Royal National Hospital for Rheumatic Diseases
NHS Foundation Trust

Annual Report & Accounts 2008/09

Royal National Hospital for Rheumatic Diseases
NHS Foundation Trust

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

Annual Report & Accounts
2008/09

Contents

Chair's Statement

The Royal National Hospital for Rheumatic Diseases is a small, specialist Foundation Trust in the centre of Bath, providing tertiary services for a range of specialist inpatient and outpatient rheumatology and complex rehabilitation services, including neurology, pain and chronic fatigue syndrome. The Trust attracts increasing levels of referrals from across the UK in addition to providing secondary rheumatology and rehabilitation services for the local health community.

This has been a challenging year for the RNHRD and I am particularly pleased to be able to state that despite the complex nature of financial and strategic issues, the Trust has been able to consistently deliver a high quality of clinical services that have met patients' needs. This was demonstrated in a number of ways:

- the Healthcare Commission's rating of the Trusts quality of services as excellent;
- the RNHRD's achievement of all National targets, including cleanliness and MRSA;
- Very good results for the National In-Patient survey with the Trust being rated in the top 20% for the majority of questions applicable to its services.

Throughout 2008/09 all specialties have shown a commitment to develop and grow their services and improve the patient experience. Particular points to note are:

- an upgrade of the High Dependency Unit to create a 6-bed High Dependency Unit to provide expertise in the management of people who are minimally aware and who have tracheostomies or may require feeding access via a pecutaneous endoscopic gastostromy (PEG)
- the establishment of an in-hospital service for complex pain patients too severely affected by their condition to attend regular community or hospital based pain programmes
- Rheumatology services treating more patients than plan, with an increase in the number of outpatient and Endoscopy referrals
- increasing levels of specialist referrals for the CFS/ME service from outside the local area.

In addition, activity and income exceeded planned levels for the year which helped the Trust make good progress in delivery of its Financial recovery plan, moving from a restated deficit of £513k for the financial year 2007/08 to an in year financial surplus for the first time since 2004/05.

Key challenges facing the RNHRD in 2008/09 and looking ahead:

- identification of an appropriate partner for merger through a careful and rigorous evaluation process leading to the management of a successful integration plan and maintenance of high quality services
- continuing to achieve a high level of quality research as the historical funding arrangements cease to be available
- developing the RNHRD's specialist services to deliver sustainable growth.

The RNHRD Trust Board has seen a number of significant changes in senior management during this year. Following the departure of Nicola Carmichael, Chief Executive, in August 2008 the Board was delighted to welcome Peter Hill as interim Chief Executive who performed this role until the end of April 2009. Under his

leadership a number of issues were successfully addressed and the Trust is grateful for the valuable contribution Peter made. From April 2008, Kirsty Matthews acted as a Non Executive director on the Board of the RNHRD and then on the departure of Brian Joakim took the position of Interim Chair from December 2008 to April 2009, then taking on the role of chief executive on Peter Hill's departure. I was appointed interim chair to fill the vacancy The Board has throughout retained a strong team of Executive and Non executive Directors who have provided leadership and managerial control during this period of change. This work has resulted in the successful delivery of a £1.2m cost improvement programme in year to which all staff at the RNHRD contributed.

The relationship between the Council of Governors and Board has strengthened over the year with a clear determination to work together to secure the best possible outcome for the Trust's services going forward. We are fortunate to have such a committed and enthusiastic Council supported by a strong membership.

Stephen Cole
Interim Chair

5th June 2009

Directors' Report

The RNHRD has a clear focus on tertiary referral for a range of specialist inpatient and outpatient rheumatology and complex rehabilitation services, including inflammatory and non-inflammatory rheumatic disease, complex neurological conditions, complex pain and chronic fatigue syndrome which attract referrals from across the UK. The RNHRD provides secondary rheumatology and rehabilitation services for the local health community.

The core clinical activities aim 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. Services are provided for adults, adolescents and children.

