Royal National Hospital for Rheumatic Diseases
NHS Foundation Trust

Annual Report & Accounts 2009/10

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

Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

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Contents

Chair's Statement

I am delighted to present the Chair's Statement in the Annual Report for 2009/10. It enables me to provide some reflection on how the Trust has performed over the last 12 months, and to introduce the content of the Annual Report. Background, history and a definition of the services of the Trust can be found on pages 9 and 10.

As members and stakeholders may recall, at the time the Annual Report for 2008/09 was produced, in which a small financial surplus for that year was reported, the Trust continued to face considerable challenges which may be encapsulated as:-

- Managing a position of net indebtedness caused by large deficits from earlier years.
- A consequential strategy to identify a suitable partner with which to merge in order to redress the adverse financial position.
- Uncertainties for patients and staff so caused alongside maintaining the high standards of patient care across all services and the stream of research work for which the Trust is renowned.

So how has the Trust done in 2009/10?

The annual accounts set out on pages 52 to 95 show:-

- The Trust has generated a financial surplus of £64k for the 09/10 financial year. This is in spite of a significant decline in activity in the Neuro Rehabilitation service due to competitive pressures, not standards of care, which has been compensated by increasing activity levels in Rheumatology and Pain Management services and careful management of the cost base.
- The surplus is however insufficient to have made a significant reduction in the net indebtedness. Nevertheless, the level of payables has been reduced through the use of proceeds from the disposal of a property considered surplus to requirements and a reduction in total receivables with an overall reduction in net liabilities of £590k.
- Budgeted capital expenditure plans and PDC dividends have been met through earnings before depreciation charges.
- Cash balances have increased from £327,000 to £512,000.

The merger process identified the Royal United Hospital, Bath (RUH) as a suitable partner with which to merge. However, regulation stipulated that the Trust as a Foundation Trust can only merge with a fellow Foundation Trust. It is understood the Board of the RUH intends to make application for the RUH to obtain Foundation Trust status, but the making of an application and its success is contingent on a number of matters which means the timing of merger at this stage is not definitive. Consequently the Trust needs to continue to operate as a stand alone entity for the foreseeable future albeit financial issues mean that the overall strategy remains the pursuit of merger.

Page 15 of the Operational Review describes the actions which have taken place or are in train as a consequence of the delay in executing a merger which are intended to enable the Trust to continue to operate effectively as an independent Foundation Trust pending merger, and to continue to deliver high quality services in a safe environment.

The issues of finance and merger have occupied the time of the Board and the Council of Governors for a considerable proportion of the year – but that is not to say the issues of quality and safety of patient care and staff welfare have not also been given due attention. I am glad to say that in spite of the uncertainties I mentioned above, the Trust has performed admirably through the year with patient and staff surveys showing positive results. Details of the surveys can be found on pages 43 and 47. The Quality Report set out on pages 36 to 45 shows that key targets have been met. The conclusion to the Francis Report published in February 2010 provides a list of recommendations for how Trusts should act towards patients, staff and its other stakeholders. We have noted these and can confirm that many of the procedures, checks and balances are in place at the Trust – but we shall continue to be

vigilant to ensure continued compliance. This sits alongside the steps in place to assess Quality of Care which includes the use of the Trust's own proprietary measurement tool, Vital Aspects of Clinical Care.

Across the year, the Trust has continued to attract funding to invest in research. The update on Research & Development on page 10 shows where the Trust continues to be a major contributor to research projects in its service areas, in addition to these projects successes for the Trust's staff, some of which are described more fully on page 43.

Throughout the year, there has been a huge level of interest in the Trust's performance exhibited by the Council of Governors who have challenged the Board on both strategic direction and operations. The Trust is fortunate to have a group of Governors who show ceaseless enthusiasm for the Trust and all it stands for.

Whilst members of the Board have driven the developments across the year and provided direction, communicated to staff through the Chief Executive's briefings and staff meetings, it has been through the hard work and dedication of the Trust's staff that the achievements of the Trust set out in this Annual Report have been made. The Board and Council of Governors are extremely grateful for these efforts and I am proud to have been Chair of the Trust with staff prepared to face up to the vagaries of these challenging times.

The outlook for the Trust, which is summarised on pages 15 and 21, is no less if not more challenging. However, having gone through the experiences and developments of the last year, which include the changes to the leadership team set out on page 15, I believe the Trust is well placed to meet the additional challenges that are going to arise as the Trust moves into the next financial year and beyond.

Stephen Cole

Interim Chair 7 June 2010

Directors' Report

Background information:

Founded in 1738 the Royal National Hospital for Rheumatic Diseases (RNHRD), also known as 'The Min', a reference to its original name 'The Mineral Water Hospital', is a specialist hospital in central Bath with an international reputation for research, and expertise in Rheumatology, complex Neuro Rehabilitation, Pain Management, and Chronic Fatigue Syndrome/ME (CFS/ME). These areas of work remain core to the Trust today. The Trust has a small but internationally known Clinical Measurement Department with access to advanced equipment and technology.

The RNHRD has a strong tradition of innovation. It was one of the earliest hospitals in the world to specialise in the treatment of rheumatic diseases, and was the first truly national hospital to be founded in Great Britain, admitting patients from all over the country. The specialist rehabilitation skills required for the management of rheumatic diseases led to the development of services in neurological rehabilitation and the management of chronic pain and CFS/ME. In 1991 it was one of the first wave of NHS Trusts and in 2005 became a second wave NHS Foundation Trust.

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

Directors

Directors of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust who served and their positions during 2009/10:

Name	**Role**
Stephen Cole	Interim Chair (From 29.04.09)
Kirsty Matthews	Interim Chair (Until 29.04.09) Interim Chief Executive (from 29.04.09)
Peter Hill	Interim Chief Executive (Secondment ended May 2009)
Christopher Johns	Non Executive Director
Sir Peter Spencer KCB	Non Executive Director
Julie O'Donnell	Vice Chair and Senior Independent Director
Rod Barnes	Director of Finance (Until December 2009)
Steven Haynes	Interim Director of Finance (From January 2010)
Tim Jenkinson	Medical Director
Karen Kerley	Director of Human Resources and Membership
Amanda Pacey	Acting Director of Clinical Practice, Professional Nurse Advisor and Director of Infection Prevention and Control
Hayley Sewell	Director of Performance and Governance and Deputy Chief Executive

Principal activities of the Trust

The RNHRD provides a range of general and specialist inpatient and outpatient rheumatology and complex rehabilitation services, including services for Inflammatory and Non-inflammatory Rheumatic Disease, complex Neurological Conditions, complex Pain and Chronic Fatigue Syndrome/ME which both support the local population and attract referrals from across the UK.

The core clinical activities aim, through a specialist, multidisciplinary approach, to address patient needs, to limit disability and maximise quality of life, equipping them with the skills and tools they need to be able to function to their optimum level and reducing demand on health and social care costs post discharge. Services are provided for adults, adolescents and children.

In total the Trust employs around 470 full and part-time staff, (which equates to 306 whole-time equivalents).

Research and Development

The Trust has had a successful year with researchers continuing to engage in a significant number of projects, which provide patients with the chance to trial new treatments, test new methods of diagnosis and prognosis etc and give clinicians training and the opportunity to develop their expertise. The Trust undertakes National Institute for Health Research (NIHR) Portfolio studies, to which it recruited 837 participants, alongside several non-portfolio studies.

The Trust was also successful in increasing its R&D support funding against the original allocation through the Western Comprehensive Local Research Networks (CLRN) funds in recognition of the high level of research undertaken at the Min and the specialist nature of the organisation.

The research programme focuses on all the specialist services provided at the Trust and covers a diverse range of projects from lab-based studies identifying genetics associated with particular diseases; to clinical trials researching new treatments e.g. medications or therapies; as well as assessing the patients' experience of living with a long-term condition and the knock-on impacts on families' and carers' lifestyles.

The Trust continues to achieve a high number of papers published in peer reviewed journals and presented at national and international conferences and meetings recognising the quality of its research results.

This significant level of research activity has enabled the Trust to use funding to improve the R&D infrastructure most notably employing two part-time research nurses in 2010 to ensure dedicated research support in pain studies and Connective Tissue Disease studies. Further recruitment to support studies in Rheumatoid Arthritis, Psoriatic Arthritis and Ankylosing Spondylitis is planned for 2010/11.

The Trust was successful in attracting a significant amount of grant funding with RNHRD staff as main or co-applicants during the 2009/10 financial year. Funding awarded was just over £1.7 million, compared with £1.53 million in 2008/09. During 2009/10 external grant funding was awarded to;

- Dr Candy McCabe NIHR Career Development Award.
- Dr Lance McCracken NIHR Research for Patient Benefit award and St John's Hospital project grant.
- Prof Neil McHugh, ARC programme grant in collaboration with Manchester and a Severn Deanery Academic/clinical fellowship.
- Dr Esther Crawley Action for ME, The Linbury Trust and The Ashden Trust.

The Trust continues to work closely with local universities and maintains its support for staff undertaking higher degrees, helping to secure research infrastructure and resources for the future.

Policies for potential and existing disabled employees

The Trust operates within an equal opportunities policy framework and is recognised as a "two-ticks" disability friendly employer. It has met its relevant publication duties by publication of its Race, Gender and Disability Equality schemes together with associated workforce monitoring reports and any adverse equality impact reports.

We are currently consulting on a Single Equality Scheme. In line with legislation, the Trust always makes reasonable adjustments for disabled staff or job applicants.

Information and involvement of employees

Staff are regularly kept informed as to the performance of the Trust in order to achieve a common awareness of the Trust's situation and to involve staff in decision making. Formal mechanisms to ensure they are informed and involved include:

- A joint staff management committee which meets monthly.
- Monthly operational management group.
- Involvement of staff representatives in the Council of Governors.
- Chief Executive monthly face-to-face briefing open to all staff which is followed up by a written briefing.

In addition, to support the 2010/11 business planning process, a series of business planning workshops has taken place across the Trust in order to engage staff and achieve a common awareness of the financial and economic factors affecting the Trust and raising awareness of the part they play in helping the Trust to achieve its organisational goals.

Business review

Operational review

With the appointment of a new Interim Chair and Chief Executive at the beginning of this financial year with a clear focus on creating an effective platform for merger, the focus of the Executive Team was on maintaining the high quality of care experienced by our patients whilst stabilising the financial performance of the Trust. Pressures were experienced on both income and expenditure with a significant reduction in referrals to the Neuro Rehabilitation Unit against the plan triggering a root and branch review of the service provision. Activity and income levels across the year were maintained by the growth in Rheumatology and Pain Services and this, and the success of the cost improvement plan, allowed the Trust to deliver a surplus at the end of the year. The analysis, against a robust quality agenda, of the range, positioning, price and fit with commissioning intentions of all the services provided at the Min and subsequent developments through the planning process has created a more robust income and activity plan for 2010/11.

A breakdown of patient activity by service area is summarised below:

Service area	**2009/10**	**2008/09**
Rheumatology admitted patients	1,969	1,963
Rheumatology outpatients	19,103	17,590
Neuro Rehabilitation bed days	6,180	7,321
Pain Management programmes	168	135
Pain Management assessments	402	505
CFS/ME adult attendances	522	436
CFS/ME paediatric attendances	636	592

Key issues and developments in Services at the Trust during 2009/10 were:

Rheumatology

Due to improvements in the management of Rheumatic Diseases, outpatient activity and day-case Rheumatology activity for biologic therapy (TNF therapy) continues to grow with a corresponding decrease in inpatient length of stay.

During the year, Rheumatology made a number of service improvements:

- Achiever in meeting the Government 18 week referral to treatment target, and met the NHS South West target of 13 week for all new patient pathways.
- At 2 weeks wait for majority of diagnostic tests.
- Inpatient waiting times have continued to reduce.
- Implementation of MRSA screening has been achieved for all inpatient and day-case patients.

Significant activities during 2009/10:-

- Outpatient Rheumatology referrals increased by 6.5% and activity by 8.6% compared with 2008/09.
- Two Locum Consultant Rheumatologists were employed to increase capacity in outpatient rheumatology.
- Appointment of a new Consultant Rheumatologist, Dr Raj Sengupta, to lead our national specialist Ankylosing Spondylitis Service.
- Physiotherapy Outpatient Lead and Occupational Therapy Service Lead/Clinical Specialist reached the final three in the enhancing self-care and independent living category of the national 2010 Advancing Healthcare Awards, for the Fibromyalgia Outpatient Coping Skills programme at the RNHRD.

Plans for 10/11 include:

- Re-launch the specialist Ankylosing Spondylitis service.
- Expand the TNF service.

- Continue to drive down the length of stay for inpatients in line with best practice.
- Increase the percentage of work carried out on a day-case basis.

Neuro Rehabilitation Services

The trend for a significant shift in case mix away from normal to high dependency patients, across both adult and adolescent services, has continued. However during 2009/10 the level of referrals in to the unit dropped by 15.5% against the previous year and the total number of occupied bed days fell to 6180. This triggered a significant and detailed internal review of the unit which resulted in the following changes:-

- A change in number of planned, staffed beds to 17 with flexibility of staffing and resource to allow an increase in occupancy as demand fluctuates.
- Strengthening of the multidisciplinary team approach.
- A move to more standardised packages of care, whilst maintaining specialist focus.
- Strengthening links with local commissioners and the Southwest Specialist Commissioning Group to agree patient pathways and appropriate positioning against the local providers.

Plans for 10/11 include:

- Provide an outpatient service to assess for Functional Electrical Stimulation treatment. Service already commenced with agreement from the PCT.
- Actively promote Young People's Neuro Rehabilitation as one of the few dedicated younger people's units in the UK and the only unit in the South West and increase activity in this area.
- Work with acute Trusts to meet their waiting time targets by providing the rehabilitation component of the pathway.
- Develop rehabilitation services for the young adult, adult and adolescent stroke patients in line with South West SHA review.
- Strengthen positioning of service through individualised collaborative working with PCTs for the very complex patient.
- Utilise specialist staff to grow the spasticity clinics further. Referrals during 09/10 have increased from 8 patients a month to 16 patients a month.
- Collate evidence-based outcome measures that meet the commissioner requirements to drive an increase in referrals on clinical grounds.

Complex Pain Services

The Trust offers inpatient services in Complex Regional Pain Syndrome (CRPS) and Chronic Pain Management. The Complex Regional Pain Service at the RNHRD is the only one in the UK dedicated to delivering intensive treatment programmes for this condition, and offers both outpatient assessment and treatment and admission to hospital for intensive rehabilitation. This service has expanded to treat younger children with CRPS on a residential basis.

Referrals for Pain Services have increased during 2009/10 by 12% against 2008/09 and the service has seen a continued increase in the complexity of patients treated. This has resulted in the ongoing development of more individual, bespoke packages of care for those patients who are too disabled to access even hospital-based programmes.

Developments during the year included:

- Maintaining the unit's strong research focus and provision of evidence-based treatment. Publications are detailed in the RNHRD Annual Research report.
- Collaborative working arrangements with secondary care providers and academic bodies such as the University of Bath; University of West of England, ongoing work on the SMART research project, secured NIHR funding for research into community based pain management services, research funding for the development of locally delivered, outpatient services for older adults, and ARC funding for a multi-centred trial of different treatment approaches for the management of chronic pain.
- Establishment of a rapid access, psychology/physiotherapy CRPS treatment for children.
- Continued support via Consultant Clinical Psychologist to the children's outpatient pain service at University Hospitals Bristol NHS FT.

Plans for 10/11 include:

- Developing local services, including older adults outpatient programme.
- Continue to develop children's CRPS service.
- Increase activity in pain management programmes for young people and adolescents.

Chronic Fatigue Services (CFS/ME)

The RNHRD is one of the few providers to offer specialist CFS/ME services to both adults and children. The Adult Service is offered at a local level and treatment is provided on a group basis. The Paediatric Service is provided at a national level and the treatment is offered on an individual basis. People severely affected with CFS/ME can be offered treatment at home if appropriate.

The adult CFS/ME team is a therapy led service and has particular expertise in work related rehabilitation. It is active in contributing to work-related research and national agendas around health, work and wellbeing and disability issues in the workplace. The team has a proven track record of effective partnership working in the region.

The paediatric team has nearly doubled activity over the last two years and has developed a unique national service for severely affected children and young people who are seen at home and followed up with local paediatric services. Over the last year, the paediatric service has started to provide clinics in regions without a paediatric CFS/ME service. In order to fill the gaps nationally (only 15% of the country has access to paediatric CFS/ME services) the team has now developed a model satellite service which is due to start early in the 2010/11 financial year. Patient satisfaction surveys demonstrate a high level of satisfaction and the service was the only one to be mentioned publicly by the Health Secretary as providing a good service for children with CFS/ME in the recent parliamentary enquiry into CFS/ME services.

Developments during the year included:

- The paediatric CFS/ME service continues to participate fully in research with the Bristol paediatric CFS/ME team with over £1 million of research funds raised, three clinical studies completed and four papers published in this financial year.

Plans for both CFS/ME Services in 10/11 include:

- Continued involvement in research.
- Continue to develop paediatric satellite services.
- Explore opportunities to develop post Cancer fatigue services.
- Continue to develop and grow work and vocational rehabilitation services.

Clinical Measurement

Throughout 2009/10 the Clinical Measurement team has continued to reduce the DEXA Bone Densitometry waiting time, with many patients seen within two weeks.

Developments during the year included:

- Continuing to deliver a Falls and Fracture Liaison Service in partnership with the Royal United Hospital, BANES PCT and Wiltshire PCT. The aim is to reduce both the number of people who fall, and proportion of falls which result in a fracture, thereby reducing the number of hospital admissions due to falls. This service was recognized by the SW falls, bone health and fractures review (Sept 2009) as an example of good practice.
- The department is currently providing scientific support for a new research study to further investigate non-invasive microvascular imaging techniques in the assessment of Raynaud's Phenomenon and Systemic Sclerosis, funded by the Raynaud's and Scleroderma Association.

Plans for 10/11 include:

- Continue to develop the Falls and Fracture Liaison service.

- Continue to improve and develop the Direct Access Bone Densitometry service.

Future developments

Merger

As part of the 2008/09 financial recovery plan the Trust Board decided to seek an NHS partner with which to merge. Following due process in 2009/10, the Board selected the Royal United Hospital, Bath NHS Trust as the preferred merger partner. However in the autumn of 2009 the Board of the RUH confirmed that they were not in a position to proceed with their Foundation Trust application process at that time which is a pre-requisite to a merger. However, it remains the strategic intention of both Boards to merge with a date of a potential merger of 1 October 2011.

Within this context, the RNHRD presented a three-year stand alone strategy to Monitor, the Independent Regulator of NHS Foundation Trusts, in February 2010 to ensure that the Trust continues to meet the priority of ensuring the high quality services offered to our patients develops and grows within the delivery of an operating surplus.

