Health Partnership NHS Trust
Somerset Partnership NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust

Other Agencies
Health Education England
Department Of Health
Bath and North East Somerset Council
Wiltshire Unitary Authority
Welsh Assembly Government (including all other Welsh Health Bodies)
Public Health England
NHS Litigation Authority
NHS Blood and Transplant (excluding Bio products Laboratory)

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Her Majesty's Revenue and Customs in relation to Value Added Tax, National Insurance Contributions and Income Taxes.

The Trust has also received revenue and capital payments from the Royal United Hospital Bath NHS Trust Charitable Funds, for which the Trust Board acts as Corporate Trustee. 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.

Note 36 Events after the reporting date

The Trust has identified a material and non-adjusting post balance sheet event. On 1 June 2021 the Trust acquired the entire issued share capital of Circle Hospital (Bath) Ltd. The name will be changed to The Sulis Hospital, Bath.