Neuro Rehabilitation Services

Bath Neuro Rehabilitation Services (BNRS) at the RNHRD is a specialist service offering assessment and intensive rehabilitation in a 27-bed unit to adults and young people who suffer from a wide range of complex neurological conditions as a result of accident or illness, and who have profound and complex needs. Services are offered on an inpatient, outpatient and outreach basis.

Staff at the RNHRD have particular expertise in 'locked in' syndrome, providing assessment and treatment for individuals in a minimally conscious state. Staff have developed expertise such that it is one of the few centres in the UK that uses the much acclaimed SMART assessment tool.

Referrals to BNRS have remained stable and there has been a significant shift in case mix away from normal to high dependency patients across both adult and adolescent services.

The service has continued to develop over the last year. Service developments include:

- the High Dependency Unit has been upgraded, providing a 6-bed facility to allow expert management of people who are minimally aware and who may have tracheostomies or PEG
- the Consultant in Rehabilitation Medicine and a senior clinician have been in regular attendance on a Bath and North East Somerset (BANES) PCT Spasticity Management pathway. This has led to joint agreements being reached on the most appropriate patients being referred to RNHRD for their management
- the Consultant-run Spasticity clinic is now well established twice monthly with a clear pathway in place for follow up
- work is ongoing with the Specialist Commissioning Group and BANES PCT to identify ways of repatriating patients to more local facilities at the earliest opportunity
- development of outreach outpatient services with local teams needing support with complex patients across the UK.

Complex Pain Services

The Trust offers inpatient services in Complex Regional Pain Syndrome and Chronic Pain Management.

Consultants and staff at the RNHRD's Bath Centre for Pain Services have acquired a national and international reputation for their clinical services and research and development of effective interventions for chronic pain. The Pain Service provides a range of intensive residential rehabilitation programmes to address the variety of needs and complexity seen in chronic pain across the lifespan (from 11yrs old).

The core of pain management programmes delivered at the RNHRD is to focus the patient on self-management whilst seeking to address both the physical and emotional impact of chronic pain, so that patients can return to an active, meaningful and productive life, despite the ongoing presence of pain.

The Complex Regional Pain Service at the RNHRD is the only one in the UK dedicated to the treatment of this condition, and offers both outpatient assessment and treatment and admission to hospital for intensive rehabilitation.

Referrals for pain services have increased over the last year and the service has seen an increase in the complexity of patients treated. This has led to a reduction in the number of less intensive 3-week pain management programmes delivered in 2008/09 and an increase in the number of 4-week and in-hospital programmes for complex patients.

Developments during the year included:

- continued development of individualised care packages for highly complex adult and young chronic pain patients
- the establishment of an in-hospital service for complex pain patients too severely affected by their condition to attend regular community or hospital based pain programmes
- maintaining the unit's strong research focus and provision of evidence-based treatment. Publications are detailed in the RNHRD Annual Research report
- application for national specialist service funding for pain services unique in England (Chronic Pain, In-hospital and adolescent programmes)
- collaborative working arrangements with secondary care providers and academic bodies such as the University of Bath; ongoing work on the SMART research project and grant applications to secure research funding for community based pain management services
- involvement and working with the Arthritis & Musculoskeletal Alliance (ARMA) network and BANES on developments which includes a musculoskeletal triage /treatment service.

Rheumatology

The Consultants and other clinical staff at the RNHRD use their well-established expertise to provide specialist services on an inpatient (28-bed unit), day case, outpatient and outreach basis in rheumatological and musculoskeletal medicine for adults, young children and adolescents. Services provided include general rheumatology and specialist services for Ankylosing Spondylitis, Connective Tissue Diseases, Complex Regional Pain Syndrome, Paget's Disease, Psoriatic Arthritis,

Osteoporosis, Fibromyalgia, and Hypermobility. There is a large hydrotherapy pool on site to facilitate rehabilitation. The RNHRD provides Rheumatology clinics at Paulton, Warminster, Malmesbury, Chippenham, Devises, Frome and Tetbury.