RNHRD Organisational review

To support the delivery of the three-year plan agreed with Monitor the Trust committed to an organisational review of the Executive and Senior Management structure of the Trust. This review concluded in March 2010 and the proposals were approved for consultation by the Board. The consultation and implementation period for the Board and Senior Management posts was approved at the May 2010 Board meeting. The changes have created a streamlined Executive Team best placed to support the challenges of the three-year plan and prepare for merger. The new appointments create an Executive Team as outlined below:

- Chief Executive - Kirsty Matthews, 12 month extension to interim contract.
- Director of Operations and Clinical Practice - Rayna McDonald, who will hold the post of Director of Infection Prevention and Control and registered nurse on the Board.
- Director of Finance - Steven Haynes.
- Medical Director - Dr Tim Jenkinson.
- Director of Governance - Hayley Sewell.

Significant changes have also been made at the Senior Management level with the introduction of General Management posts to support the delivery of operational services. These changes will ensure clear operational and professional lines of accountability and ensure the clinicians are supported in the delivery of high quality services that add value to patients and the taxpayer.

Finance review

The organisation saw growth in some areas of its service, notably outpatient services in Rheumatology and Pain Management Programmes but a significant reduction in the Neuro Rehabilitation inpatient service. Overall, the level of income from patient related activities was below plan, but this was mitigated by the Trust's Cost Improvement Programme which enabled the Trust to deliver a surplus of £64k. This is the second consecutive year the Trust has returned an in-year financial surplus.

This again demonstrates the Trust's ability to deliver a surplus, but it also shows that the Trust continues to operate on a small margin of profitability and that it remains extremely difficult for an organisation of this size to support the overhead costs associated with maintaining the governance structure required of an independent Foundation Trust. However, the Trust has produced a three-year financial plan which has been discussed with and reviewed by Monitor and which shows a planned surplus in each of the next three years. In addition, all contract values have now been agreed and signed with local Commissioners for 2010/11 and the values within these contracts are in line with the income assumptions in the 2010/11 plan.

The Trust currently has a working capital facility with its bank for £500k. There are ongoing discussions between the two parties where agreement is being sought to replace the present arrangement with a committed finance facility. In the meantime the Trust has produced a cash

flow forecast for 2010/11 which shows that the cash position is planned to improve against the 2009/10 year end value.

In order for the Trust to deliver its target surplus in 2010/11 it plans to deliver a Productivity and Innovation Plan of £810k. This is a challenging target particularly following the cost savings delivered in recent years. A rigorous programme of monitoring and reporting will be in place to ensure that this is delivered. Actions to mitigate any non delivery of savings will be taken promptly in order to ensure the successful delivery if the Trust's 2010/11 financial plan.

In 09/10 the Trust did not make any political or charitable donations. Disclosures relating to market values of non-current assets are in included in the accounts on pages 87 and 88. As a consequence of adopting an update to the value of property assets as estimated in consultation with the district valuer, a decrease in the value of freehold land and freehold buildings of £702k has been recognised in the Statement of Comprehensive Income and reduction in Taxpayers' Equity.

In so far as the Board of Directors is aware, there is no relevant information of which the auditors are unaware, and the Directors have taken all of the steps that they should take as Directors to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Kirsty Matthews

Interim Chief Executive 7th June 2010

Operating and Financial Review 2009/10

Introduction

This report presents an analysis of the RNHRD's performance for the year ended 31st March 2010, reviewing significant events and looking forward to key events and issues expected in the year ahead.

In setting out its objectives for 2009/10 the Trust identified the importance of delivering financial balance and realising a capital cash receipt through the sale of 11 Trim Street to support investment in services and to improve the speed with which payments are made to suppliers.

The delivery of higher overall levels of clinical activity and income and improved cost management across the organisation during the year meant that the Trust was able to deliver a financial surplus of £64k for the twelve months to the 31st March 2010, following the surplus in 2008/09 after three successive years' financial deficits. The Trust has also been able to make reasonable progress in reducing its level of short-term payables through the utilisation of its capital cash receipt. At the end of the year the Trust has recognised from an update to the value of property assets as estimated in consultation with the district valuer, a decrease in the value of freehold land and freehold buildings of £702k has been recognised in the Statement of Comprehensive Income and reduction in Taxpayers' Equity.

Overall the Trust's performance during the last year demonstrates a stabilising of the work undertaken in the previous year and continues to be a sign of the commitment shown by the Trust's staff and stakeholders to tackling and resolving the organisation's recent difficulties. Nevertheless it is also recognised that there is still much to be achieved to ensure longer-term financial assurance.

Our Financial Objectives as an NHS Foundation Trust

The Trust's financial performance is reviewed by Monitor, the Independent Regulator of NHS Foundation Trusts. The system of regulation assigns a financial risk rating to the Trust and uses a scorecard system to compare key financial metrics on a consistent basis across all NHS Foundation Trusts. These measures assess organisations' performance in relation to achievement of a financial surplus, delivery of annual plan targets, return on capital employed and financial liquidity. In addition the Board is provided with regular reports on performance by service line, capital expenditure, cashflow and delivery of cost improvement schemes.

As can be seen from the financial tables that follow, further improvements have been made in the Trust's underlying financial performance building on the position in the previous year. However this has yet to translate into improvements in the organisation's financial risk rating. Principal issues remain high levels of amounts owed to payables and relatively low profitability of services. Overall the Trust has been assigned a risk rating of 2, out of a possible maximum of 5 (with 5 being the lowest risk and 1 being the highest risk).

The Trust has developed and implemented a number of measures to improve both the financial liquidity and profitability in the coming year, including cost saving measures and improved plans on cash management.

Funding Overview

The Trust earned £19.7m in income during 2009/10 - compared with £19.1m in 2008/09 an increase of 3.1%. This is primarily from NHS clinical activities, but the Trust also receives income from education, training and research, private patients and non-clinical services such as running conferences and catering services.

Clinical income received by the Trust is generated by five main areas of practice, Rheumatology, Neuro Rehabilitation, Chronic Pain, Chronic Fatigue Syndrome/ME and Diagnostics. Overall clinical income was £842k less than planned. This was due to a significant underperformance against plan in Neuro Rehabilitation of £961k. The issue of growing clinical income remains one of the major challenges in the years ahead. A breakdown of income by service area is set out below:

Breakdown of clinical income, including high cost drugs:

Service area	**09/10 £'000**	**08/09 £'000**
Rheumatology	11,899	10,901
Neuro Rehabilitation	3,933	4,681
Pain	1,605	1,281
CFS/ME	499	333
Others	557	363
Total	18,493	17,559

Income for Rheumatology services comes under the national fixed price funding system known as Payment by Results. Under this system, the Trust receives income based on the number of inpatients, day cases and outpatients treated at national tariff rates. Because of the specialist nature of the Trust's activities, the remainder of the Trust's patient-related services fall outside of the scope of Payment by Results and income is received based on locally agreed prices. Rheumatology income increase is largely due to movement of tariff from HRG3.5 to HRG4 in April 2009, but also higher income from High Cost Drugs of £700k in 2009/10 (offset by an increase in the cost of high cost drugs of a similar size).

Income from patient care	**Operating income**	
	2009/10	**2008/09**
	£'000	**£'000**
Elective Patients	5,415	5,772
Non-Elective Patients	4,307	5,116
Outpatients	4,166	2,850
Sub-total of PCT patient related income	13,888	13,738
Private Patients	208	136
High cost drugs	4,048	3,359
Other patient income	349	326
sub-total	18,493	17,559
Other income		
R&D	643	350
Education & Training	279	*1,001
Transfers from donated asset reserve	62	0
Charitable contributions	53	67
Other income	182	78
sub-total	1,219	1,496
Total income	19,712	19,055

*During the year, there has been some reclassification of the income categories but the prior year's figures have not in every case been restated. As a consequence, there are some apparent anomalies in comparing current year individual income categories with the previous year.

Under its terms of authorisation, the hospital's proportion of income from private patients should not exceed the proportion of this income to total clinical income achieved in 2002/03. This figure equates to a maximum level of private patient income being 1.31% of total clinical income. Private patient income for 2009/10 was £208k; representing 1.12% of RNHRD's total patient related income and therefore the Trust is compliant with this obligation.

Expenditure Overview

Containing and managing costs whilst improving the quality of our services also continues to be a major challenge for the organisation. Significant cost reductions in excess of the original plan have been delivered in year in order to offset the underachievement in income against plan from clinical activities. In the main these have come from improved management of temporary staff and sickness, reduction in support and administrative functions, and stringent review of vacancies when they occur.

Further savings have been achieved by reviewing areas of non-pay discretionary expenditure to reduce non-essential costs as well as continuing to negotiate lower charges for both clinical and non-clinical services bought in from external organisations.

Operating Expenditure	**Operating expenses**	
	2009/10	**2008/09**
	£'000	**£'000**
Staff Costs	10,334	10,643
Directors' Costs	465	456
Clinical Supplies & Services	336	353
Services from other NHS Trusts	976	922
Non Clinical Supplies & Services	176	139
Premises Costs	1,064	864
Depreciation	501	459
Audit Fees	144	94
Other Costs	1,052	1,137
Sub-total	15,048	15,067
Drug Costs	4,369	3,628
Total	19,417	18,695

Management Costs

The Trust is required to record its management costs according to parameters set by Monitor and to state these in relation to relevant income. Management costs of the Trust equate to 10.1% of the Trust's total income, as shown below.

	2009/10	**2008/09**
	£'000	**£'000**
Management costs	1,998	2,165
Income	19,712	19,055
Costs as a percentage of income	10.1%	11.4%

Management costs and related income figures are as defined in the documents which can be found on the internet at http://www.doh.gov.uk/managementcosts

Cash and Working Capital

During 2009/10, action has been taken to improve working capital management including the use of the cash generated by the sale proceeds of 11 Trim Street. This has reduced the level of payables. Alongside this, the Trust is continuing to improve its receivables and cash management processes. The cash position through the year had fallen below the £327k opening balance, but stands at £512k at the close of the financial year.

The overall movement in net liabilities in the year can be summarised as follows:

	£'000	£'000
Operating surplus		295
Depreciation	501	
Adjustment relating to donated assets on disposals	(23)	
Sales of property, plant and equipment	455	
Purchase of property, plant and equipment	(320)	
Purchase of intangible assets	(23)	
Adjustment relating to capital liabilities	(25)	
Capital element of finance lease payments	(11)	
		554
Net interest paid	(18)	
PDC Dividend paid	(241)	
		(259)
Net cash flow to reduce net indebtedness		590
Opening net liabilities		(1,150)
Closing net liabilities		(560)

Formal intervention actions taken by Monitor during July and December 2008 resulted in the Trust's committed working facility being replaced with a facility "repayable on demand" by the Trust's bankers, The Royal Bank of Scotland (RBS). This facility remains in place for £500k although the Trust has not needed to utilise this facility through management of working capital balances.

Better Payment Practice Code

The Better Payment Practice Code requires NHS organisations to aim to pay all valid non-NHS invoices within 30 days of receipt or the due date whichever is later.

Better Payment Practice Code – measure of compliance

	2009/10		2008/09	
	Number	**£000**	**Number**	**£000**
Total bills paid in the year	4,284	6,052	4,614	5,989
Total bills paid within target	2,158	1,431	1,786	883
Percentage of bills paid within target	50.37%	23.65%	38.71%	14.74%

The Board of Directors recognises that compliance with this code is compromised by pressures on the organisation's short term liquidity arising from previous years' financial deficits.

Borrowing Limit

The tests for setting the Prudential Borrowing Limits changed during the year. The amounts of the Prudential Borrowing Limits are set out at note 18 to the annual accounts page 90. The Trust has not borrowed against the borrowing limits during the financial year.

Capital Developments in 2009/10

Capital expenditure plans are focused on improving the hospital environment and clinical services. During 2009/10, the Trust carried out capital projects with an in-year cost of £345k. These capital schemes included upgrading and improving patient facilities under the NHS single sex initiative and the provision of an enhanced Fracture Clinic facility.

Managing Risks

In common with other healthcare providers the organisation faces a number of operational and strategic risks related to the clinical delivery of services and corporate governance. The Trust is also exposed to a variety of financial risks such as the loss of income due to national funding changes, failure to deliver activity in line with plans and unforeseen cost pressures or failure to achieve cost improvement/efficiency targets.

In order to manage these risks, the Trust needs to continue to ensure that appropriate systems are in place. These are based on reporting on and forecasting the Trust's financial position along with the receiving of, and taking appropriate action on, the reports provided by the Trust's internal and external Auditors.

Improvement in invoicing procedures, strengthening of debt recovery arrangements and a more proactive approach to creditor management during 2009/10 have avoided the need to use the Trust's on demand credit facility; however the size of the working capital deficit remains a significant financial risk.

It should also be noted that the relatively small size of the Trust means that clinical services carry a higher proportion of overhead costs associated with the Trust Board and back office services. These factors hinder the delivery of larger financial surpluses.

Success in mitigating these risks will be dependant on continuing actions to deliver against budgets and reduce costs in order to deliver sufficient financial headroom to meet both expected and unforeseen financial and business risks.

Looking Ahead: Future Spending Plans

2010/11 is the final year of the current comprehensive spending review with the planned allocations to PCTs increasing nationally by an average of 5.5% over 2009/10. Locally, BANES and Wiltshire have received uplifts of 5.1% and 5.3% respectively. However, no additional funding has been allocated to Trusts through the national price tariff so all internal cost pressures such as pay awards will need to be met through internally generated funds. In addition, strong early indications are that there will be no growth in the following two years due to tighter government spending plans for 2011/12 and 2012/13.

Within this context, the Trust's current three year financial plan projects the delivery of small financial surpluses in each of the three years from 2010/11 through ongoing delivery of savings above national efficiency assumptions and some income growth through expansion of Chronic Pain and Paediatric CFS/ME services.

Competitive environment

In the NHS, the Trust is now exposed to a more commercial environment than ever before, in which income is increasingly at risk from competition from other NHS hospitals, the independent sector and community healthcare providers. However, all contracts with local commissioners for the new year have been signed and significant work has been undertaken to deliver cost reductions in the Productivity and Innovation Plan.

Going Concern

After making enquiries, the Board of Directors has a reasonable expectation that the Trust has adequate resources to continue operating for the foreseeable future. For this reason, the Trust continues to adopt the going concern basis in preparing the accounts.

External Auditors

The external auditor for RNHRD is: PricewaterhouseCoopers LLP, 31 Great George Street, Bristol BS1 5QD. The external auditor is independently appointed by the Council of Governors from an approved list recommended by the Board of Directors. The total cost of audit services for the year was £82k. This was for the statutory audit of accounts for the 12 months ending 31st March 2010 and services carried out in relation to this.

To ensure the independence of its external auditors, the Trust is careful not to commission relevant PricewaterhouseCoopers staff to perform operational roles. This assurance is also maintained by the firm's own internal practices.

Annual Accounts

Full details of the Trust's 2009/10 financial position can be found in the Trust's audited annual accounts (from page 52 of this report).

The Trust's accounting policies are set out in note 1 of the annual accounts.

The accounts have been prepared under a direction issued by Monitor.

Accounting policies for pensions and other retirement benefits are set out in note 7.1 (page 84) to the accounts.

Remuneration Report

In 2009/10 remuneration for Executive and non-voting Directors was decided by the Remuneration Committee in accordance with the existing terms and conditions of service of these Directors and there were no variations to this. The Remuneration Committee uses external advice to assess market and NHS factors relating to remuneration and to advise on determining appropriate levels of remuneration for the Trust's Executive Directors taking into account the Trust's size and complexity.

Membership of the Committee is made up of the Trust Chair and all Non-Executive Directors. The Remuneration Committee met four times during the year:-

Name	Role	Attendance from 4 meetings
Stephen Cole	Chair, and committee Chair	4
Chris Johns	Non Executive Director	4
Sir Peter Spencer KCB	Non Executive Director	4
Julie O'Donnell	Non Executive Director	4
Karen Kerley	Director of HR & Membership	In attendance at 2 meetings
Kirsty Matthews	Interim Chief Executive	In attendance at 1 meeting and partial attendance at 1 meeting

Details of remuneration and pension information are detailed within the financial statements at the end of this report.

Pensions and Remuneration

Accounting policies for pensions and other retirement benefits are set out in note 7.1 to the accounts. Details of senior employees' remuneration can be found in note 6.4 to the accounts page 82 to 83, this is subject to audit. The remainder of the remuneration report is not subject to audit.

Statement of the policy on the remuneration of senior managers

The Remuneration of executive posts was agreed at a 1.5% uplift from April 2009. There are no remuneration arrangements subject to performance conditions.

Name	Role	Appointed	Length of Term	Notice period
Kirsty Matthews	Interim Chair	Appointed by Monitor December 08	6 months	N/A
Kirsty Matthews	Interim Chief Executive	Appointed by Monitor April 09	6 months	3 months
Stephen Cole	Interim Chair	Appointed by Monitor April 09	6 months	3 months
Sir Peter Spencer KCB	Non Executive Director	December 07	3 years	3 months
Julie O'Donnell	Non Executive Director	September 07	3 years	3 months
Chris Johns	Non Executive Director	October 07	3 years	3 months
Peter Hill	Interim Chief Executive	Seconded to the RNHRD August 08	Secondment ended May 09	N/A
Rod Barnes	Director of Finance	February 08	Resigned December 2009	N/A
Steven Haynes	Interim Director of Finance	January 10	6 months	N/A
Tim Jenkinson	Medical Director	April 07	3 years	3 months
Amanda Pacey	Acting Director of Clinical Practice, Professional Nurse Advisor, Director of Infection Prevention & Control	March 09	12 months	2 months
Hayley Sewell	Director of Governance &	July 05	N/A	3 months

	Performance			
Karen Kerley	Associate Director of HR & Membership	October 05	N/A	3 months

With the exception of the Interim Directors, for whom the arrangements are described above, Executive Directors are on permanent employment contracts, with terms and conditions consistent with those for Agenda for Change. Directors are covered by the redundancy and retirement provisions of the NHS Pension Scheme. There are no additional early termination provisions in place. Full details are included in the audited accounts note 6.4 on page 82 to 83.

Performance of the Board and Senior Management team is assessed through the Trust's annual appraisal system whereby staff are set individual objectives and development plans which support delivery of the organisations strategy and performance targets.

The Chair leads in the annual appraisal of the Non-Executive Directors with input from the Council of Governors. The Senior Independent Director leads in the annual appraisal of the Chair with input from the Council of Governors.