Rheumatology had a busy year, with an increase in the number of outpatient and Endoscopy referrals. Referrals to the rheumatology Coping Skills Programme and Hypermobility have also increased. Changes to the coding and pricing of some drug therapies had a detrimental impact on income during the year, which was offset by growth in income for other services.

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

- early achiever in meeting the Government 18 week wait 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
- successful introduction and implementation of MRSA screening has been achieved for all inpatient and day case patients.

Chronic Fatigue Services (CFS)

The RNHRD is one of the few providers to offer CFS/ME services to both adults and children at both a local and national level for specialist referrals. Treatment is offered on an individual or group basis and severely affected people can be offered treatment at home if appropriate.

These services have continued to grow with increasing referrals to our specialist services.

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

Clinical Measurement

The Clinical Measurement department provides a bone densitometry service for people in the BANES, Wiltshire, Mendip and Bristol areas and inpatients generally. The department is one of only a few national centres with a thermography and microvasular assessment laboratory. Thermographic imaging is used for the diagnosis of Raynaud's phenomenon and for the investigation of patients with Complex Regional Pain Syndrome. Laser Doppler imaging and capillaroscopy are used for the diagnosis of Microvascular Disease, particularly in patients with Connective Tissue disorders. As well as specialist diagnostic services, the Trust has X-ray and musculoskeletal diagnostic ultrasound services on site.

Throughout 2008/09, the Clinical Measurement team has worked hard to bring the DEXA Bone Densitometry waiting time down to four weeks, and to be in a position to offer two week waiting from April 2009. New administration systems and more direct reporting systems will be implemented to cope with this. The new service specification for our direct access service will specify a maximum three week reporting time.

In 2008/09, following additional investment from the PCT, the team has implemented a full Falls and Fracture Liaison Service at the Royal United Hospital Bath. This is a partnership between the RNHRD, Royal United Hospital Bath and BANES PCT.

These organisations are working together to identify and treat patients with osteoporosis, and to help people who experience frequent falls. The aim is to reduce the number of people admitted to hospital as a result of a fall and reduce the number of fractures in older people.

The department continues to contribute to research and development within the Trust. Working with radiologists at the Royal United Hospital Bath, the team has successfully completed a 2 year Department of Health funded study, to develop a new ultrasound scanning system to detect early signs of damage in the joints of people with arthritis.

Operations and Finance

The organisation saw strong growth in activity and income levels during the year which resulted in activity and income plans being exceeded across all clinical specialties. During the first half of the year, this additional patient activity resulted in high use of bank and agency staff attracting premium rates of pay. In last year's annual report, the Board identified problems with financial assumptions underpinning in-year financial reporting during 2007/08 and the 2006/07 year end accounts, in-year expenditure during the early part of this year was also adversely affected by prior year issues which came to light as work was undertaken to improve systems and processes. To address this situation, the Board developed and successfully implemented a financial recovery plan which delivered £1.2m of savings and additional income in year. These actions resulted in the Trust returning to an in year financial surplus for the first time since 2004/05.

Although this demonstrates good progress in delivering the organisation's financial turnaround, the trust is continuing to take action to address the profitability of all services. However the Board recognises that it is extremely difficult for an organisation of this size to support the overhead costs associated with maintaining an independent Board and management structure. Changes to national tariffs for Rheumatology services in 2009/10 and beyond will also have a potential adverse impact upon future income. For these reasons, following consultation with Medical Staff, Senior Managers and a representative of the Governors, the Board has agreed that, in addition to the financial and organisational improvements outlined, the Trust will seek expressions of interest from other NHS organisations with a view to future merger. This action is seen as the most viable way of securing the financial investment required to maintain and develop the excellent clinical services currently provided within the hospital.

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 ought to 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

5th June 2009

Background Information

History / Context

Founded in 1738 the 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 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 is 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, CFS/ME, and diagnostic services. 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.

Quality Report

The RNHRD is committed to providing high quality services and continuously improving quality. We are delighted to report that, during 2008/09, the Healthcare Commission rated the Trust's Quality of Services as "Excellent" for the 2007/08 assessment. This was the third year in succession that the Healthcare Commission had rated the Trust's quality of services as Excellent.

The RNHRD achieved all national quality performance targets during 2008/09. Those that are set out in Appendix B of the Compliance Framework and relevant to the Trust are;

- Methicillin Resistant Staphylococcus Aureus (MRSA); number of infections. The Trust had a target of 12 cases or less and there were no MRSA bacteraemia infections during the year.
- Rates of Clostridium Difficile infections; the target was 12 cases or less and there were 3 cases during the year.
- Patients seen within 18 weeks for non-admitted pathways; the Trust was an early achiever in meeting the 18-week Referral to Treatment Time target ahead of the December 2008 national target.

The Trust also achieved the NHS South West target, with 97% of patients starting treatment or other clinically appropriate outcome within 13 weeks of GP referral for non-admitted pathways.

The Healthcare Commission Hygiene Code Inspection visit took place during summer 2008. At the time of the inspection the Trust was upgrading endoscopy washer equipment and the one recommendation from the inspection reflected the action that was already in progress to upgrade this equipment.

As well as meeting national quality performance targets, the RNHRD has developed a bespoke quality measurement system to improve the patient experience by monthly audit of various areas of patient safety (Vital Aspects of Clinical Safety). During 2008/09 the Trust extended this quality measurement system to include physiotherapy as well as nursing. The outcomes provide assurance and identifies any potential risks to patient safety.

The Board monitors progress against key national and local targets in regular Board Performance Reports and ensures action is taken to continuously improve quality.

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. The service helps 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.

Complaints

The Trust received 18 written complaints in 2008/09. All complainants received a written acknowledgement within two working days and received a response within the timeframes set out in the complaints policy.

The Trust had no requests for an Independent Review of a complaint during 2008/2009.

Action taken as a result of Complaints

- Improvement in the communication of discharge arrangements.
- Staff attended additional customer care training.
- System set up for staff checking pharmacy stock supplied in time for appointments.
- Improvements in access to appointments.

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. The group has reviewed over 70 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. The group has also developed guidelines to assist staff when producing patient

information and literature and an audit procedure to ensure the literature meets 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.

We regularly 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 2008/09 staff have contributed to the development of NICE guidance for the management of rheumatoid arthritis (RA), the British Society for Rheumatology guidelines for RA, revised guidance produced by the British Association of Dermatology, international guidelines published by the Group for Research and Action for Psoriasis and Psoriatic Arthritis, standards of care being developed for Juvenile Idiopathic Arthritis by the Arthritis and Musculoskeletal Alliance (ARMA), and the Complex Regional Pain Syndrome Clinical Guidance Working Group. The Clinical Effectiveness & Audit Facilitator is also part of an external group which reviews NICE audit criteria prior to publication. Structures are in place to ensure that we audit against any guidelines relevant to this Trust.

Information Governance

To ensure that all NHS Trusts have appropriate Information Governance arrangements in place, they were required to complete the Information Governance Toolkit assessment by 31st March 2009. The assessment includes requirements for Information Governance Management, Confidentiality and Data Protection Assurance, Information Security Assurance, Clinical Information Assurance, Secondary Use Assurance and Corporate Information Assurance. There were a total of 62 requirements for the 2008/09 Assessment, 2 of which were not relevant to this Trust. An aggregate score is then calculated from all the scores. The Trust score was 90% and this was within the highest range of the traffic light system so the Trust was rated as "green" for Information Governance. The Trust achieved compliance against the requirements of the Information Governance Statement of Compliance (IGSoC) in the 2008/09 assessment.

National In-patient Survey 2008

The Inpatient Survey is a requirement of all Acute NHS Trusts by the Healthcare Commission. The results of this survey feed into the Annual Health Check (performance ratings) in 2009.