Signed: ……

Kirsty Matthews

Interim Chief Executive Date: 7th June 2010

NHS Foundation Trust Code of Governance

The Trust considers that it complies with the specific disclosure requirements set out in Monitor's best practice advisory document "The NHS Foundation Trust Code of Governance". Particular provisions within the Code addressed in this report are as follows:

- A statement of how the Board of Directors and the Board of Governors operate, including a high-level statement of which types of decisions are to be taken by each of the Boards and which are to be delegated to management by the Board of Directors (Code of Governance ref. A.1.1); page 26 in this report.
- The names of the Chairman, the deputy Chairman (where there is one), the Chief Executive, the Senior Independent Director and the Chairmen and members of the Nominations, Audit and Remuneration Committees (A.1.2); pages 30 and 33.
- The number of meetings of the Board of Directors and those committees and individual attendance by Directors (A.1.2); page 32 in this report.
- The names of the Non-Executive Directors whom the Board determines to be Independent, with reasons where necessary (A.3.1); page 30 to 32 in this report.
- A description of each Director's expertise and experience (A.3.4); from page 30.
- A clear statement about the Board of Directors' balance, completeness and appropriateness (A.3.4); page 30 in this report.
- The names of the Governors and details on their constituency, whether they are elected or appointed and the duration of their appointments, together with details of the nominated lead Governor (B.1.3); pages 26 to 28 in this report.
- The number of meetings of the Board of Governors and individual attendance by Governors and Directors (B.1.3); pages 26 to 28 in this report.
- The other significant commitments of the Chairman and any changes to them during the year (C.1.7); page 31 in this report.
- A separate section describing the work of the Nominations Committee, including the process it has used in relation to Board appointments and an explanation if neither external search consultancy nor open advertising has been used in the appointment of a Chairman or Non-Executive Director (C.1.14); page 33 in this report.
- How performance evaluation of the Board of Directors, its committees and its Directors has been conducted (D.2); page 24 in this report.
- As part of the remuneration disclosures of the annual report, where an Executive Director serves as a Non-Executive Director elsewhere, whether or not the Director will retain such earnings (E1.3); pages 23 and 30 in this report.
- An explanation from the Directors of their responsibility for preparing the accounts and a statement by the auditors about their reporting responsibilities (F.1.1); page 16 and 61 of this report.
- A statement from the Directors that the business is a going concern, with supporting assumptions or qualifications as necessary (F.1.2); page 21 in this report.
- A report that the Board has conducted a review of the effectiveness of the group's system of internal controls (F.2.1); page 55 to 60 in this report.
- A separate section describing the work of the Audit Committee in discharging its responsibilities (F.3.3); page 33 in this report.
- Where the Board of Governors does not accept the Audit Committee's recommendation on the appointment, reappointment or removal of an external auditor, a statement from the Audit Committee explaining the recommendation and the reasons why the Board of Governors has taken a different position (F.3.5); page 33 in this report.
- An explanation of how, if the auditor provides non-audit services, auditor objectivity and independence is safeguarded (F.3.8); page 22 in this report.
- Contact procedures for members who wish to communicate with Governors and/or Directors (G.1.4); page 35 in this report , and
- The steps the Board has taken to ensure that members of the Board, and in particular the Non-Executive Directors, develop an understanding of the views of Governors and members about their NHS Foundation Trust (G.1.5). page 26 in this report.

Council of Governors

This Foundation Trust has a framework of local and national accountability through members and of governance through our Council of Governors and Board of Directors. Our Council of Governors has an invaluable role in representing members' views, contributing to the Trust's strategic direction and ensuring that the Board of Directors meets its terms of authorisation.

Relationship with the Board of Directors

The Board of Directors is collectively responsible for the exercise of the powers and the performance of the Trust. The role of the Board of Directors is to provide active leadership of the Trust. It is responsible for the operational running of the trust and is responsible for ensuring compliance with our terms of authorisation, constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.

The Board sets the Trust's strategic aims, but in setting forward plans takes into consideration the views of the Council of Governors. The Board is responsible for ensuring that the necessary financial and human resources are in place for the NHS foundation trust to meet its objectives.

The Council of Governors

The Council of Governors provides a direct link to our community and represents the interest of members and stakeholder organisations in the stewardship and development of the Trust. The Council of Governors ensures that the Trust is responsive to the needs and values of all stakeholders; patients, public, staff and partners organisations. The Council of Governors holds the Board to account for the performance of the Trust, including ensuring that the Board acts so that the Trust does not breach the terms of its authorisation. The Council of Governors regularly feeds back information about the Trust, its vision and its performance to the membership constituencies and stakeholder organisations that either elected or appointed them.

In addition the Council of Governors has statutory responsibilities which are set out on pages 28 and 29.

Representatives from the Council of Governors attend the Board Meetings on a rotational basis and present the views of the Council and the members. Non-Executive Directors and Executive Directors each have a link into one of three Governors working groups: Governance, Service Development, and Membership. This allows individual members of the Board to understand the views of the Council of Governors. Further feedback is directed to the Board through the Chair of the Board who regularly meets with the Chairs of the three working groups.

Governors of the Council are appointed or elected for a two or three-year period. At the end of this period, elected Governors have the opportunity to stand for re-election and appointed Governors may be re-appointed by their organisation for a further two or three-year period. The maximum term for all members of the Council of Governors is six years.

Constituencies

The Council of Governors is made up of three constituencies as well as appointed partnership organisations as follows:

- The Public constituency is made up of non-patient members
- The Patient constituency is made up of patients of the Trust
- The Staff constituency is made up of employees of the Trust.

There were no elections during 2009/10. The table below shows the composition of the Council of Governors, the constituency or organisation each Governor represents how the Governors were elected/appointed and the length of office.

There have been five formal meetings of the Council of Governors between April 2009 and March 2010. Attendance by Governors, Directors and Non-Executive Directors is also shown in the table below.

Elected Governors – Public constituency

Name	Date elected / re-elected	Term of Office	Attendance from 5 meetings
Judith Beresford Smith	01/03/2008	3	5
Hilary Elms	01/03/2008	3	4
Peter Miles	01/03/2008	3	5
Francis Ring	01/03/2008	3	4
Ben Rogers	01/03/2008	3	5

Elected Governors – Patient constituency

Name	Date elected / re-elected	Term of Office	Attendance from 5 meetings
John De Normann	01/03/2008	3	5
Donn Boyland	01/03/2008	3	5
George Odam	01/03/2008	3	2
Judy Coles	01/03/2008	3	5
Tony Barber	01/03/2008	3	5
Vivienne Pozo	01/03/2008	3	4
Kenneth Bray (Nominated Lead Governor)	01/03/2008	3	3
Brian Jenkins (Resigned 26/09/2009)	01/03/2008	3	1/2
Elizabeth Brealey (lead Governor, resigned 09/12/2009)	01/03/2008	3	3/3

Staff Governors

Name	Date elected / re-elected	Term of Office	Attendance from 5 meetings
Caroline Holcombe (Resigned 12/03/2010)	01/03/2008	3	0/4
Jo Earley (Resigned 02/03/2010)	01/03/2008	3	1/4

Appointed Governors

Name	Organisation	Appointed / re-appointed	Term of Office	Attendance from 5 meetings
Tim Bilham	Bath University	03/11/2009	2	1/2
Stephen Booth	UWE	27/10/2008	2	0
Sara Brooks	Action for ME	30/01/2010	2	1
Lee Eborall (resigned 8/05/2009)	BANES PCT	02/10/2008	2	0/0 – There were no meetings from 1st April 2009-8th May 2009
Corinne Edwards	BANES PCT	03/11/2009	2	0/2
Peter Haines	Headway	26/03/2009	2	5
David Lavington	National Ankylosing Spondylitis Society	01/03/2009	2	4
Sue Meadows	National Osteoporosis Society	01/03/2009	2	2
Connie Wright	BANES LINKS	17/02/2010	2	2/2
Pippa Penfold-English (resigned 12/03/2010)	Arthritis Care	19/08/2008	2	0/3
Jo Hunt	Arthritis Care	12/03/2010	2	0/1
Alan Hall	BANES Council	01/11/2009	2	0

Directors' attendance

Name	Position	Attendance from 5 meetings
Stephen Cole	Trust Chair & Chair of the Council of Governors	5
Kirsty Matthews	Interim Chief Executive	5
Hayley Sewell	Director of Performance & Governance	3
Karen Kerley	Director of HR & Membership	3
Tim Jenkinson	Medical Director	0
Steven Haynes	Director of Finance	1/2
Amanda Pacey	Acting Director of Clinical Practice, Professional Nurse Advisor and Director of Infection Prevention & Control	1
Rod Barnes (resigned December 09)	Director of Finance	3/3
Julie O'Donnell	Non Executive Director	1
Peter Spencer	Non Executive Director	2
Chris Johns	Non executive Director	3

Vacancies on the Council of Governors

Constituency	Vacancies
Public	3
Patient	3
Staff	4

The Council of Governors meets formally four times a year, and informally twice a year, and additionally when called. Council Governors are requested to attend all of these meetings each of which run between 10am and 3.30pm. In addition to this time commitment for Council of Governors meetings, the Trust holds an Annual Members Day, which the Council are asked to attend. Council Governors also have the opportunity to be involved in sub-groups and promotional work.

All Council Governors complete an annual declaration of interest. This information is available from the Membership Support Team:

RNHRD NHS Foundation Trust
FREEPOST SN1301
Upper Borough Walls
Bath
BA1 1RL
Telephone: 01225 465941 x295
Email: nhsft@rnhrd.nhs.uk, Website: www.rnhrd.nhs.uk

Members can contact the Council of Governors or request information on Council of Governors meetings and attendance by Council Governors at these meetings through the Membership Support Team.

The Monitor Code of Governance and the Trust's Constitution set out various powers of, and obligations upon Council Governors, as summarised below:

- To represent members and partner organisations from the local health economy.
- To feed back information to members.
- To receive, consider and provide feedback on the Trust's Annual Report and Accounts and Annual Plan.
- To take responsibility for appointing, re-appointing and removing the Chair and other Non-Executive Directors.
- To decide the remuneration and allowances and the other terms and conditions of office of the Chair and Non-Executive Directors and to review this on an annual basis.

- To be involved in agreeing a process for and outcome of evaluation of the Chair and Non-Executive Directors.
- To approve the appointment, re-appointment or removal of the Chief Executive Officer.
- To appoint and remove the Trust's auditor.
- To develop the Trust's membership in line with the Trust's Membership Strategy.
- To act in the best interests of the Trust and adhere to its values.
- To engage in dialogue with the Trust's Board of Directors and invite members of the Board to their meetings as appropriate.
- To hold the Board of Directors to account for the performance of the Trust, ensuring that it does not breach its terms of authorisation and informing Monitor if there is a risk of these being breached.
- To undertake an annual self-evaluation of its own collective performance and its impact on the Trust and develop an Annual Work plan arising from this evaluation.
- To regularly communicate the outcomes of their involvement within the Trust to members, including their impact and effectiveness.

Members of the Board of Directors attend the Council of Governors' four formal meetings. The Chief Execuive provides updates to the Council on the present work of the Trust and takes feedback, the Finance Director provides information on the present financial situation and the Council has the opportunity to put questions to the Finance Director and feed-in their views and opinions. Representatives from the Non-Executive Directors attend the Council of Governors' formal meetings. In addition representatives from the Council of Governors attend open board meetings. Non-Executive Directors (NEDs) sit on committees along-side the Council Governors, e.g. the Audit Committee. NEDs also attend, with the rest of the Board, the Annual Members Day to meet active interested members. This day is an opportunity for market research and to find out members' views of the hospital's services.

Board of Directors

Statement about the balance, completeness and appropriateness of the membership of the Board

The Constitution requires the Board to comprise the Chair, Chief Executive, four additional Executive Directors and five Non-Executive Directors. An Associate Director attends the Board meetings but does not have any voting rights at the Board of Directors. Throughout 2009/10 there have been two non executive director vacancies. However, in view of the status of the Trust as explained more fully throughout this report, it was decided by the Board in agreement with the Council of Governors that it would not have been appropriate during the period to seek appointees to fill the vacancies. Governance requirements have been met through the Chair and Non-Executive Directors roles on committees and their attendance at Board meetings as set out on page 32. There is a clear separation of the roles of the Chair and the Chief Executive. The Chair has responsibility for the running of the Board and the Council of Governors, setting the agenda for the Trust and for ensuring that all directors are fully informed of matters relevant to their roles.

In addition to the Non-Executive Director vacancies, the Audit Committee had highlighted a gap in the Board composition because none of the Non-Executive Directors has an accountancy qualification. However, the Chair has an accountancy qualification and the current Non-Executive Directors have extensive experience of budget management. Members of the Board have a wide range of experience from both the public and private sectors. The Chair and Non-Executive Directors have combined experience of corporate finance, social care, voluntary sector, armed forces and civil service. The Executive Directors have extensive experience in the NHS and private sector. Short biographies are detailed below.

Non-Executive Director appointments to the Board may be terminated at the wish of the incumbent, or by the Council of Governors ratified by a two-thirds majority. A term of office for Non-Executive Directors is three years. All the Non-Executive Directors are Independent Directors in line with the NHS Trust Code of Governance. The Trust holds a public Register of Interests which is available from the Chief Executive's Office.

The Chair conducted appraisals of the Chief Executive and with Governors forming the Appointments Committee the Non-Executive Directors in 2009/10. The Executive Directors were appraised by the Chief Executive.

The Board has identified the need to address its balance, completeness and appropriateness. As part of an organisational review started in January 2010 and concluded in May 2010, the Board has agreed that the appropriate balance between the Executive and Non-Executive Directors, including Chair, should be revised to Chair, Chief Executive, three other Executives and four Non-Executive Directors. Consequential amendments to the Constitution will be put for approval by the Council of Governors at a forthcoming meeting and steps taken to fill the then one vacant Non-Executive Director position.

The Board of Directors

Kirsty Matthews, Interim Chair / Interim Chief Executive Officer

Kirsty was appointed by a Monitor Intervention in December 2008 as Interim Chair. In April 2009 she was then appointed by a second Monitor Intervention as Interim Chief Executive Officer taking over from Peter Hill following the expiry of his secondment from Salisbury NHS foundation trust. Kirsty was previously Director of Strategy for a private healthcare provider and has a background in General Management in the NHS and Business Development in the Private Sector. Kirsty is educated to Masters Degree level.

Stephen Cole, Interim Chair

Stephen was appointed by a Monitor Intervention as Interim Chair in April 2009 following Kirsty Matthews' appointment of Interim Chief Executive Officer. Stephen, a FCA, was for 21 years a partner at KPMG LLP and has significant corporate experience. Stephen is Honorary Treasurer/Trustee of InControl Partnership Ltd.

Christopher Johns, Non Executive Director

Chris was appointed in October 2007 for a period of three years. Chris has a background in the management and regulation of social care. He has worked in local and central government and in the voluntary sector. Chris is currently a senior lecturer at the University of Wales Institute, Cardiff, and his employment immediately prior was as Policy and Campaigns Manager for Arthritis Care and a part time management consultant. Chris is a Trustee of Tubbs Charity.

Sir Peter Spencer KCB, Non Executive Director

Peter was appointed in December 2007 for a term of three years. Peter has had a distinguished career in the Royal Navy where he finished his service as Second Sea Lord and C in C Naval Home Command. In 2003 he retired from the Royal Navy and became a senior civil servant in the Ministry of Defence, as Chief of Defence Procurement, until April 2007. Since then he has taken on the position of Chief Executive of Action for ME, a charity that is committed to improving the lives of people with ME today whilst working to create a better future, and a Non-Executive Director of Firebuy ltd.

Julie O'Donnell, Non Executive Director (Vice Chair & Senior Independent Director)

Julie O'Donnell was appointed in September 2007 for a term of three years. She was appointed to the position of Vice Chair, and Senior Independent Director in January 2009. She originally trained as a nurse, and moved into various positions within the social and residential care sectors, all of which involved close liaison with the NHS. She previously worked as the Chief Executive of a national charity, the British Institute for Brain Injured Children. She was responsible for transforming the charity into a thriving national organisation from its modest beginnings as a local charity. Julie is a Director of Fulford House Consulting Ltd, Cassis Consulting Ltd and Café Junior Ltd, patron of Vital for Children and a Trustee of Bath Institute for Rheumatic Diseases (BIRD).

Peter Hill (secondment ended May 2009)

Peter Hill was appointed Interim Chief Executive in August 2008. Peter is an experienced Executive Director of Salisbury NHS Foundation Trust. Peter has a wealth of NHS experience which includes nursing, and senior management positions including several at executive level. He is educated to Master degree level with an MBA that majored on finance, marketing, public sector and human resource management.

Rod Barnes, Finance Director (resigned Dec 2009)

Rod joined the Trust in March 2008 from Taunton and Somerset NHS Foundation Trust where he was Deputy Director of Finance. Prior to this he has worked for a number of hospitals across England in roles incorporating finance, clinical information and capital planning and in the private sector. Rod is an Associate Member of the Chartered Institute of Management Accountants and holds an MBA from Bath University.

Steven Haynes, Interim Finance Director

Steven was appointed Interim Finance Director in January 2010 following Rod Barnes' resignation. Steven has worked in senior positions in NHS Finance since 1990.

Tim Jenkinson, Medical Director

Tim Jenkinson was appointed as Medical Director in April 2007. Tim started as a Consultant in Rheumatology and Sports Exercise Medicine at the Trust in 2000. He is an Honorary Senior Lecturer in Sports and Exercise Medicine at the University of Bath and is an Honorary Senior Medical Advisor to the Football Association.

Karen Kerley, Associate Director of Human Resources & Membership

Karen Kerley was the HR manager before taking on the role of Director of Human Resources and Membership. Karen was appointed to the Board in 2005 as an Associate Director and brings with her extensive public sector knowledge including that gained from the civil service.

Amanda Pacey, Acting Director of Clinical Practice, Professional Nurse Advisor and Director of Infection Prevention and Control

Amanda was appointed to the Board in March 2009 as Acting Director of Clinical Practice, Professional Nurse Advisor and Director of Infection Prevention and Control. She has previously acted in the role between August and October 2008. Amanda started work at the RNHRD in 2001 undertaking a number of different nursing roles, prior to which Amanda worked as a midwife and infection control nurse. Amanda has a BSc in English and Biology and a BSc in Specialist Practice.

Hayley Sewell, Director of Governance and Performance and Deputy Chief Executive

Hayley Sewell was appointed to the Board in 2005 and has responsibility for Governance, Performance Management, Marketing, Rheumatology, Neuro Rehabilitation and Chronic Fatigue Syndrome/ME. She has 21 years experience in the NHS and completed the NHS Clinical Strategist Programme at INSEAD in 2003, an MSc from Kings College London in 1994 and began her NHS career as a Chartered Physiotherapist.