A total of 457 patients, discharged between January and August 2008, were sent a questionnaire. Overall, 307 responded or 69%, which was well above the national average of 53%. (Overall the results for our hospital are very good as the Trust was better than average in five out of seven areas in the survey relevant to the services we provide). The Trust was rated in the **top 20%** of trusts for 24 questions: relating to single sex accommodation, waiting times, hospital cleanliness, food and involvement in decisions about care and treatment.

The Trust recognises that the excellent result in the 2008 national in-patient survey is directly due to the hard work and dedication of our staff.

Core Standards Declaration

The Board has declared full compliance with 21 out of 24 core standards during 2008/09. The following 3 standards were declared as not met:

C7 a & c The healthcare organisation has effective corporate governance arrangements in place. The Trust declared that this standard is partially met due to Monitor's intervention during 2008. The Trust has implemented a recovery plan, which includes a plan for financial recovery and the plan to merge with another organisation.

C11b - The healthcare organisation verifies that staff participate in those mandatory training programmes necessary to ensure patient safety. This is partially met as gaps in child protection training were due to be complete after the year end in May 2009.

C20a - The healthcare organisation effectively manages the health and safety and environmental risks. This was partially met as the fire risk assessment and update to policy took place during April 2009.

Quality Overview

Indicator	**Data Source**	**2007/08**	**2008/09**
Patient Safety			
MRSA	Data reported nationally and data governed by standard national definition	0	0
C Difficile	Data reported nationally and data governed by standard national definition	7	3
Meet core standards regarding safety	Data reported to Healthcare Commission Annual Healthcheck and reported through quality report to PCT	Met	Met
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
Improve availability of follow up appointments	Number of complaints regarding availability of follow up appointments reported through quality report to PCT and annual report.	0	15
Meet core standards regarding clinical effectiveness	Data reported to Healthcare Commission Annual Healthcheck and reported through quality report to PCT	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	40%	39%
Improve telephone access for appointments	Number of Complaints or PALs on this issue reported in Quality Report to PCT	6	30
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.	8	18

Quality Improvement Initiatives for 2009/10

The Trust Board has agreed action plans to ensure that the core standards are met in full during 2009/10. In addition the Trust has identified the following quality improvement initiatives for 2009/10;

- 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.

- The Trust will continue to improve all aspects of the patient experience, in particular areas identified through patient feedback:

- 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.

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 also provide additional Consultant Rheumatologist sessions to provide an improved follow up appointment service. The Trust will monitor this through the number of complaints about access to appointments and follow up appointments.

Kirsty Matthews
Interim Chief Executive

5th June 2009

Emergency Preparedness

Although we are a small, specialist Trust, we are 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.

Research and Development

The Trust has always prided itself on achieving a high level of quality research for its size as a small specialist Trust. It provides patients with opportunities to be involved in the development and trialling of new treatments and clinicians an opportunity to learn and grow their expertise.

Research at the RNHRD covers a spectrum from laboratory based studies e.g. investigating the genetics associated with particular diseases and potential differences in prognosis; clinical trials researching new treatments e.g. medications or therapies; as well as assessing the patient experience e.g. finding out what, how and when patients need education about having a long term condition. Projects exist in all the specialty areas treated within the Trust with particular emphasis on rheumatology/autoimmune disease, pain and chronic fatigue syndrome.

It has been a challenging year for research and development as the Department of Health (DH) changes to funding, brought about by the introduction of Best Research for Best Health (the Government strategy introduced in 2006), continued to be implemented. This resulted in a fall in R&D transitional funding although additional funding for 2 new posts was awarded from the Western Comprehensive Local Research Network to be recruited at the end of the financial year.

The forthcoming year will continue to be difficult in terms of supporting researchers and their projects, as DH transitional funding will not be available at all and, as a specialist trust with a relatively finite capacity for hosting large numbers of research projects, funding via the new DH system via Comprehensive Local Research Networks (CLRNs) is difficult to obtain. Challenging decisions about the level of research which can be sustained will be considered.

Grant funding comes from a number of charities and organisations and includes the Engineering and Physical Sciences Research Council (EPSRC), Arthritis Research Campaign, Sport Aiding Research for Kids (SPARKS) etc. The following staff were successful at being awarded external funding; Dr Esther Crawley (National Institute of Health Research Clinician Scientist Award), Dr John Pauling (Dorothy Dando Fellowship – Royal College of Physicians & Raynauds and Scleroderma Association); and Dr Jenny Lewis (2009 Ronald Melzack Pain Research Fellowship) amongst others.

The amount of grant funding awarded to RNHRD staff as main or co-applicants during the 2008-09 financial year was £1.2 million.

The Trust continues to work closely with local universities including the University of Bath, School for Health and Pharmacy and Pharmacology, University of Bristol and

University of the West of England (UWE), Centre for Child and Adolescent Health and UWE School for Health and Social Care. The Trust maintains its support for staff undertaking higher degrees, helping to secure research infrastructure and resources for the future.

Operating and Financial Review 2008/09

Introduction

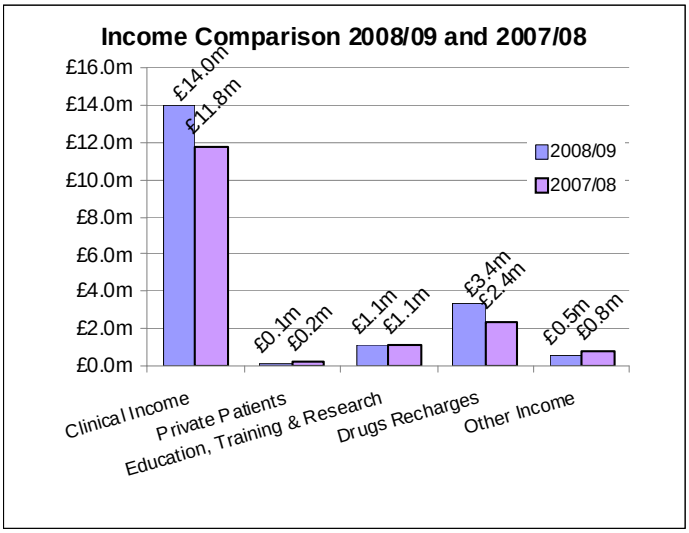
This report presents an analysis of the RNHRD's performance for the year ended 31st March 2009, reviewing significant events and looking forward to key events and issues expected in the year ahead.

In setting out its objectives for 2008/09 the Trust identified the importance of returning to financial balance and the delivery of surpluses as key to support investment in services and improve the speed with which payments are made to suppliers.

The delivery of higher 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 £54k for the twelve months to the 31st March 2009 after three successive years' financial deficits. However the Trust has only been able to make limited progress in reducing its level of short-term creditors and this is reflected in the time scales taken to pay suppliers. Overall the Trust's performance during the last year demonstrates a significant step forward and is 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.

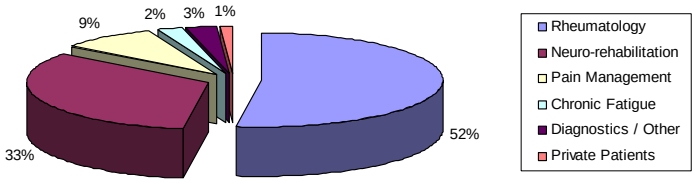
Funding Overview

The Trust earned £19.1m in income during 2008/09 compared with £16.2m in 2007/08 an increase of 17%. 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 / M.E. and Diagnostic services. During the second half of the year Rheumatology income declined due to medical staff vacancies, however in revenue terms, this was offset by over-performance in other areas such as Chronic Pain and Neuro-rehabilitation. Overall clinical income exceeded planned levels by £324k for the year. A breakdown of income by service area is set out below.