Board of Directors' attendance

Name	Trust Board (From 13 meetings)	Audit Committee (From 5 meetings)	Remuneration Committee (From 4 meetings)
Stephen Cole	12/12	1	4
Kirsty Matthews	13	5	In attendance at 1 partial attendance at 1
Christopher Johns	11	-	4
Sir Peter Spencer	12	5	4
Julie O'Donnell	12	5	4
Peter Hill	1/1	-	-
Rod Barnes	10/10	3/3	-
Steven Haynes	3/3	2/2	-
Tim Jenkinson	11	-	-
Karen Kerley	13	-	In attendance at 2
Amanda Pacey	12	-	-
Hayley Sewell	12	2/2	-

Audit Committee

Audit Committee Membership: Peter Spencer is Chair of the Committee. Julie O'Donnell is the other member. The Chair of the Foundation Trust, Stephen Cole, is available to attend as and when appropriate. Two Governors attend all meetings.

There were five meetings of the Audit Committee in 2009/10:

Name	Role	Attendance from 5 meetings
Peter Spencer	Chair	5
Julie O'Donnell	NED	5
Rod Barnes	Finance Director	3/3
Kirsty Matthews	CEO	5
Steven Haynes	Finance Director	2/2
Hayley Sewell	Director of Governance & Performance	2/2
Stephen Cole	Chair RNHRD	1

During 2009/10 the Audit Committee has continued to discharge its responsibilities in accordance with its Terms of Reference and the requirements of the Code of Governance and the Audit Code for Foundation Trusts. In particular the main performance evaluation activities have been:

- Strategic risk management with particular emphasis on mitigating risks to health standards and risks to the financial status of the Trust.
- Reviewing reports from the Risk Management Committee.
- Conducting the annual self-assessment against the standard format and producing an action plan for implementing further improvements.
- Feedback from the representatives from the Council of Governors who attended Audit Committee meetings.
- Private discussions with the internal and external auditors to get their feedback on Audit Committee processes and effectiveness.
- Tracking the implementation of a consolidated list of all audit recommendations. This is now reported at every meeting of the Audit Committee.
- Reviewing our Terms of Reference.

During the year the Council of Governors accepted a recommendation of the Committee, made via the Board of Directors, for the re-appointment of the existing external auditors for 2009/10.

Appointments Committee of the Council of Governors

The Appointments Committee of the Council of Governors is the nomination committee responsible for the appointment and remuneration of the Chair and other Non-Executive Directors of the Board. The membership of this committee is decided as and when required; members are used from the Governance sub committee of the Council of Governors.

The following Governors served as members of the Appointments Committee in 2009/10:

Kenneth Bray (Chair), Tony Barber, Donn Boyland, John de Normann, Francis Ring, Viv Pozo, Caroline Holcombe.

There was one appointments committee meeting in 2009/10 when the committee met to discuss the remuneration of the Chair and Non-Executive Directors. Along with the members of the Committee, outlined above, Stephen Cole, Trust Chair, and Karen Kerley, Director of HR and Membership, and Peter Miles (Governor) attended the meeting. There were no appointments made in 2009/10.

There have been no board appointments necessitating action by the Appointments Committee of the Council of Governors over the last year.

Membership

Membership is free; there are no obligations if you sign up as a member. On the registration form there are three levels of membership:

Level 1 Keep in touch. All members receive a regular newsletter and information.

Level 2 Get involved. Some members choose to be consulted on plans for future development of the hospital and its services and attend the Annual Members Day.

Level 3 Work with us. For further active membership involvement some members stand for election to the Council of Governors. There are also individual volunteer opportunities within the hospital.

Constituencies

There are three membership constituencies in the RNHRD membership. The criteria are as follows:

Public Constituency

Individuals are eligible to become members of the public constituency if:

- They live in England or Wales.
- They are not eligible to become a member of the staff constituency.
- They are not a member of the patient constituency.

The minimum number of members of the public constituency is 400.

Staff Constituency

Individuals are eligible to become members of the staff constituency if they:

- Are employed under a contract of employment by the Trust (provided that Non-Executive Directors of the Trust shall not be regarded as employees for this purpose); or
- Are employed or engaged through a designated Trust provider and otherwise exercise functions on behalf of the Trust.

Individuals shall only be eligible to become members of the staff constituency if:

- They are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least 12 consecutive months; or
- They have been continuously employed by the Trust for at least 12 months;
- They have been employed by a designated Trust provider or been exercising the Trust's functions for a continuous period of 12 months.

The minimum number of members of the staff constituency is 100.

Patient Constituency

Individuals are eligible to become members of the patient constituency if:

- they are a patient or carer;
- they are not eligible to become a member of the staff constituency; and
- they are not a member of the public constituency.

Individuals who are eligible to join the patient constituency will be allocated to the patient constituency unless they notify the membership office that they wish to be allocated to the public constituency. The minimum number of members of the patient constituency is 500.

Membership Numbers

In March 2010, the RNHRD had 4,710 members, with 3,733 patient and carer members, 977 public members and 472 staff members.

Further information on the diversity of the Trust's membership can be obtained from the Membership Support Team.

Membership Strategy

This strategy is written by the Council of Governors' Membership sub group and:

- Defines the membership community and how the Trust will establish a more diverse and representative membership.
- Recognises that the process of building a meaningful membership involves effective communication between the Trust and members.
- Sets out the Council of Governor's accountability and responsibility and how the Trust will work in partnership with the Council of Governors to achieve this.
- Sets out how the members and membership support the marketing and communication strategy and promote the Trust and patient choice to the wider-public.
- Outlines how the Trust evaluates the success of membership.

Over the last year, the Trust has effectively communicated with members through the Minformation newsletter, with feedback from members in response to the April 2008 edition and increased email correspondence with Members to reduce mailing costs.

Members who wish to contact Governors or Directors may do so through the Membership Support Service at the Hospital. Email nhsft@rnhrd.nhs.uk

Members were invited to attend our Annual Members Day in July 2009. This was an opportunity to provide information on the work of the Trust and its accounts and gather feedback from members. Sessions included:

- The Min in the local health community.
- Council of Governors lead small group sessions to gain feedback from members.

We also invited members to:

- Attend Council of Governors meetings.
- Join the Council of Governors Membership Sub-group.
- Apply for volunteer roles.
- Attend the Medicine at the Min lectures.
- Attend the Trust's AGM.
- Join the Friends of the Min.

The Trust aims to have a diverse and representative membership. We have a system which informs all new patients about membership opportunities. Our Council of Governors has produced an information / presentation pack to use when doing promotional presentations. They have promoted the Trust and membership to the hospital through promotional presentations to local groups, and organised bi-monthly coffee mornings at the hospital to communicate with members and patients.

The majority of patient involvement activities through the year have been organised as part of membership activities. However other activities include regular Patient Literature Group meetings and a thriving volunteer programme and annual volunteers' garden party.

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

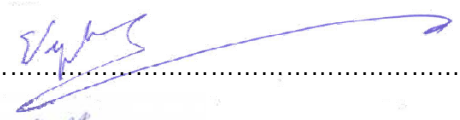
The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report. In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:-

- the Quality Report presents a balanced picture of the Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at http://www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at http://www.monitor-nhsft.gov.uk/annualreportingmanual).

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

N.B. : Sign and date in any colour ink except black

7th June 2010
……Date  ……Chairman

7th June 2010
……Date  ……Chief Executive

Part 2. Priorities for improvement and statements of assurance from the Board.

Priorities for improvement

The Trust Board agreed the following quality improvement initiatives for 2009/10;

Quality Improvement Initiatives 2009/10	**Results**
The Trust will maintain excellent standards in cleanliness, infection prevention and control. The Trust will maintain its performance against the national minimum levels of 12 or less cases of MRSA and Clostridium Difficile.	There were no cases of MRSA bacteraemia or Clostridium Difficile during 2009/10.
The Trust will improve bathroom signage and bathroom facilities to ensure that privacy and dignity is maintained and that patients are confident that all bathroom facilities are single sex use only. The Trust will continue to monitor patient feedback on this issue through national patient surveys to ensure that patient satisfaction improves.	The improvements to bathroom signage during 2009/10 resulted in a significant improvement from 39% to 79% responding "NO" to the national inpatient survey question "Whilst staying in hospital, did you ever share the same bathroom or shower area as patients of the opposite sex?"
The Trust will also provide additional Consultant Rheumatologist sessions to provide an improved follow up appointment service.	In 2009/10 there were 3 complaints regarding availability of follow up appointments compared with 15 in 2008/09. The Trust employed 2 locum Consultant Rheumatologists during 2009/10 to improve services for follow up appointments. There was a resulting 10% increase in the number of follow up appointments in 2009/10 compared with 2010/11.
As a result of patient feedback through PALs and complaints services, we are extending the opening hours of our appointments office to improve response times to incoming calls. The Trust will monitor this through the number of complaints about access to appointments and follow up appointments.	There were 34 PALs/Complaints in 2009/10 about access to the appointments department compared with 30 in 2008/09. The number of outpatient attendances increased by 16% in 2009/10 compared with 2008/09 and therefore the number of calls to the appointments department increased proportionally. The Trust employed additional appointments staff and installed an additional outside line and extended the opening hours of the appointments office in early 2010 to improve access to the department. Our plans for further improvements in 2010/11 include the introduction of email access to the appointments department and upgrade to the telephone.

Priorities for Quality Improvements in 2010/11

Following feedback from the 2009 national outpatient and inpatient surveys*, and consultation with patients and members at the Annual Members day**, Governors***, staff and local LINKs** members the following quality improvements have been agreed by the Board:

Priorities for improvement	Monitoring	Measurement	Reporting
Follow up appointment times*	Patient Survey	Patient Survey results	Annual Report
Communication for patients waiting in outpatient department*	Patient Survey	Patient Survey results	Annual Report
Communication about test results*	Patient Survey	Patient Survey results	Quarterly board Quality Report Annual Report
Improve communication about danger signals to watch for on leaving hospital*	Patient Survey	Patient Survey results	Annual Report
Improve access for patients with rheumatoid arthritis flare**	Clinical Governance Service Developments	Clinical Governance Minutes	Annual Report
Improve access to appointment department by introducing email access***	PALs and Complaints	Number of PALs and Complaints regarding access to appointments department	Quarterly board Quality Report Annual Report

Statements of assurance from the board

- Information on the review of services:

During 2009/10 the Royal National Hospital for Rheumatic Diseases NHS FT did not sub-contract any Services.

- Information on participation in clinical audits and national confidential enquiries:

The Royal National Hospital for Rheumatic Diseases NHS FT was not eligible to participate in any national clinical audits and national confidential enquiries during 2009/10.

- Information on participation in clinical research:

The number of patients receiving NHS services provided by the Royal National Hospital for Rheumatic Diseases NHS FT that were recruited during the period to participate in research approved by a research ethics committee was 1566.

- Information on the use of the CQUIN framework:

A proportion of Royal National Hospital for Rheumatic Diseases NHS FT income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed between Royal National Hospital for Rheumatic Diseases NHS FT and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2009/10 and for the following 12 month period are available on request from Hayley Sewell, Director of Governance, Royal National Hospital for Rheumatic Diseases NHS FT, Upper Borough Walls, Bath. BA1 1RL.

The monetary total for the amount of income for 2009/10 conditional upon achieving quality improvement and innovation goals was £130K which was received in full.

- Information relating to registration with the Care Quality Commission and periodic/special reviews:

The Royal National Hospital for Rheumatic Diseases NHS FT is required to register with the Care Quality Commission and its current registration status is there are no conditions related to this Trust's registration.

The Care Quality Commission has not taken enforcement action against the Royal National Hospital for Rheumatic Diseases during 2009/10.

The Royal National Hospital for Rheumatic Diseases is subject to periodic review by the Care Quality Commission and the last review date was on 3rd September 2009. The Care Quality Commission performed an unannounced inspection on this date to assess whether Royal National Hospital for Rheumatic Diseases NHS Foundation Trust is adequately protecting patients, workers and others from healthcare-associated infection.

On inspection, the Care Quality Commission found no evidence that the Trust has breached the regulation to protect patients, workers and others from the risks of acquiring a healthcare-associated infection.

While the Care Quality Commission found no evidence that the Trust was breaching the regulation overall, they identified one area for improvement - using effective arrangements for the appropriate decontamination of instruments and other equipment, which are detailed in appropriate policies.

The Care Quality Commission recommended after the initial inspection that the Trust should ensure it uses effective arrangements for the decontamination of patient equipment and these should be detailed in appropriate policies.

When the Care Quality Commission followed up, the Trust provided assurance that it had addressed the areas for improvement.

The Royal National Hospital for Rheumatic Diseases NHS FT has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

- Information on the quality of data:

The Royal National Hospital for Rheumatic Diseases NHS FT submitted records during 2009/10 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was: 98% for admitted patient care; 99% for outpatient care; and there is no percentage for accident and emergency care as there is no accident and emergency service provided by the Trust.
- which included the patient's valid General Practitioner Registration Code was: 98% for admitted patient care; 98% for outpatient care; and there is no percentage for accident and emergency care as there is no accident and emergency service provided by the Trust.

The Royal National Hospital for Rheumatic Diseases NHS FT score for 2009/10 for Information quality and Records Management, assessed during the Information Governance Toolkit was 90%

There were no serious untoward incidents involving data loss of confidentiality breach during 2009/10.

The Royal National Hospital for Rheumatic Diseases NHS FT is subject to Payment by Results. The results of the clinical coding audit conducted by the Audit Commission during the reporting period for diagnoses and treatment coding (clinical coding) were

Area audited	Specialty/ Chapter/ HRG	% Procedures coded incorrectly		% Diagnoses coded incorrectly		% of episodes changing HRG	% of spells changing HRG
		Primary	Secondary	Primary	Secondary		
Specialty	Rheumatology	1.3%	6.5%	13.0%	5.5%	11.0%	11.0%
Sub-Chapter	FZ-Digestive System Procedures and Disorders	0.0%	0.0%	10.0%	6.0%	0.0%	0.0%
HRG	AB06Z -Minor Pain Procedures	0.0%	0.0%	16.7%	0.0%	0.0%	0.0%
Overall	Overall	0.6%	6.5%	12.5%	4.7%	5.5%	5.5%

The results should not be extrapolated further than the actual sample audited.
The services reviewed in the sample were Rheumatology:

Part 3. Other Information

- An overview of the quality of care offered by the RNHRD NHS FT based on performance in 2009.

Quality Overview

Indicator	Data Source	2009/10	2008/09	2007/08
Patient Safety				
MRSA	Data reported nationally and data governed by standard national definition	0	0	0
C Difficile	Data reported nationally and data governed by standard national definition	0	3	7
Meet core standards regarding safety	Data reported to Care Quality Commission Annual Healthcheck and reported through quality report to PCT	Met	Met	Met

Indicator	Data Source	2009/10	2008/09	2007/08
Clinical Effectiveness				
The Trust will continue to implement NICE Guidelines relevant to the Trust services	Data reported through Healthcare Commission special data collection and reported through quality report to PCT	Met	Met	Met
Improve availability of follow up appointments	Number of complaints regarding availability of follow up appointments reported through quality report to PCT and annual report.	3	15	0
Meet core standards regarding clinical effectiveness	Data reported to Healthcare Commission Annual Healthcheck and reported through quality report to PCT	Met	Met	Met
Patient Experience				
Improve Bathroom facilities and signage on wards	Results of national inpatient survey question on mixed-sex bathroom or shower areas by percentage who answered no to the question "Whilst staying in hospital, did you ever share the same bathroom or shower area as patients of the opposite sex?"	79%	39%	40%
Improve telephone access for appointments	Number of Complaints or PALs on this issue reported in Quality Report to PCT	34*	30	6
All written complaints to continue to be managed effectively locally within policy timescales.	Number of written complaints received and number managed locally within national complaints policy timescales.	17	18	8

The quality indicators are the same as those used in the 2008/09 report.

- **Performance against key national priorities and National Core Standards**

The RNHRD achieved all national quality performance targets during 2009/10. Those that are set out in the Compliance Framework 2009/10 and relevant to the Trust are:

- Clostridium Difficile year on year reduction (to fit the trajectory for the year as agreed with PCT = 0 cases).
  There were 0 cases of Clostridium Difficile in 2009/10.
- Methicillin Resistant Staphylococcus Aureus (MRSA); number of infections. The Trust had a target of 0 cases or less.
  There were no MRSA bacteraemia infections during the year.
- Screening all elective in-patients for MRSA.
  The Trust achieved an average of 88% by quarter 4 for screening all elective in-patients for MRSA.
- Patients seen within 18 weeks for non-admitted pathways.
  The Trust achieved the 18-week Referral to Treatment Time and the South West target of 13 weeks.

Core Standards Declaration

The Board has declared full compliance with 23 out of 24 core standards in the final quarter of 2009/10. The following standard was declared as not met:

C7 a & c The healthcare organisation has effective corporate governance arrangements in place.

The Trust has declared it is not compliant with this standard due to financial governance issues which themselves resulted in a restatement of its 2006/2007 accounts at the time it issued its 2007/08 accounts. These accounts disclose income and expenditure losses and a significant level of net current liabilities. Accordingly in August 2008 Monitor, the Foundation Trust Regulator, issued an Intervention Notice to the Trust which have been followed by two further orders relating to Board director appointments. Monitor confirmed at the date of each intervention order that there were no concerns as to the quality of the clinical care provided by the Trust to its patients. The intervention orders related solely to issues of financial management and control. The Trust delivered an operating surplus for 2008/09 and 2009/10 but this was insufficient to correct the Trust's ongoing net current liability position. Consequently the Trust remains under Monitor's intervention orders and thus its Board is declaring that it is non compliant.

This is reflected in a governance risk rating of red from Monitor.

During 2009/10, the Healthcare Commission rated the Trust Quality of Services as “Good” for the 2008/09 assessment.

Complaints

Information on Complaints Handling

The Trust has an established Patient Advice and Liaison Service (PALS). This service is available to provide patients and their carers and families with confidential information, advice and support. PALS provides information about the hospital, the NHS, and organisations and support groups outside the NHS. They help resolve concerns when patients are using hospital services and work with patients to improve hospital services, by listening to their experiences and ensuring that staff who deliver the services are aware of and address any issues raised.

Action taken as a result of PALs queries

- Extended opening hours of appointments office to improve telephone access.
- Improvements made to quality of information provided for patients.
- Additional clinics introduced to expedite follow up appointments.
- Maintenance of public toilet facilities improved by additional checks.
- Process introduced for informing patients of short notice appointments.

Written complaints

The Trust received 17 written complaints in 2009/10. All complainants received a written acknowledgement within three working days and received a response within the timeframes set out in the complaints policy.

The Trust contacted the Royal College of Paediatrics and Child Health to identify three clinicians who completed a clinical review for one complaint received during 2008/2009.

Action taken as a result of written complaints

- Improvements to the information staff provide to patients / relatives regarding changes to work procedures.
- Improvements completed to administrative systems booking appointments for the day case unit.
- Anti-TNF nurse identified and addressed improvements to the administrative systems when doctors refer to the anti-TNF clinic.