Break-down of Clinical Income 2008/09



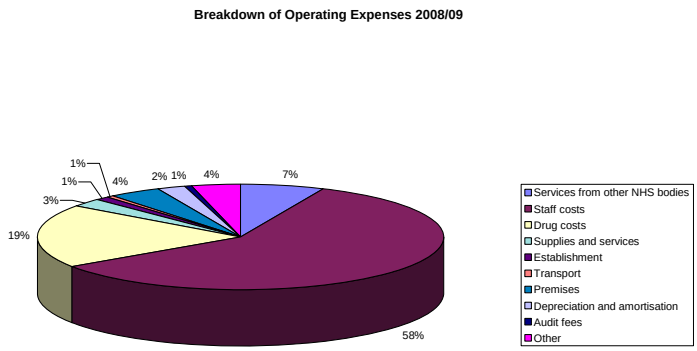
Income for Rheumatology services comes under the national fixed price funding system known as Payment by Results. Under this system, the Trust receives income based on the number of inpatients, day cases and outpatients treated at national tariff rates. Because of the specialist nature of the Trust's 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 set prices. The only exception to this is the Chronic Fatigue service, where the Trust receives a set amount of income for providing specific services. This fixed price agreement comes to an end this year and will be replaced by locally agreed tariffs for 2009/10.

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 2008/09 was £136k, representing 0.8% of RNHRD's total patient related income and therefore the Trust is compliant with this obligation.

Expenditure Overview

Containing and reducing costs whilst improving the quality of our services has been and continues to be the major challenge for the organisation. During the first half of the year, higher than planned patient numbers led to a corresponding increase in the use of temporary staff. Reviews of shift patterns and staffing across all departments brought these costs under greater control during the second half of the year. In addition, the organisation has continued to see rising pay costs due to the ongoing impact of the national Agenda for Change pay system with many staff still moving up wider incremental pay scales. With staff pay accounting for just under two thirds of all Trust expenditure, attention has been focused on reducing costs of support and administrative functions and controlling use of more expensive temporary and agency staffing.

At the end of January 2009, the Trust vacated its offices in Chartist House, relocating staff to the main hospital and other existing accommodation. This action will save the organisation in excess of £100k per annum. Further savings have been achieved by reviewing catering provision to reduce wastage and negotiating lower charges for clinical services bought in from external organisations.



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 the Trust equate to 11.4% of the Trust's total income, as shown below.

	2008/09 £000	2007/08 £000
Management costs	2,165	1,990
Income	19,056	16,237
Costs as a percentage of income	11.4%	12.3%

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 2008/09, action has been taken to improve working capital management through agreements with long standing creditors and commissioners to pay outstanding invoices to improve debt recovery. The cash position was expected to deteriorate between February 2009 and the 31st March due to the continued impact of agreements to repay long standing creditors, improving in July 2009 through receipt of sale proceeds and ongoing implementation of planned savings.

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). The Trust has not needed to utilise this facility through management of working capital balances.

The Trust had a cash balance of £327k at the close of its financial year. This balance significantly exceeded the original plan and was due to actions identified above, early payment of outstanding invoices by PCTs and careful management of the Trust's creditor payments position. Thus the underlying cash position was in line with plan.

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, much has been achieved during the last year to improve the organisation's underlying financial performance. However this has yet to translate into significant improvements in the organisations financial risk rating. Principal issues remain high levels of amounts owed to creditors 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). This implies that the Trust may be at risk of a significant breach of its Terms of Authorisation in the medium term, e.g. 12 to 18 months, if remedial action does not continue.

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 further disposal of surplus accommodation. These actions should continue to improve delivery of core financial objectives in the coming year.

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

	2008/09		2007/08	
	Number	£000	Number	£000
Total bills paid in the year	4,614	5,989	5,755	6,659
Total bills paid within target	1,786	883	3,106	1,887
Percentage of bills paid within target	38.71%	14.74%	53.97%	28.34%

The Board of Directors recognise that compliance with this code is compromised by pressures on the organisation's short term liquidity arising from previous years' financial deficits. As such the organisation's cash management strategy is acknowledged to have a detrimental impact on this performance measure.