- Development of a new policy for Intravenous Zoledronic Acid guidelines for the prescribing and administration of Intravenous Zoledronic Acid.
- Plans to provide a reception area for day-case diagnostics/Rheumatology.
- Extended opening hours of appointments office to improve telephone access.

Improvements in Patient/ Carer Information

The Membership and Patient Involvement Manager chairs the Trust's Patient Literature Group. This group's membership represents patients from all of the hospital's specialties. Since it began in November 2005 the group has reviewed 150 leaflets and pieces of information produced for patients and carers, by staff in the Trust. All literature is reviewed to ensure information is accessible to and appropriate for patients, and produced to Trust standard. The group has also developed a policy to assist staff when producing patient information and literature, and a monitoring system to ensure the literature is meeting the Trust's standards.

Clinical Effectiveness

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. The Trust has a commitment to clinical effectiveness and audit, to evidence-based medicine, monitoring practice and continuously improving local and national standards.

Members of staff from the Trust have significant input to clinical guidelines developed by national professional bodies and bodies such as the National Institute for Health and Clinical Excellence (NICE). In 2009/10 the following staff have contributed to the development of national guidelines:

Clinical Nurse Specialists Sue Brown and Nicola Waldron contributed to the publication: Assessing, managing and monitoring biologic therapies in Inflammatory Arthritis 2009 Royal College of Nursing RCN ISBN 978-1-906633-13-4.

Dr E Korendowych, Consultant Rheumatologists is a clinical expert nominated by the BSR for the recent NICE appraisal of Etanercept, Adalimumab and Infliximab for Psoriatic Arthritis. Dr Korendowych is also a member of the BSR Guidelines working group (together with Neil McHugh and Nicola Waldron) currently working on updating the guidelines for anti-TNF therapy in Psoriatic Arthritis.

Prof N McHugh is currently Chair of the BSR subcommittee for revising guidelines for use of biologics in Psoriatic Arthritis and is a member of the EULAR taskforce for guidelines on management of Psoriatic Arthritis and GRAPPA and the British Association of Dermatology treatment guideline groups that have published respectively over the last 12 months in Psoriatic Disease.

Structures are in place to ensure that we audit against any national guidelines relevant to this Trust.

National patient survey results for 2009

To improve the quality of services that the Trust delivers, it is important to understand what patients think about their care and treatment. One way of doing this is by asking patients who have recently used the Trust's services to tell us about their experiences.

National outpatient survey results for 2009

850 patients who used the Trust's outpatient services during March 2009 were sent the national outpatient survey.

The results for the RNHRD were;

- In the 20% of Trusts with the highest scores for 29 out of 40 questions.
- In the middle range of scores for 6 out of 40 questions.
- In the lowest scores for 5 out of 40 questions.

The RNHRD had the highest score achieved for all Trusts for the following questions:

- If you had important questions to ask [another professional] did you get answers that you could understand?
- Were you given enough privacy when discussing your condition or treatment?
- Were you given enough privacy when being examined or treated?
- Were you involved as much as you wanted to be in decisions about your care or treatment?
- Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?

The five questions with results in the lowest scores were;

- From the time you were told you needed an appointment, how long did you wait?
- Do you see the same doctor or other member of staff whenever you go to the Outpatients Department?
- Were you told how long you would have to wait?
- Did a member of staff tell you how you would find out the results of your test(s)?
- Did a member of staff explain the results of the test in a way you could understand?

An action plan has been developed to address the five questions with results in the lowest scores to improve quality in these areas and will form part of the local measures for the 2010/11 Quality Account.

National inpatient survey results for 2009

The results for the RNHRD are detailed below. 504 patients who used the Trust's inpatient services during 2009 were sent the national outpatient survey.

The results for the RNHRD were;
316 patients who were inpatients at the RNHRD in 2009 completed the survey. They were asked a range of questions covering areas relating to; care and treatment, cleanliness, mixed sex accommodation, waiting times, quality of food, complaints, and overall experience.

The Trust was rated in the top 20% of Trusts for 37 out of 60 questions and of these achieved the highest scores nationally for 7 questions. The Trust was in the middle 60% for 22 questions and the lowest 20% for 1 question.

The Trust was rated in the top 20% of Trusts overall for the following questions;

- Did you feel you were treated with respect and dignity while you were in hospital?
- How would you rate how well the doctors and nurses worked together?
- Overall, how would you rate the care you received?
- While in hospital, were you ever asked to give your views on the quality of care you received?
- Did you see any posters or leaflets explaining how to complain about the care you received?
- Did you want to complain about the care you received in hospital?

The Trust achieved the best scores nationally for the following 7 questions;

- Was your admission date changed by the hospital?
- Did you ever share a sleeping area with patients of the opposite sex?
- Did you feel threatened during your stay in hospital by other patients or visitors?
- Were you offered a choice of food?
- Did a member of staff explain how the procedure had gone?
- Did you receive copies of letters sent between hospital doctors and your family doctor?
- While in hospital, were you ever asked to give your views on the quality of care you received?

The Trust was in the lowest 20% of Trusts for one question:

Did a member of staff tell you about any danger signals you should watch for?
Improvement actions will be developed to address this issue as part of the 2010/11 Quality Account.

Site Visit by BANES PCT March 2010

As part of our commitment to improve quality, representatives from our host PCT, BANES, completed a site visit during March 2010. The outcome of the visit was summarised by the PCT as:

- Cleanliness good.
- Skilled at rehabilitation.
- Very positive visit.

The Trust agreed with the PCT to update the venous thrombi-embolism assessment tool due to changes in national guidance at the time of the site visit.

Sustainability/Climate Change

A key action for the Trust in 2010/11 is to develop a robust sustainability strategy and the supporting processes required to support the management and reporting of sustainability performance.

The Trust Board has identified the Director of Finance as the lead for sustainability.

The table below summarises key data required for the Estates Returns Information Collection.

Area		**Non-financial data (applicable metric)**	**Non-financial data (applicable metric)**		**Financial data (k)**	**Financial data (k)**
		2009/10	2008/09		2009/10	2008/09
Waste minimisation and management	Absolute values for total amount of waste produced by the Trust	*110.92 Tonnes	52.8 Tonnes	Expenditure on waste disposal	£8,014	£7,898
Finite Resources	- Water** - Electricity - Natural Gas - Oil	- 2,465 GJ 7,373 GJ 65 GJ	- 2,874 GJ 7,153 GJ 1,071 GJ	Total energy consumption costs	£159,136	£168,486

Notes:
*Basis of calculation has changed. Difference year on year is not due to change in practice.
**Special dispensation due to the history of the Mineral Water Hospital.

Equality and diversity

Equality and Diversity (Policies applied to Staff with Disabilities)

The Director of Human Resources and Membership leads on equality and diversity within the Trust. Performance is monitored against the three individual Race, Gender and Disability Equality Schemes in place and progress with their underpinning action plans. The Trust is currently consulting on a Single Equality Scheme with the aim of streamlining actions and reporting the six equality areas as described in the Equalities Bill.

The Trust has met its relevant publication duties by publication of all three schemes on its website together with associated workforce monitoring reports and any adverse equality impact reports. The Trust has an equal opportunities policy and is recognised as a "two-tick" disability friendly employer. In line with legislation, the Trust always makes reasonable adjustments for disabled staff or job applicants. Current adjustments for disabled staff include adjusted working hours, computer equipment and provision of mentoring through Remploy.

A key priority within all three Equality Schemes has been ensuring all our staff receive equality and diversity training and remains a key priority for the Trust. The 2009 staff survey showed that the Trust had made statistically significant improvements in this area and we score within the top 20% of Specialist Acute Trusts for this factor in the Staff Survey.

Key priorities for the coming year include maintaining our high standards on equality training for staff and developing and embedding our Single Equality Scheme and action plan. Action plan and associated monitoring schedule are currently at consultation stage.

A summary of workforce equality statistics are detailed below:

	Staff 2009/10	Staff 2008/09	Membership 2009/10	Membership 2008/09
Age				
0-16	0	0	0	0
17-21	12	12	21	29
22+	455	402	4581	4563
Ethnicity				
White	399	359	4496	4424
Mixed	9	6	11	11
Asian or Asian British	26	19	17	41
Black or Black British	21	22	17	16
Other	12	9	24	24
Gender				
Male	81	67	1545	1513
Female	386	348	3161	3111
Trans-gender	0	0		
Disability	7			

Staff Survey

The Joint Staff Consultative Committee discusses staff survey results and jointly agrees an action plan which is monitored through its meetings. This is communicated with staff through staff side meetings, the monthly face-to-face "Chief Executive's Brief" and its written follow up. A briefing on the staff survey and action points is also considered by the Board.

Our response rate for 2009 was 49% against a national average for acute specialist Trusts of 55%. This is a slight decrease on our response rate of 57% for the 2008 year.

Key areas of improvement were:

- Support from immediate managers. Our score was 3.79 compared to 3.62 last year.
- Percentage of staff having equality and diversity training in the last 12 months. Our score for 2009 was 61% compared to 37% in 2008.
- Percentage of staff receiving health and safety training in the last 12 months. Our score was 78% against a score of 66% in 2008.
- Trust commitment to work life balance. Our score was 3.60 compared to 3.44 in 2008.

Staff experience had deteriorated in one area and that was in relation to the percentage of staff reporting errors, near misses or incidents witnessed in the last month. In 2008 we scored at 100% for this factor and in 2009 our score had deteriorated to 93%.

Our top 4 ranking scores were:

- Percentage of staff saying hand washing materials are always available. Our score was 89% compared to an average of 71% for acute specialist Trusts.
- Percentage of staff having equality and diversity training in the last 12 months. Our score was 61% against an average of acute specialist Trusts of 40%.
- Percentage of staff feeling valued by their work colleagues. Our score was 82% compared to an average for acute specialist Trusts of 77%.
- Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell. Our score was 17% against an average for acute specialist Trusts of 23%.

Our 4 bottom ranking scores were:

- Percentage of staff experiencing physical violence from staff in last 12 months. The Trust score was 3% in 2009 against an average of 1% for acute specialist Trusts.
- Percentage of staff experiencing harassment, bullying or abuse from patients/relatives in the last 12 months. Our score was 19% against a national average of 14% for acute specialist Trusts.
- Percentage of staff suffering work related stress in last 12 months. Our score was 31% against an average for acute specialist Trusts of 24%.
- Percentage of staff feeling there are good opportunities to develop their potential at work. Our score was 39% against an average for acute specialist Trusts of 47%.

Action plan

Our current action plan from the 2008 staff survey has concentrated on improving our appraisal and mandatory training figures. Good progress has been made and we believe that this will be reflected in future staff surveys.

Our action plan as a result of the 2009 staff survey will be put together jointly with the Joint Staff Consultative Committee. By putting the staff survey central to discussions with the Joint Staff Consultative Committee we hope to gain ongoing feedback into the reasoning behind responses and the solutions to issues highlighted. We will also use this committee to publicise the 2010 survey and will aim to improve our response rate over the 2009 figure.

We are already undertaking an investigation into the reported staff physical violence as this finding is surprising to us as there have not been any reported incidents. However, the level of harassment and abuse from patients and relatives was not a surprise. We expect this always to be higher than in an average Trust owing to the fact that our biggest staff group is employed on our Neuro Rehabilitation Unit. There are often behaviour challenges associated with lack of inhibition in this client group. There are very few incidents outside this particular client group.

Further priorities include promoting training and development opportunities across the Trust and addressing issues of stress and wellbeing within our workforce.

Regulatory ratings

The Financial Risk Rating (FRR) of the Trust assessed by Monitor through their annual risk assessment of the Trust's Annual Plan for 2009/10 produced a rating of '2'. This is based on a scorecard approach in measuring key financial metrics and is intended to reflect the likelihood of a financial breach of the authorisation.(the ratings run from '1' as high risk to '5' as low risk. The rating assigned to the Trust requires the provision of additional information on a monthly basis. The quarterly actual ratings were:

	Annual Plan	**Q1**	**Q2**	**Q3**	**Q4**
	2008-09	**2008-09**	**2008-09**	**2008-09**	**2008-09**
Financial risk rating	1	2	2	2	2
Governance	Amber	Red	Red	Red	Red
Mandatory	The Trust's mandatory services are: Trauma and Orthopedics, General Medicine, Rehabilitation, Dermatology, Rheumatology, Chronic Fatigue Syndrome – Adults, Chronic Fatigue Syndrome – Paediatrics, Pain Management. There have been no changes over the financial year.				
	Annual Plan	Q1	Q2	Q3	Q4
	2009-10	2009-10	2009-10	2009-10	2009-10
Financial risk rating	2	1	2	2	2
Governance	Green	Red	Red	Red	Red
Mandatory	The Trust's mandatory services are: Trauma and Orthopaedics, General Medicine, Rehabilitation, Dermatology, Rheumatology, Chronic Fatigue Syndrome – Adults, Chronic Fatigue Syndrome – Paediatrics, Pain Management. There have been no changes over the financial year.				

The key financial constraint the Trust faces is its current liability position, due to historic income & expenditure deficits, combined with its limited ability to deliver future annual surplus in excess of 1% of turnover which would redress the position.

Public Interest Disclosures

Emergency Preparedness

Although the RNHRD is a small specialist Trust, it is involved in NHS South West plans for both clinical and non clinical major incidents. The Trust's plans are integrated within a regional and national major incident plan, and the Trust tests its plans through the engagement and participation of multi-agency local, regional and national incident exercises. Senior managers within the organisation have specific training in how to use the major incident plans. The lead for emergency planning has regular contact with the local and regional emergency planner in the Strategic Health Authority.

Communication and Consultation

A formal consultation with individuals affected by the organisational review and restructuring process, this is alongside a Trust wide staff engagement process.

Health & wellbeing

The Trust has no current health and safety enforcement notices.

An occupational health service including an employee assistance scheme is provided to staff via a contract with the RUH Bath NHS Trust Occupational Health providers

Sickness absence for the year April 2009 to March 2010 is set out below.

The promotion of health and wellbeing and associated actions recommended by the Boorman Review are key priorities for the year ahead.

Sickness Absence Data

Sickness absence figures for the years April 2009 to March 2010 was 3.68%. This figure is a significant improvement on the previous years figures of 5.53%. This reflects a concerted effort across the Trust on health promotion and sickness absence management.

A breakdown of the sickness absence figures is outlined below:

Period	**% sickness absence**
April	3.31
May	3.68
June	3.03
July	4.59
August	4.36
September	3.61
October	4.48
November	4.22
December	4.07
January	4.83
February	3.20
March	2.86
Year to date April 2009 - March 2010	3.68

This figure of 3.68% is within the Trust's internal target of 4.7% sickness and reflects a continually improving figure over the last three months.

Cost Allocation and Charges

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

Policies and procedures with respect to countering fraud and corruption

The Trust has policies and procedures with respect to countering fraud and corruption and has recently taken a more pro-active approach in raising awareness of the potential of fraud amongst its staff.

Management costs

The management costs of the Trust have been calculated for 2009/10 in accordance with the Department of Health's definitions. The calculated cost is £1,998k, on an income value of £19,712k (10.1%). This compares with £2,165k on an income value of £19,055k (11.4%) in 2008/09.

Charitable Funds

The Royal National Hospital for Rheumatic Diseases NHS FT Charitable Funds is the main fundraising charity for research, building and equipment projects across the Trust.

We would like to thank all those patients, friends and relatives who have contributed to the charity over the past year.

The Charitable Funds Annual Report and Accounts is published separately and is available on request.

Royal National Hospital for Rheumatic Diseases
NHS Foundation Trust

Annual Accounts 2009/10

Contents

Statement of the Chief Executive's responsibilities as the accounting officer of Royal National Hospital for Rheumatic Diseases 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 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 accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust ("the Trust") to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Royal National Hospital for Rheumatic Diseases NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis.
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed……..…….....

Kirsty Matthews

Interim Chief Executive Date: 7th June 2010

Statement on Internal Control

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation 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 National Hospital for Rheumatic Diseases 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 in place in the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust as described herein has operated effectively for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

The risk and control framework

Capacity to handle risk

Leadership is given to the risk management process through

- The Audit Committee and Board developing and agreeing the Assurance Framework.
- Accountability of the Risk Management Steering Group to the Trust Audit Committee and Board.
- The Risk Management Steering Group meets every other month. The Risk Management Steering Group Chair is a Non-Executive Director. Other members of the Risk Management Steering Group include the Chief Executive, Medical Director, Finance Director, Director of Governance and Performance and Acting Director of Clinical Practice, Professional Nurse advisor and Director of Infection Prevention and Control.
- The Risk Management Steering Group reviews all risks on the risk register rated moderate and above and ensures that appropriate controls are in place to minimise risks.
- The Risk Management Steering Group reviews all incidents rated moderate and above and ensures that appropriate actions are taken and controls are in place to minimise risk.
- The Risk Management Steering Group receives reports on complaints, claims and health and safety committee minutes and reviews reports from the National Patient Safety Agency.
- The Executive Directors led on the NHSLA assessment against the Clinical Negligence Scheme for Trusts during 2009 with achievement of level 1.
- Staff are trained or equipped to manage risk in a way appropriate to their authority and duties.
- All staff receive training at induction on risk management policy and process and staff responsibilities and duties.
- The Trust seeks to learn from good practice through membership of the Strategic Health Authority Patient Safety Campaign and implementation of a range of patient safety initiatives.

- Risk Management Steering Group reviews Trust incident reporting against other organisations through the National Patient Safety Agency National Reporting and Learning Systems reports.
- Regular briefs for the Senior Managers at Operational Management Group on Risk Management issues.

The risk and control framework

The objective of the Risk Management Strategy is to ensure that the Trust will conduct business to the best possible standard and provide the highest quality of care in a safe environment, through identifying, prioritising and managing all aspects of risk.

The Trust Risk Management strategy aims to achieve the key objective above and ensure:

- Management processes are in place to minimise risks.
- High patient safety standards are maintained.
- The cost of risk is reduced.
- Safe practices exist.
- Safe systems exist.
- Safe premises.
- Awareness of dangers and liabilities.

The strategy harnesses the knowledge and expertise of individuals within the organisation and translates it with their help into positive action, to help the Trust to achieve its objectives.

Risks to data security are managed and controlled through implementation of the Code of Conduct in Respect of Confidentiality and Data Security Policy and procedures and staff training at Induction on Information Governance. There have been no incidents of significant data loss during 2009/10.

Major risks - In year:

Financial consequences of failure to deliver activity, especially in Neuro Rehabilitation, and failure to deliver cost improvement plans resulting in financial deficit.

- The risk was managed through the cost improvement plan.
- The risk was managed through the business plans including marketing agreed by the Trust Board.
- The outcomes were assessed through financial reporting to Board, Audit Committee and Monitor.

Failure to exercise Trust functions “effectively, efficiently and economically”.

- This risk is managed through the review of financial procedures.
- This risk is mitigated through appropriate management of working capital balances.
- The outcomes are assessed through Audit Committee, Board, Internal and external audit opinion and Monitor risk rating.

Future risks:

Financial sustainability of Services:

- This risk will be managed through monitoring activity levels and the implementation of productivity and improvement plan agreed in December 2009.
- The risk will be managed through pursuing business plans including marketing of all Specialties.
- This risk will be mitigated through a new organisational structure.
- The outcomes will be assessed through financial reporting to Board, Audit Committee and Monitor.

Equality impact assessments are integrated into core Trust businesses through completion of standard equality impact assessment forms in Trust policies and procedures and review by the appropriate ratifying committee.

Public stakeholders are involved in managing risks which impact on them through:

- Governor representatives attendance at Board meetings and Audit Committee meetings and through discussion with Executive Directors at Council of Governor meetings.
- Members and Local Involvement Committee member representation at the Trust education and clinical governance committees.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS *Foundation Trust Annual Reporting Manual*.

Steps which have been put in place to assure the Board that the Quality Report given in this year's annual report (pages 36 to 45) presents a balanced view, and that there are appropriate controls in place to ensure the completeness and accuracy of data on which it is based, include:

- Whilst authority is delegated to the Director of Governance and Performance to take overall strategic responsibility for data quality and lead for Information Governance, procedures exist for the Trust Board to review activity information monthly.
- Internal audit review non-financial performance indicators which are reported to the Board.
- Information risk management arrangements are regularly assessed through the six-monthly Information Governance Toolkit Assessment. The Trust is also a signatory to the Avon IM&T Consortium Information Sharing Principles.

The data included in the Quality Report has been approved by the Medical Director and Acting Director of Clinical Practice, Nurse Advisor and Director of Infection Prevention and Control, on behalf of all clinicians.

Review of effectiveness

Internal audit reviewed the performance management reporting framework for non-financial performance indicators during 2009/10. The conclusion was that taking account of the issues identified, in the opinion of the internal auditors, the Board can take substantial assurance that the controls upon which the organisation relies to manage this area as currently laid down and operated are effective.

The Foundation Trust is not fully compliant with the core Standards for Better Health.

The Board has declared full compliance with 23 out of 24 core standards in the final quarter of 2009/10. The following standard was declared as not met:

C7 a & c Healthcare organisations:
a) apply the principles of sound clinical and corporate governance; and
b) undertake systematic risk assessment and risk management.

The Trust has declared it is not compliant with this standard due to financial governance issues which themselves resulted in a restatement of its 2006/2007 accounts at the time it issued its 2007/08 accounts. These accounts disclose income and expenditure losses and a significant level of net current liabilities. Accordingly in August 2008 Monitor, the Foundation Trust Regulator, issued an intervention Notice to the Trust which have been followed by two further orders relating to Board director appointments. Monitor confirmed at the date of each intervention order that there were no concerns as to the quality of the clinical care provided by the Trust to its patients. The intervention orders related solely to issues of financial management and control. The Trust delivered an operating surplus for 2008/09 and 2009/10 but this was insufficient to correct the Trust's ongoing net current liability position. Consequently the Trust remains under Monitor's intervention orders and thus its Board is

declaring that it is non compliant. However, there has been an improvement in the cash balances of the Trust during 2009/10. The plans for 2010/11 have been produced and shared with Monitor and the Trust's bank and all parties are confident that further improvement in the cash position of the Trust will occur in line with Trust plans.

The Trusts internal auditors gave limited assurance in their internal audit annual report. In particular, during the year, reviews conducted by internal audit into areas of particular risk requested by the management team identified three areas where limited assurance was given:

- Management of Service Level Agreements
- Financial Management and Budgetary control
- Financial Recovery and Sustainability plan

Only limited assurance was given as procedures were considered not to be as tight or evidenced as suggested by good practice. The individual points of the findings were noted by the audit committee and implementation plans are in place to action the key recommendations.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into 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.

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

The Foundation Trust has undertaken risk assessments and carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

In June 2008, the Trust's Annual Report and Accounts for 2007/08 first identified that toward the end of the financial year problems were discovered with underlying financial assumptions underpinning in-year financial reporting and the 2006/07 annual accounts. As a result of these issues the Trust made a prior period adjustment of £583K to the accounts for 2006/07. The identification of these losses and the resultant impact upon operational liquidity resulted in the Trust's year end financial risk rating falling to a rating of 1 (the highest possible level of risk).

In August 2008, following further investigation and explanation of these issues, Monitor, the Independent Regulator of NHS Foundation Trusts, issued an Intervention Notice to the Trust stating that the Trust was in significant breach of its terms of Authorisation on the basis of failure of financial governance; in particular that the Trust was failing at all times to exercise its functions "effectively, efficiently and economically". Using its powers of intervention Monitor commissioned PricewaterhouseCoopers to undertake a review of financial controls and governance within the Trust and asked the Board to prepare and present a detailed recovery plan to the Monitor Board.

Peter Hill joined the organisation as Interim Chief Executive in August 2008. In December 2008 a further intervention order appointed Kirsty Matthews as Interim Chair and Stephen Cole as Director of Corporate Strategy. In April 2009 a third intervention order put Stephen Cole into position of Interim Chair and Kirsty Matthews as Interim Chief Executive.

The interventions related purely to financial governance issues and Monitor's official statement confirmed there were no concerns as the quality of the clinical care provided by the Trust to its patients.

Action

During summer of 2008 the Trust developed a detailed financial recovery plan to address these concerns. The plan focused on measures to improve financial controls and reduce costs, without compromising the quality of patient care provided. The Trust delivered an operating surplus in 2008/09 and an improvement in its financial risk rating to 2.

The Board recognises that its relatively small size, leads to a higher proportion of income being used to support overhead costs and back office functions than is the case with most other NHS providers. Therefore to maximise opportunities for reinvestment of income directly into patient services the Trust Board decided to seek to merge with another NHS organisation during 2008/09.

Following due process in 2009/10, the Board selected the Royal United Hospital, Bath NHS Trust as the preferred merger partner.

However in the Autumn of 2009 the Board of the RUH confirmed that they were not in a position to proceed with their foundation Trust application process at that time which was a pre-requisite to the merger process. However, it remains the strategic intention of both Boards to merge with a target date of a potential merger of 1 October 2011.

Within this context, the RNHRD presented a three-year stand alone strategy to Monitor in February 2010 including a Productivity and Innovation Plan to ensure that the Trust continued to meet the priority of ensuring the high quality services offered to our patients continue to develop and grow within delivery of an operating surplus.

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 and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board and the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The board received reports from:

- The audit committee on systems of internal control.
- The risk management steering committee including all organisation risks rated as moderate or above.
- The information governance toolkit annual assessment results and action plan.
- Assurance framework.
- Finance reports.

The audit committee; completed a review of the assurance framework and received reports from the risk management committee including all organisation risks rated as moderate or above.

An audit of Assurance Framework and Risk Management was undertaken as part of the approved internal audit periodic plan for 2009/10.

Taking account of the issues identified, the internal audit opinion was that the Board can take adequate assurance that the controls upon which the organisation relies to manage risk, as currently laid down and operated, are effective.

Conclusion

The Trust Board's strategic intent remains to merge. However, in the absence of a date for merger, the Trust has a 3 year strategic plan in place and the Trust Board and its regulator, Monitor, continue to receive regular reports detailing progress against the Trust's plan and actions taken to address any variances as they arise. Positive progress has been made in delivering these plans.

Signed……..

Kirsty Matthews

Interim Chief Executive Date: 7th June 2010

Independent Auditors' Report to the Board of Governors of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

We have audited the financial statements of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust for the year ended 31 March 2010 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Respective Responsibilities of Directors and Auditors

As explained more fully in the Statement of Accounting Officer's Responsibilities (set out on page 54) the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit the financial statements in accordance with relevant statute, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Board of Governors of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Scope of the Audit of the Financial Statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and the overall presentation of the financial statements.

Opinion on Financial Statements

In our opinion the financial statements:-

- give a true and fair view, in accordance with the NHS Foundation Trust Annual Reporting Manual, of the state of the NHS Foundation Trust's affairs as at 31 March 2010 and of its income and expenditure and cash flows for the year then ended; and

- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.

Opinion on other Matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion

- the part of the Director's Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual; and

- the information given in the Directors' 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

The Audit Code for NHS Foundation Trust requires us to report where we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We draw your attention to the Trust's Statement on Internal Control on page 55. Monitor considers that the NHS Foundation Trust has contravened and is failing to comply with the terms of its Authorisation which require it to exercise its functions "effectively, efficiently and economically" and the contravention and failure are significant.

Consequently we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and our certificate in this report is qualified in this regard.

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:-

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from locations not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit; or
- the Statement on Internal Control does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with information of which we are aware from our audit.

Qualified Certificate

Monitor considers that the NHS Foundation Trust has contravened and is failing to comply with the terms of its Authorisation which require it to exercise its functions "effectively, efficiently and economically" and the contravention and failure are significant. We have therefore been unable to satisfy ourselves that the Trust has put in place adequate arrangements for securing economy, efficiency and effectiveness in its use of resources.

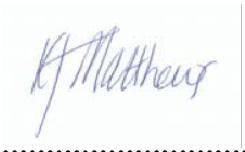
We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Simon Cookson (Senior Statutory Auditor)
For and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Bristol
7 June 2010

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2010 have been prepared by the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust under Schedule 7 para 24 and 25 of the National Health Service Act 2006 in the form which Monitor has, with the approval of the Treasury, directed.

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust Annual Report and Accounts are presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006.



Signed…….…….

Kirsty Matthews - Interim Chief Executive

Date: 7 June 2010

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2010

	Note	2009/10 £000	2008/09 £000
Income from activities	3-4	**18,493**	17,559
Other operating income	5	**1,219**	1,496
Operating income		**19,712**	19,055
Operating expenses	6-7	**(19,417)**	(18,695)
Operating surplus		**295**	360
Finance costs			
Finance income	8	**2**	22
Finance expense	8	**(20)**	(32)
PDC dividends payable	9	**(213)**	(296)
Net finance costs		**(231)**	(306)
Surplus for the year		**64**	54
Other comprehensive income			
Revaluation gains/(losses) and impairment losses property, plant and equipment		**(702)**	4
Increase in the donated asset reserve due to receipt of donated assets		**20**	7
Reduction in the donated asset reserve in respect of depreciation, impairment, or disposal of donated assets		**(62)**	9
Total comprehensive income and expense for the year		**(680)**	74

The notes on pages 68 to 95 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2010

	Note	31 March 2010 £000	31 March 2009 £000	01 April 2008 £000
Non-current assets				
Intangible assets	12	**81**	71	50
Property, plant and equipment	13	**6,677**	7,957	7,968
Total non-current assets		**6,758**	8,028	8,018
Current assets				
Inventories	14	**14**	31	6
Trade and other receivables	15	**2,143**	2,336	2,326
Cash and cash equivalents	20	**512**	327	523
Total current assets		**2,669**	2,694	2,855
Current liabilities				
Trade and other payables	16	**(2,713)**	(3,454)	(3,603)
Borrowings	19	**(13)**	(10)	0
Tax payables	16	**(199)**	(192)	(187)
Deferred income	16	**(236)**	(150)	(265)
Total current liabilities		**(3,161)**	(3,806)	(4,055)
Non-current liabilities				
Borrowings	19	**(15)**	(29)	0
Provisions	17	**(9)**	(9)	(14)
Deferred income	16	**(44)**	0	0
Total non-current liabilities		**(68)**	(38)	(14)
Total assets employed		**6,198**	6,878	6,804
Financed by taxpayers' equity				
Public dividend capital		**6,015**	6,015	6,015
Revaluation reserve		**45**	701	698
Donated asset reserve		**340**	428	411
Income and expenditure reserve		**(202)**	(266)	(320)
Total taxpayers' equity		**6,198**	6,878	6,804

The notes on pages 68 to 95 form part of these accounts.

The Annual Accounts were formally approved by the Board and were signed on its behalf by:

Kirsty Matthews - Chief Executive

Date: 7 June 2010

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2010

	Public Dividend Capital £000	Revaluation Reserve £000	Donated Assets Reserve £000	Income and Expenditure Reserve £000	Total £000
Taxpayers' equity at 1 April 2008	6,015	698	411	(320)	6,804
Surplus for the year	0	0	0	54	54
Revaluation gains on property, plant and equipment	0	3	1	0	4
Increase in the donated asset reserve due to receipt of donated assets	0	0	7	0	7
Reduction in the donated asset reserve in respect of depreciation, impairment, or disposal of donated assets	0	0	9	0	9
Taxpayers' equity at 31 March 2009	6,015	701	428	(266)	6,878
Taxpayers' equity at 1 April 2009 as previously stated	**6,015**	**701**	**428**	**(266)**	**6,878**
Surplus for the year	**0**	**0**	**0**	**64**	**64**
Revaluation gains/(losses) and impairment losses property, plant and equipment	**0**	**(656)**	**(46)**	**0**	**(702)**
Increase in the donated asset reserve due to receipt of donated assets	**0**	**0**	**20**	**0**	**20**
Reduction in the donated asset reserve in respect of depreciation on and disposal of donated assets	**0**	**0**	**(62)**	**0**	**(62)**
Taxpayers' equity at 31 March 2010	**6,015**	**45**	**340**	**(202)**	**6,198**

See Note 1.13

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2010

	2009/10 £000	2008/09 £000
Cash flows from operating activities		
Operating surplus/(deficit)	**295**	360
Non-cash income and expense:		
Depreciation and amortisation	**501**	459
Transfer from the donated asset reserve	**(62)**	9
(Increase)/decrease in trade and other receivables	**221**	(10)
(Increase)/decrease in inventories	**17**	(25)
Increase/(decrease) in trade and other payables	**(766)**	(102)
Increase/(decrease) in other liabilities	**130**	(115)
Increase/(decrease) in provisions	**0**	(5)
Tax (paid) / received	**7**	5
Net cash generated from/(used in) operations	**343**	576
Cash flows from investing activities		
Interest received	**2**	22
Purchase of intangible assets	**(23)**	(31)
Purchase of Property, Plant and Equipment	**(320)**	(419)
Sales of Property, Plant and Equipment	**455**	0
Net cash generated from/(used in) investing activities	**114**	(428)
Cash flows from financing activities		
Capital element of finance lease rental payments	**(11)**	(16)
Interest paid	**(20)**	(32)
PDC dividend paid	**(241)**	(296)
Net cash generated from/(used in) financing activities	**(272)**	(344)
Increase/(decrease) in cash and cash equivalents	**185**	(196)
Cash and cash equivalents at 1 April	**327**	523
Cash and cash equivalents at 31 March	**512**	327

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trusts Annual Reporting Manual which has been agreed with HM Treasury. Consequently, the financial statements have been prepared in accordance with the 2009/10 NHS Foundation Trusts Annual Reporting Manual issued by Monitor. The accounting policies contained in the manual follow the EU endorsed International Reporting Standards (IFRS), IFRIC interpretations and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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

1.1 Income recognition

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

The categories of income disclosed in the notes include analysis by patient type, mandatory/non-mandatory services, and by type of NHS organisation.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

The sum included in the accounts is an indicative estimate based on the actual volume of inpatients in hospital at 31 March 2010, taking into account their tariff cost and an average length of stay. Income is recognised based on the proportion of the average length of stay realised.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

PCT contract income is recognised based on tariffs and activity schedules agreed with other NHS organisations on an annual basis for a number of treatment areas. Income is recognised based on regular billings throughout the course of the year, with over or under-performance against agreed totals being billed or credited as appropriate.

High cost drugs - this income is in respect of drugs provided to patients of the Trust, for which the Trust is charged. These charges are then directly recharged to the partner NHS organisation commissioning the treatment at invoice value. Income is recognised in the period in which the treatment drugs are purchased.

R&D income is recognised income from grant giving bodies. It is recognised in two methods. Firstly income will be recognised on the basis of expenses incurred in the course of research-funded activities, and the Trust will bill the funding body periodically on the basis of expenditure incurred up to a maximum of the agreed funding. The second method of income recognition will be where funding agreed is to be provided on a regular basis to the Trust over a defined period of time. Therefore income will be recognised on the basis of funding provided during the accounting period which forms part of that period of time.

Education and training income is based on an agreed amount of Service Increment for Teaching (SIFT) income which is provided to the Trust throughout the financial year. This is recognised as it is received, or accrued for in the period in which it relates to.

1.2 Expenditure

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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.3 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. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Measurement

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

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments 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'.

Amortisation and impairment

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

The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

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.

Purchased computer software licences are capitalised as intangible non-current assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the licence and their useful lives.

Asset category	Useful life (years)
Software licences	5

Research and development

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.3 Intangible assets (continued)
Research and development (continued)

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the statement of comprehensive income on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible the Trust will disclose the total amount of research and development expenditure charged in the statement of comprehensive income separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

1.4 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 and;
    - has an individual cost of at least £5,000; or
    - the items form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
    - form part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.
- where a component is separable from its host asset and is considered significant it is capitalised separately.

Measurement

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. Property assets are measured subsequently at fair value.

Property assets

The fair value of land and buildings are determined by valuations carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out primarily on the basis of modern equivalent cost for specialised operational property and existing use value for non-specialised operational property. For non-operational properties, including surplus land, the valuations are carried out at open market value. For property assets the frequency of revaluations will be at least every five years, in line with Monitor's view, but more frequently in volatile times in the property market.

Assets under construction are valued at cost and are subsequently revalued by professional valuers when brought into use or when factors indicate that the value of the asset differs materially from its carrying value.

Non-property assets

For non-property assets the depreciated historical cost basis has been adopted as a proxy fair value in respect of assets which have short or low values. Non property assets acquired up to 31 March 2008 were re-valued through an annual uplift by the change in the value of the GDP deflator. These re-valued assets are included in the non-property assets valuation, but further indexation of these assets has ceased.

Additional alternative open market value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.4 Property, Plant and Equipment (continued)

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

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. Where a large asset, such as a building, includex a number of components with significantly different asset lives then these components are treated as separate assets and depreciated over their own useful economic lives.

The Trust depreciates its non-current assets on a straight-line basis over the expected life of the asset after allowing for the residual value. Useful lives are determined on a case by case basis. The typical life for the following assets are:

Asset category	Useful life (years)
Freehold property - buildings	13 – 60
Freehold property - dwellings	36 – 52
Plant	5 – 15
Equipment - transport	7 – 10
Equipment - information technology	5
Equipment - furniture and fittings	10

Freehold land is considered to have an infinite life and is not depreciated.

Assets under construction are not depreciated until the asset is brought into use.

Revaluation and impairment

The carrying values of property, plant and equipment assets are reviewed for impairment when events or changes in circumstances indicate their carrying value may not be recoverable.

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments 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'.

1.5 Donated assets

Donated non-current assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated non-current assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the statement of comprehensive income. Similarly, any impairment on donated assets charged to the statement of comprehensive income is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the income and expenditure reserve.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

1.7 Inventories

Inventories are costed at the lower of cost and net realisable value on a first in first out basis. High turnover items such as drugs are held in the accounts at cost.

1.8 Provisions

Clinical negligence costs

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms.

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 the NHS Litigation Authority 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 as and when the liability arises. Assessed risks as advised by the NHSLA are provided for as disclosed in Notes 17 and 23.

1. 9 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.10 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 non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.11 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual; see note 26.

1.12 Leases

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 inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.13 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust, the Royal National Hospital for Rheumatic Diseases NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.14 Financial instruments and financial liabilities

Recognition

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

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

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

Classification and measurement

Financial assets are categorised as 'Loans and receivables'. Financial liabilities are classified as 'Other financial liabilities'.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the balance sheet date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

1. ACCOUNTING POLICIES (CONTINUED)

1.14 Financial instruments (continued)

Impairment of financial assets

At the date of the Statement of Financial Position, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision that is determined specifically on individual assets.

1.15 Corporation Tax

The Trust does not foresee that it will have any material commercial activities on which corporation tax liability will arise under the guidance issued by HM Revenue and Customs.

1.16 Charitable Funds

The Trust currently provides separate accounts for its Charitable Funds, in line with current national guidance. The Charitable Funds are subsidiaries under IAS 27, but are not consolidated, as directed by HM Treasury.

1.17 Accounting standards that have been issued but have not yet been adopted

The following accounting standards have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Standards Interpretations Committee (IFRIC) but have not been adopted because they are not yet required to be adopted.

IAS 27 (Revised) Consolidated and separate financial statements

This standard concerns the accounting for subsidiaries and associates. The Trust has no subsidiaries or associates so this standard would not impact upon the Trust's financial statements.

Amendment to IAS 32 Financial Instruments: - Presentation on classification or rights issues

The nature of this standard deals with setting out the principle of determining whether a financial instrument is a financial liability or an equity instrument and the disclosure of each. The Trust does not have equity in the same way that a Limited Company would have and therefore this standard would not impact upon the Trust's financial statements.

Amendment to IAS 39 Eligible hedged items

The nature of this amendment relates to financial instruments - eligible hedged items. The Trust does not have any hedged items and therefore this standard would not impact upon the Trust's financial statements.

IFRS 3 Business Combinations

The nature of this standard is to recognise the assets acquired and liabilities assumed when a business acquires another business. The values used are as at their acquisition date, fair values, and the entity is required to disclose information that enables users to evaluate the nature and financial effects of the acquisition.

The effect on the Trust is nil as the Trust does not have any subsidiaries as at 1 April 2009 and has not acquired any during the year.

1. ACCOUNTING POLICIES (CONTINUED)

1.17 Accounting standards that have been issued but have not yet been adopted (continued)

IASB Improvements to IFRS - amendment to IFRS 5

This amendment concerns Business Combinations and does not apply to the Trust for the reasons set out above.

IFRIC 17 Distributions of Non-cash Assets to Owners

The nature of this standard is to cover the situations where an entity would distribute assets other than cash as dividends to its owners acting in their capacity as owners. This does not apply to Foundation Trusts as the only dividends that can be issued are Public Dividend Capital Dividends which are payable to the Department of Health. Therefore this standard would not impact upon the Trust's financial statements.

IFRIC 18 Transfer of assets from customers

This standard deals with situations where customers may transfer assets to an entity. Examples of this include the utilities industry where certain items of property, plant and equipment must be used to connect those customers to a utility network. Another example is where an entity outsources its Information Technology functions and may transfer its existing items of property, plant and equipment to the outsourcing provider. None of these situations apply to the Trust and therefore this standard would not impact upon the Trust's financial statements.

1.18 Accounting standards issued that have been adopted early

In line with the HM Treasury Financial Reporting Manual, Monitor has chosen to early adopt for 2009/10 the amendment to IFRS 8 set out in the IASB's 'Improvements to IFRS' issued in April 2009. Consequently, NHS Foundation Trusts need only disclose total assets attributable to each operating segment where this information is regularly provided to the Chief Operating Decision Maker.

1. ACCOUNTING POLICIES (CONTINUED)

1.19 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, 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.

Key sources of estimation uncertainty

Only key sources of estimation uncertainty that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are disclosed.

Contingencies

Advice from the senior executive team is taken when reporting contingencies. However, the nature of contingencies is such that uncertainty is inherent.

2. Segmental analysis

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision maker. The chief operating decision maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Trust's Board of Directors. The individual segments are consistent with the organisational structure of the Foundation Trust which is based on clinical specialties.

The operating income for each segment is mainly derived from Primary Care Trusts as a result of delivery of patient care in these specialties. In addition, income is sourced from the Strategic Health Authority to fund education and training costs in line with national policy.

The Trust's income and activities are for the provision of health and health related services within the UK. The services provided by the Trust are designated between specialties. Details of the services provided within each of the Trust's main clinical specialties are included below. The information is a summary of activity by specialty level.

2.1 Segmental analysis - explanation of the services provided by specialties

Service Area	Examples of services provided
Rheumatology	Inpatients, daycases and outpatients including clinical measurement services, such as bone scans
Neuro rehabilitation	Care provided in an outpatient and inpatient setting for patients requiring intensive neuro rehabilitation
Pain Management	Inpatient and outpatient services for patients with chronic pain
Chronic Fatigue Syndrome (CFS)	Care provided in an outpatients in clinics with therapies, for example physiotherapy

2.2 Segmental Analysis - revenues from external customers by country

Income arising from external customers during the year was from the following countries:

	£000
England	18,751
Wales	472
Scotland	276
Republic of Ireland	71
Saudi Arabia	142
Total operating income	19,712

NOTES TO THE ACCOUNTS

2. Segmental analysis (continued)

2.3 Segmental analysis 2009/10

	Rheumatology *	Neuro	Pain Management	CFS	Total
	£000	£000	£000	£000	**£000**
PCT Patient Related Income					
Patient income as per management accounts	7,590	3,781	1,578	499	**13,448**
Adjustment to reflect annual accounts	261	152	27	0	**440**
Annual accounts value for patient related revenue	7,851	3,933	1,605	499	**13,888**
Direct Expenditure					
Pay	3,904	2,667	797	349	**7,717**
Clinical supplies	229	75	1	0	**305**
Non-clinical supplies	5	4	1	0	**10**
Other non-pay	124	104	75	19	**322**
Direct Costs	4,262	2,850	874	368	**8,354**
Contribution to Overheads and Indirect costs	3,589	1,083	731	131	**5,534**

* Rheumatology includes Clinical Measurement Services

The above numbers are in accordance with information reviewed at board meetings. A reconciliation from the Patient Related income as above to total patient related income is given in Note 3.3, which together with Other Operating income in note 5 make up the total Trust income of £19,712,000. Segmental analysis is not reported for the Statement of Financial Position.

Comparatives for the previous year are not available.

2.4 Revenues from customers greater than 10 percent of total

	£000	£000	£000	£000	**£000**
Bath and North East Somerset Primary Care Trust	2,877	0	0	121	**2,998**
Wiltshire Primary Care Trust	3,150	0	0	122	**3,272**
Somerset Primary Care Trust	1,552	0	0	77	**1,629**
Hampshire Primary Care Trust	0	0	246	0	**246**
South West Specialised Commissioning Group	0	1,322	334	0	**1,656**
South Central Specialised Commissioning Group	0	1,634	0	0	**1,634**
West Midlands Specialised Commissioning Group	0	0	194	0	**194**
	7,579	2,956	774	320	**11,629**

NOTES TO THE ACCOUNTS

3.1 Income from activities

	2009/10	2008/09
	£000	£000
Elective income	**5,415**	5,772
Non-elective income	**4,307**	5,116
Outpatient income	**4,166**	2,850
Block contract income	**0**	326
Private patient income	**208**	136
Other clinical income from mandatory services	**4,397**	3,359
	18,493	17,559

Other clinical income includes £4,048,000 for high cost drugs (2008/09: £3,359,000)

Income from mandatory services	**18,285**	17,423
Income from non-mandatory services	**208**	136
	18,493	17,559

3.2 Income from activities - by source

	2009/10	2008/09
	£000	£000
NHS Foundation Trusts	**0**	7
NHS Trusts	**34**	26
Primary Care Trusts	**17,936**	15,636
Department of Health - Other	**46**	1,006
NHS Other	**122**	0
Non-NHS: Private Patients	**208**	136
NHS injury scheme	**63**	39
Non-NHS: Other	**84**	709
	18,493	17,559

3.3 Income from activities - by type

	2009/10	2008/09
	£000	£000
PCT Income	**13,888**	14,064
High Cost Drugs Income	**4,048**	3,359
Private Patient Income	**208**	136
Other Clinical Income	**349**	0
Total Patient Related Income	**18,493**	17,559

The Trust has treated income from PCTs for high cost drugs as patient related income.

4. Private patient income

	2009/10	2008/09	2002/03
	£000	£000	£000
Private patient income	**208**	136	128
Total patient related income	**18,493**	17,559	9,748
Proportion (as a percentage)	**1.12%**	0.77%	1.31%

Section 44 of the National Health Services Act 2006 requires that the proportion of private patient income to the total patient related income of NHS Foundation Trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03. For the Trust this is 1.31%.

5. Other operating income

	2009/10	2008/09
	£000	£000
Research and development	643	350
Education and training	279	1,001
Transfers from donated asset reserve	62	(8)
Charitable and other contributions to expenditure	53	67
Other income	182	86
	1,219	1,496

During the year, there has been some reclassification of the income categories but the prior year's figures have not in every case been restated. As a consequence, there are some apparent anomalies in comparing current year individual income categories with the previous year.

6. Operating expenses

6.1 Operating expenses comprise:	2009/10 £000	2008/09 £000
Services from NHS Foundation Trusts	**0**	2
Services from NHS Trusts	**976**	922
Services from other NHS bodies	**8**	143
Executive directors costs	**403**	417
Non-executive directors' costs	**62**	39
Staff costs	**10,334**	10,643
Drug costs	**4,369**	3,628
Supplies and services - clinical (excluding drug costs)	**336**	353
Supplies and services - general	**176**	139
Establishment	**282**	202
Transport	**45**	99
Premises	**1,064**	864
Bad debts	**286**	(32)
Depreciation and amortisation	**501**	459
Audit fees	**82**	38
Internal audit fees	**62**	56
Other auditor's remuneration	**8**	10
Other	**423**	713
	19,417	18,695

The reduction in inventory levels of £17,000 is included as an expense for the year 2009/10 (2008/09 increase in inventory £25,000 as reduction of expense). See note 14

6.2 Other auditor remuneration	2009/10 £000	2008/09 £000
IFRS Review	**8**	0
Corporate finance transactions	**0**	10
	8	10

6.2.1 Auditors' liability cap

The Board of Governors appointed PricewaterhouseCoopers LLP as external auditors for the financial year ending 31 March 2010. The engagement letter signed on 23 November 2009, states that the liability of PricewaterhouseCoopers LLP, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1 million in the aggregate in respect of all services (2008/09 - £1 million).

6.3 Operating leases

The Trust's obligations under operating leases mainly relate to a lease for the hiring of apartments used for accommodating patients attending training courses. This lease was extended during the year and will expire in September 2014. Other payments relate to minor items of equipment. There are no contingent rents or sublease arrangements.

6.3.1 Operating expenses include:-	2009/10 £000	2008/09 £000
Other operating lease rentals - land and buildings	**64**	54
plant and machinery	**5**	5
	69	59

The Foundation Trust sold 11 Trim Street in April 2009 and leased back the premises through agreement until 30 April 2010 at a peppercorn rent.

6.3.2 Annual commitments under non - cancellable operating leases are:	2009/10 £000	2008/09 £000
Operating leases which expire between 1 and 5 years	**78**	59
	78	59

6.3.3 Total future minimum lease payments are:	2009/10 £000	2008/09 £000
Not later than one year	78	32
Later than one year and not later than five years	265	6
Later than five years	0	0

NOTES TO THE ACCOUNTS

6.4 Salary and pension entitlements of senior managers

Remuneration

Name and Title	Salary	Other Remuneration	Golden hello / compensation for loss of office	Benefits in kind
	(bands of £5000)	(bands of £5000)	(bands of £5000)	(Rounded to the nearest £100)
2009/10	£000	£000	£000	£
Kirsty Matthews, Interim Chief Executive (From April 2009)	70-75	0	0	0
Dr T Jenkinson, Medical Director	120-125	0	0	0
Rod Barnes, Finance Director (Left December 2009)	55-60	0	0	0
Steven Haynes ,Interim Finance Director (From January 2010)	20-25	0	0	0
Karen Kerley, Director of Human Resources & Membership	55-60	0	0	0
Amanda Pacey, Director of Clinical Practice/Nursing Professional Advisor	45-50	0	0	0
Hayley Sewell, Director of Governance & Performance	55-60	0	0	0
Stephen Cole, Interim Chair (From April 2009)	25-30	0	0	0
Julie O'Donnell nee Spencer-Cingoz	5-10	0	0	0
Christopher Johns	5-10	0	0	0
Peter Spencer	5-10	0	0	0

Performance of the Board and Senior Management team is assessed through the Trusts' annual appraisal system whereby staff are set individual objectives and development plans which support delivery of the organizations strategy and performance targets.

The aggregate directors' remuneration in the year was £465,000. The highest paid director was paid £121,000 in the year.

2008/09				
Nicola Carmichael, Chief Executive (left August 2008)	30-35	0	0	0
Peter Hill , Interim Chief Executive (from September 2008 to March 2009)	45-50	0	0	0
Dr T Jenkinson, Medical Director	120-125	0	0	0
Rod Barnes, Finance Director	70-75	0	0	0
Karen Kerley, Director of Human Resources & Membership	55-60	0	0	0
Chris Fokke, Director of Clinical Practice/Nursing Professional Advisor (left March 2009)	40-45	0	0	0
Amanda Pacey, Director of Clinical Practice/Nursing Professional Advisor (from March 2009)	0-5	0	0	0
Hayley Sewell, Director of Governance & Performance	55-60	0	0	0
Brian Joakim - Chairperson (left December 2008)	25-30	0	0	0
Kirsty Matthews - Chairperson (from January 2009)	15-20			
Julie O'Donnell nee Spencer-Cingoz	5-10	0	0	0
Christopher Johns	5-10	0	0	0
Peter Spencer	5-10	0	0	0

Costs for Peter Hill, seconded to the Trust as Interim Chief Executive from September 2008 represent a recharge from Salisbury NHS Foundation Trust and pension costs are not separately identifiable.

6.4 Salary and pension entitlements of senior managers

Pension Benefits

Name and Title	Real increase/ (decrease) in pension at age 60 at 31 March 2010 (bands £2,500)	Real increase in lump sum at age 60 at 31 March 2010 (bands £2,500)	Total accrued pension at age 60 at 31 March 2010 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2009	Real Increase/ (decrease) in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Kirsty Matthews, Interim Chief Executive (from April 2009)	7.5-10.0	20-22.5	5-10	20-25	125	0	115
Dr Tim Jenkinson, Medical Director	0-2.5	0-2.5	20-25	60-65	428	373	36
Rod Barnes, Finance Director (left December 2009)	0-2.5	2.5-5.0	15-20	55-60	288	233	33
Steven Haynes, Interim Finance Director (from January 2010)	(0-2.5)	(0-2.5)	25-30	85-90	596	575	(2)
Karen Kerley, Director of Human Resources & Membership	0-2.5	0-2.5	5-10	15-20	97	79	14
Hayley Sewell, Director of Governance & Performance	0-2.5	0-2.5	5-10	25-30	166	144	15
Amanda Pacey, Acting Director of Clinical Practice/Nursing Professional Advisor and DIPC	0-2.5	5.0-7.5	10-15	30-35	168	122	39

Non-Executive members do not receive pensionable remuneration.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Employers' contributions to the pension scheme in respect of directors was £60,000 in the year 2009/10. Benefits are accruing to 7 directors under the defined benefit scheme.

NOTES TO THE ACCOUNTS

7. Staff costs and numbers

7.1 Staff costs

	2009/10	2008/09
	£000	£000
Salaries and wages	**8,693**	8,856
Social Security costs	**628**	627
Employer contributions to NHSPA	**985**	991
Agency and contract staff	**431**	586
	10,737	11,060

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.
The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 with summary global member and accounting data.

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

7. Staff costs and numbers (continued)

7.1 Staff costs (continued)

c) Scheme provisions

In 2008-09 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions
The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Pensions Indexation
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement
Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits
A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds
Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits
Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement
Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

7.2 Average number of persons employed

	2009/10 Total Number	**2009/10 Permanently Employed**	**2009/10 Other**	2008/09 Total Number
Medical and dental	**19**	**19**	**0**	15
Administration and estates	**111**	**111**	**0**	114
Nursing, midwifery & health visiting staff	**84**	**84**	**0**	105
Scientific, therapeutic and technical staff	**60**	**60**	**0**	64
Bank and agency staff	**32**	**0**	**32**	110
Total	**306**	**274**	**32**	408

The average number of persons employed includes directors on a service contract.

7. Staff costs and numbers (continued)

7.3 Employee benefits

An NHS corporate account was set up with Wiltshire DC Leisure Centres, which enables all employees to receive 15% of the membership subscription. There is no cost to the Trust (2008/09: £nil).

7.4 Retirements due to ill-health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year 2009/10.

There were three retirements at an additional cost of £74,000. (2008/09: £nil)

This information has been supplied by NHS Pensions.

7.5 Directors' Remuneration and other benefits

The aggregate Directors' remuneration for the year is £465,000 (2008/09: £456,000) (see note 6.1)

The employer contributions to the defined benefit pension scheme was £60,000 relating to 7 directors through 2009/10.

8. Financing income and expenditure	**2009/10**	2008/09
	£000	£000
8.1 Finance income		
Finance income	**2**	22

Finance income relates to interest paid to the Trust on its bank account balances.

8.2 Finance expense		
Finance expense	**(20)**	(32)

Finance expense relates to payments made to suppliers due to payment outside payment terms (£19,000) and interest component of payments on Finance Leases (£1000).

9. Public Dividend Capital dividend

	£000	£000
Public dividend capital (PDC) dividend paid	**241**	296
Actual public dividend capital dividend incurred during the year	**213**	296
Overpaid recoverable	**28**	0

The actual dividend rate is the dividend payable figure divided by the simple average of opening and closing relevant net assets expressed as a percentage.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

10. Public Sector Payment Policy

Better Payment Practice Code - measure of compliance

	2009/10		2008/09	
	Number	**£000**	Number	£000
Total bills paid in the year	**4,284**	**6,052**	4,614	5,989
Total bills paid within target	**2,158**	**1,431**	1,786	883
Percentage of bills paid within target	**50.37%**	**23.65%**	38.71%	14.74%

The Better Payment Practice Code requires trusts to aim to pay all valid non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

11. The Late Payment of Commercial Debts (Interest) Act 1998

There was £19,000 included within Interest Payable arising from claims made by businesses under this legislation (2008/09 £32,000).

NOTES TO THE ACCOUNTS

12. Intangible assets

	2009/10 Software Licences £000	2008/09 Software Licences £000
Fair Value at 1 April	**234**	203
Additions - purchased	**23**	31
Additions - reclassified	**5**	0
Fair Value at 31 March	**262**	234
Accumulated amortisation at 1 April	**163**	153
Provided during the year	**18**	10
Accumulated amortisation at 31 March	**181**	163
Net book value		
- Purchased assets at 1 April	**71**	50
- Purchased assets at 31st March	**81**	71

NOTES TO THE ACCOUNTS

13. Property, Plant and Equipment

13.1 Property, Plant and Equipment at the balance sheet date comprise the following elements:

	Freehold Land	Freehold buildings excluding dwellings	Plant & Machinery	Transport Equipment	Information Technology	Furniture & fittings	Assets under construction	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	2,292	5,147	1,543	48	637	73	48	9,788
Additions - purchased	0	256	7	0	23	0	59	345
Additions - donated	0	0	20	0	0	0	0	20
Reclassifications	0	35	0	0	0	0	(40)	(5)
Other revaluations	(22)	(730)	0	0	0	0	0	(752)
Disposals	(110)	(324)	(129)	0	0	0	0	(563)
At 31 March 2010	**2,160**	**4,384**	**1,441**	**48**	**660**	**73**	**67**	**8,833**
Accumulated depreciation at 1 April 2009	0	0	1,123	34	620	54	0	1,831
Provided during the year	0	351	120	5	4	3	0	483
Other revaluations	0	(50)	0	0	0	0	0	(50)
Disposals	0	(2)	(106)	0	0	0	0	(108)
Accumulated depreciation at 31 March 2010	**0**	**299**	**1,137**	**39**	**624**	**57**	**0**	**2,156**
Net book value								
- Purchased at 1 April 2009	2,292	4,802	337	14	17	19	48	7,529
- Donated at 1 April 2009		345	83	0	0	0	0	428
Total at 1 April 2009	**2,292**	**5,147**	**420**	**14**	**17**	**19**	**48**	**7,957**
- Purchased at 31 March 2010	2,160	3,809	240	9	36	16	67	6,337
- Donated at 31 March 2010	0	276	64	0	0	0	0	340
Total at 31 March 2010	**2,160**	**4,085**	**304**	**9**	**36**	**16**	**67**	**6,677**

13.2 Analysis of Property, Plant and Equipment

Net book value								
Protected assets at 31 March 2010	2,160	4,085	0	0	0	0	0	6,245
Un-protected assets at 31 March 2010	0	0	304	9	36	16	67	432
	2,160	**4,085**	**304**	**9**	**36**	**16**	**67**	**6,677**

13.3 Property, Plant and Equipment at the prior year's balance sheet date comprise the following elements:

Cost or valuation at 1 April 2008	2,308	6,293	1,393	48	602	62	0	10,706
Additions - purchased	0	190	143	0	35	11	48	427
Additions - donated	0	0	7	0	0	0	0	7
Reclassifications	0	(1,356)	0	0	0	0	0	(1,356)
Other revaluations	(16)	20	0	0	0	0	0	4
At 31 March 2009	**2,292**	**5,147**	**1,543**	**48**	**637**	**73**	**48**	**9,788**
Accumulated depreciation at 1 April 2008	0	984	1,113	26	558	57	0	2,738
Provided during the year	0	372	10	8	62	(3)	0	449
Reclassifications	0	(1,356)	0	0	0	0	0	(1,356)
Accumulated depreciation at 31 March 2009	**0**	**0**	**1,123**	**34**	**620**	**54**	**0**	**1,831**
Net book value								
- Purchased at 1 April 2008	2,308	4,923	255	22	44	5	0	7,557
- Donated at 1 April 2008		386	25	0	0	0	0	411
Total at 1 April 2008	**2,308**	**5,309**	**280**	**22**	**44**	**5**	**0**	**7,968**
- Purchased at 31 March 2009	2,292	4,802	337	14	17	19	48	7,529
- Donated at 31 March 2009	0	345	83	0	0	0	0	428
Total at 31 March 2009	**2,292**	**5,147**	**420**	**14**	**17**	**19**	**48**	**7,957**

13.4 Analysis of Property, Plant and Equipment

Net book value								
Protected assets at 31 March 2009	2,292	5,147	0	0	0	0	0	7,439
Un-protected assets at 31 March 2009	0	0	420	14	17	19	48	518
	2,292	**5,147**	**420**	**14**	**17**	**19**	**48**	**7,957**

The NHS Foundation Trust Annual Reporting Manual requires all foundation trusts to prepare their accounts in accordance with IFRS and the HM Treasury FReM, except in cases of specific divergence. This guidance does not specify any departure from Royal Institute of Chartered Surveyors standards, for which valuation on the modern equivalent asset (MEA) basis is the accepted norm. The effective date of the formal revaluation was April 2009 and was undertaken by the District Valuer using MEA value. The modern equivalent asset basis values assets by estimating the costs to create a modern equivalent of the existing asset, taking into account modern materials and building techniques. Property values have been reassessed by reference to indices for the local area provided by the District Valuer's office for the current year.

NOTES TO THE ACCOUNTS

14. Inventories

	31 March 2010	31 March 2009	01 April 2008
	£000	£000	£000
Raw materials and consumables	**14**	31	6

The movement in inventories is recognised in operating expenses - see note 6.1

15. Trade and other receivables

	31 March 2010	31 March 2009	01 April 2008
	£000	£000	£000
Current:			
NHS receivables	**1,871**	1,766	1,349
Provision for impaired receivables	**(379)**	(93)	(125)
Prepayments	**120**	55	0
Accrued income	**15**	0	110
PDC Dividend overpaid	**28**	0	0
Other receivables	**488**	608	992
Total current trade and other receivables	**2,143**	2,336	2,326
Provision for impairment of receivables			
At 1 April	**93**	125	125
Increase in provision	**310**	0	
Amounts utilised	**(24)**	(32)	
At 31 March	**379**	93	125

15.1 Analysis of impaired receivables

	31 March 2010	31 March 2009	01 April 2008
	£000	£000	£000
Ageing of impaired receivables			
Up to three months	**38**		
In three to six months	**15**		
Over six months	**326**	93	125
	379	93	125

15.2 Ageing of non-impaired receivables past their due date

	31 March 2010	31 March 2009	1 April 2008
	£000	£000	£000
Up to three months	**988**	471	112
In three to six months	**231**	104	0
Over six months	**223**	295	605
Overdue	**1,442**	870	717
Not yet due	**701**	1,466	1,609
	2,143	2,336	2,326

16. Trade and other payables

	31 March 2010	31 March 2009	1 April 2008
Current trade and other payables:	**£000**	£000	£000
NHS payables	**1,393**	2,059	2,037
Trade payables - capital	**41**	16	63
Other trade payables	**1,197**	1,379	1,476
Taxes payable	**199**	192	187
Accruals	**82**	0	27
Deferred Income	**236**	150	265
Total Current	**3,148**	3,796	4,055
Amounts falling due after more than one year:			
Deferred Income	**44**	0	0
Total non-current	**44**	0	0
Total Trade and other payables	**3,192**	3,796	4,055

In accordance with IFRS and HM Treasury's FReM The Trust has made an accrual of £78,000 for cost of untaken leave at 31 March 2010. This is a reduction from the accrual of £120,000 at 31 March 2009.

17. Provisions for liabilities and charges

	2009/10	2008/09	2007/08
	£000	£000	£000
At 1April	**9**	14	
Reversed Unused	**(2)**	(13)	
Additional Provision	**2**	8	14
At 31 March	**9**	9	14

The NHS Litigation Authority (NHSLA) has advised that we disclose a provision of £9,000 at 31st March 2010, in respect of LTPS (Liabilities to Third Parties Scheme) as part of non-clinical risk pooling (31 March 2009 £9,000). There is no provision required in respect of clinical negligence. It is probable that the liability will be cleared between one and five years. A further potential liability under the LTPS is indicated under note 23, Contingent liabilities.

18. Prudential Borrowing Limit

The NHS Foundation Trust is required to comply with, and remain within, a total prudential borrowing limit. This is made up of two elements.

- the maximum cumulative amount of long term borrowing. This is set by reference to the four ratio tests set out in Monitor's Prudential Borrowing Code (see below). The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.
- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust's Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the independent Regulator of Foundation Trusts.

The Trust has a £500,000 on demand facility in place at 31st March 2010.

	31 March 2010	31 March 2009
	£000	£000
Total long term borrowing limit set by Monitor	**3,500**	1,800
Working capital facility agreed by Monitor	**1,000**	1,000
Total Prudential Borrowing Limit	**4,500**	2,800

The approved long term borrowing and working capital facility were unused during the year.

Financial ratios	**2009/10 Actual Ratios ratios**	**2009/10 Approved PBL ratios**	2008/09 Actual Ratios ratios	2008/09 Approved PBL ratios	2007/08 Actual Ratios ratios	2007/08 Approved PBL ratios
Minimum dividend cover	**3.7x**	**>1x**	2.7x	4.0x	1.7x	3.3x
Minimum interest cover	**40.8x**	**>3x**	0	0	0	0
Minimum debt service cover	**816x**	**>2x**	0	0	0	0
Maximum debt service to revenue	**0%**	**<2.5%**	0%	0%	0%	0%

NOTES TO THE ACCOUNTS

19. Borrowings

	31 March 2010	31 March 2009	1 April 2008
	£000	£000	£000
Obligations under finance leases			
Current	**13**	10	0
Non current	**15**	29	0
Total borrowings	**28**	39	0

The Foundation Trust has two items of plant and machinery held on finance leases over a period of five years expiring in 2012. The leases can be extended by subsequent agreement. At the end of the year 2009/10 the net carrying amount was £25,000. The minimum lease payments at the end of the year were £28,000 and their present value £27,000. Payments due were:

	Minimum Payments	Present Value
	£000	£000
No later than one year	13	13
Between one and five years	15	14

20. Cash and cash equivalents

	2009/10	2008/09
	£000	£000
Net funds at 1 April	**327**	523
Net Increase / (Decrease) in cash in the period	**185**	(196)
Net funds at 31 March	**512**	327

Broken down into:	**31 March 2010**	Cash flows	1 April 2009
	£000	£000	£000
GBS and OPG cash at bank	**497**	172	325
Commercial cash at bank and in hand	**15**	13	2
	512	185	327

21. Capital commitments

The Trust had no capital commitments at 31 March 2010 (nil at 31 March 2009).

22. Events after the reporting period

There were no events after the reporting period having a material effect on the accounts for 2009/10.

23. Contingent liabilities

There was a contingent liability in respect of non-clinical risk pooling relating to LTPS of £3,000 at 31 March 2010 (£4,000 at 31 March 2009). This is related to the potential liabilities disclosed in Note 17 Provisions.

NOTES TO THE ACCOUNTS

24. Related Party Transactions

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust is a body corporate established by the issue of a licence of authorisation from Monitor.

The Trust is under the common control of the Board of Directors.

The Trust has received revenue and capital payments from the Funds Held on Trust, the Trustees of which are members of the NHS Trust Board. The audited accounts and annual report of the Funds Held on Trust are available on request from the NHS Trust.

The Trust received income totaling £132,000 from Funds Held On Trust in 2009/10. The Trust processed payments totaling £104,000 in 2009/10.

The Trust owed Funds Held on Trust £746 as at 31 March 2010 in respect of credits received by the Trust on its behalf.

The Trust also had significant transactions with the following NHS organisations during 2009/10:

	Income	Expenditure
	£000	£000
Bath and North East Somerset Primary Care Trust	2,998	232
Wiltshire Primary Care Trust	3,272	104
Somerset Primary Care Trust	1,629	10
Hampshire Primary Care Trust	246	0
South West Specialised Commissioning Group	1,656	0
South Central Specialised Commissioning Group	1,634	0
The Royal United Hospital, Bath NHS Trust	22	976

Income is in respect of services provided by the Trust to patients referred by the entities above. Expenditure is in respect of goods and services provided by the entities to the Trust.

The only payments to key management personnel are as detailed in Note 6.4.

25. Financial instruments & financial liabilities

A financial instrument is a contract that gives rise to both a financial asset of one entity and a financial liability or equity instrument of another enterprise. IFRS 7, Financial Instruments: recognition and Measurement, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The financial assets and liabilities of the Trust are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

NOTES TO THE ACCOUNTS

25.1 Financial instruments & financial liabilities recognition

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

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

All other financial assets and liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

25.2 Financial instruments & financial liabilities derecognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

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

Liquidity risk

The Trust's net operating costs are incurred under contracts with commissioners, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government. The Trust is not, therefore, exposed to significant liquidity risks. Cash is invested in accordance with approved procedures. Cashflows are monitored and monthly forecasts are produced, to ensure that commitments, including loan repayments, are met.

Interest-rate risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The Trust is not, therefore, exposed to significant interest-rate risk.

Foreign Currency Risk

The Trust has no foreign currency income or expenditure.

Market risk

Market risk arises when the Trust is exposed to the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises three types of risk: currency risk, interest rate risk and other price risk.

Credit risk

The vast majority of the Trust's income is from NHS Trusts, in particular Primary Care Trusts. The Trust therefore has very little credit risk from these organisations. Non-NHS income only represents a very small percentage of the Trust's income; procedures are in place to manage the credit risk.

25.3 Financial assets by category

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available for sale £000	**Total £000**
Assets as per balance sheet: -					
NHS receivables (net of provision for irrecoverable debts)	**1,492**	**0**	**0**	**0**	**1,492**
Accrued income	**15**	**0**	**0**	**0**	**15**
Other receivables	**488**	**0**	**0**	**0**	**488**
Cash at bank and in hand	**512**	**0**	**0**	**0**	**512**
Total at 31 March 2010	**2,507**	**0**	**0**	**0**	**2,507**
NHS receivables (net of provision for irrecoverable debts)	1,673	0	0	0	1,673
Accrued income	0	0	0	0	0
Other receivables	608	0	0	0	608
Cash at bank and in hand	327	0	0	0	327
Total at 31 March 2009	2,608	0	0	0	2,608
NHS receivables (net of provision for irrecoverable debts)	1,224	0	0	0	1,224
Accrued income	110	0	0	0	110
Other receivables	992	0	0	0	992
Cash at bank and in hand	523	0	0	0	523
Total at 1 April 2008	2,849	0	0	0	2,849

25.4 Financial liabilities by category

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	**Total £000**
Liabilities as per balance sheet: -			
NHS payables	1,393	0	**1,393**
Trade payables and other payables	1,238	0	**1,238**
Obligations under finance leases	28	0	**28**
Accruals	82	0	**82**
Total at 31 March 2010	2,741	0	**2,741**
NHS payables	2,059	0	**2,059**
Trade payables and other payables	1,395	0	**1,395**
Obligations under finance leases	39	0	**39**
Accruals	0	0	**0**
Total at 31 March 2009	3,493	0	**3,493**
NHS payables	2,037	0	**2,037**
Trade payables and other payables	1,539	0	**1,539**
Accruals	27	0	**27**
Total at 1 April 2008	3,603	0	**3,603**

26. Third party assets

The Trust held £240 cash at bank and in hand at 31 March 2010 which relates to monies held by the Trust on behalf of patients (31 March 2009 £240).

27. Reconciliation of accounts prepared under UK GAAP to IFRS

The financial year ended 31st March 2010 is the first year that the Trust has produced financial statements prepared under International Financial Reporting Standards. The Trust is required under IFRS1 to produce reconciliations that explain how the transition from UK GAAP to IFRS has affected its reported financial position, financial performance and cash flows. The transition to IFRS has caused no impact on its reported financial positions.

The Trust is required to prepare the following:

Reconciliation of equity under UKGAAP to IFRS as at 1 April 2008	Note 30
Reconciliation of equity under UKGAAP to IFRS as at 1 April 2009	Note 30
Reconciliation of profit or loss under UKGAAP to IFRS for the year ended 31 March 2009	Note 28
Effect on cashflows under UKGAAP to IFRS for the year ended 31 March 2009	Note 29

28. Reconciliation of surplus for the year ended 31 March 2009 under UKGAAP to IFRS

The transition from UK GAAP to IFRS has had no impact on the surplus of the Trust for the year ended 31 March 2009, which was £54,000.

29. Reconciliation of cashflows under UK GAAP to IFRS for the year ended 31 March 2009

The transition from UK GAAP to IFRS has had no impact on the cashflows or the cash position for the Trust. Presentational changes result from the elimination of the Operating activities, Returns on investments and servicing of finance, Capital expenditure, Dividends paid, and Financing groupings. These have been replaced by Cash flows from operating activities, Non-cash income and expense, Cash flows from investing activities, and Cash flows from financing activities, and components have been re-assigned among these as appropriate.

30. Taxpayers' equity at 1 April 2009

	Public Dividend Capital £000	Revaluation reserve £000	Donated Asset Reserve £000	Income and expenditure reserve £000	**Total Taxpayers equity £000**
Taxpayers' equity at 31 March 2009 UK GAAP	6,015	748	367	(247)	**6,883**
Adjustments for:					**0**
Prior period adjustments (under UKGAAP)		(47)	61	(19)	**(5)**
Taxpayer's equity at 1 April 2009 under IFRS	**6,015**	**701**	**428**	**(266)**	**6,878**

Taxpayers' equity at 1 April 2008

	Public Dividend Capital £000	Revaluation reserve £000	Donated Asset Reserve £000	Income and expenditure reserve £000	**Total Taxpayers equity £000**
Taxpayers' equity at 31 March 2008 UK GAAP	6,015	745	351	(301)	**6,810**
Adjustments for:					
Prior period adjustments (under UKGAAP)		(47)	60	(19)	**(6)**
Taxpayer's equity at 1 April 2008 under IFRS	**6,015**	**698**	**411**	**(320)**	**6,804**

The prior year adjustments were related to corrections to the Donated Asset reserve of £61,000 to match the valuation of non-current donated assets. £47,000 had been incorrectly taken to the Revaluation reserve and the remainder to Income and Expenditure in 2007/08. There was a rounding difference of £1,000 between the two years. There was also a small income adjustment relating to 2007/08.