Borrowing Limit

The RNHRD has a total borrowing limit set by Monitor of £1 million. This is the amount of money the Trust can borrow based upon a detailed financial risk assessment. Included within this is the working capital facility of £1 million. The organisation did not need to borrow against this limit during 2008 / 09.

Capital Developments in 2008/09

Capital expenditure plans are focused on improving the hospital environment and clinical services. During 2008/09, the Trust carried out capital projects with an in year cost in excess of £400k. These capital schemes included the purchase of a new mobile ultrasound machine, improving hygiene and infection controls by upgrading existing endoscope cleaning facilities and the replacement of the hospital's nurse call system. In the coming financial year resources will be directed towards improving the physical environment in ward and other patient areas.

Land Interests

The Foundation Trust Financial Reporting Manual (FReM) requires all foundation trusts to prepare their accounts in accordance with UK GAAP 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. To comply with this guidance at 31st March 2009, the Trust's land and buildings were revalued by the Valuation Office Agency (VOA), which is an executive agency of HM Revenue and Customs (HMRC) using the modern equivalent asset basis.

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. This differs from the approach previously used, which valued assets based on the cost to recreate an exact replica of the existing asset.

The change in the basis of valuation is considered to be a change in accounting policy and the Trust has therefore been required to review historical records and account for the change as if the modern equivalent basis had always been the basis of measurement. Comparative figures for 2007/8 are therefore restated in the 2008/9 financial statements.

The effect of adoption of the Modern Equivalent Asset basis of valuation means that the annual depreciation charge is higher than the charges previously accounted for by the Trust in the years between 1 April 2005 and 31 March 2009. This results in a cumulative decrease in the income and expenditure reserve at 1 April 2008 by £280,000. The in-year impact in 2009 (compared to the previous valuation basis) is an increased charge to the income and expenditure account of £58,000 which has been reflected in the current years financial statements.

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 or waiting time targets; and unforeseen cost pressures or failure to achieve cost improvement /efficiency targets.

In order to manage these risks, the Trust needs to ensure that appropriate systems are in place. The organisation has counter fraud arrangements in place which comply with the Secretary of State's Directions on countering fraud and the requirements specified in the NHS counter fraud and corruption policy. These arrangements are underpinned by the appointment of an accredited local counter fraud specialist and the introduction of a Trust-wide counter fraud and corruption policy. The Trust referred three cases to its Local Counter Fraud Officer during 2008/09 which led to two resulting in investigations. These investigations resulted in one disciplinary warning and improvements being made to departmental policies.

The Board has implemented a performance management framework which ensures delivery of clinical activity plans as agreed with our commissioners within agreed waiting times and to appropriate safety and hygiene standards.

Whilst efforts to improve invoicing procedures, strengthen debt recovery arrangements and take a more proactive approach to creditor management during 2008/09 have avoided the need to use the Trust's working capital facility over the last 12 months, the scale of the working capital deficit remains a financial risk. In addition changes to the Payment by Results (PbR) system in 2009/10, in particular the introduction of Healthcare Resource Group (HRG) version 4 and the loss of Central R&D transitional funding are likely to have a significant adverse impact on income and cash flow.

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 reduce costs in order to deliver sufficient financial headroom to meet both expected and unforseen financial and business risks.

Looking Ahead: Future Spending Plans

Changes to the national Payment by Results system (PbR) and turbulence in the wider economy are likely to have an adverse impact on the organisation's funding over the next three years, with tighter government spending plans for 2011–12 and 2012–13. Changes made to the Payment by Results system which come into effect on the 1st April 2009 present the Trust with immediate challenges. For those services which fall within the scope of PbR, we are required to provide services at a nationally fixed tariff. The concept of 'averaging out' differences in costs across the country, which underpins national tariffs, does not always benefit specialist hospitals such RNHRD as we tend to have a higher proportion of complex patients requiring more intensive and higher cost treatment. A reduction in tariffs set for Rheumatology in 2009/10 will significantly reduce income in the coming year.

Within this context, the Trust's current three year financial plan projects the delivery of small financial surpluses for 2009/10 and 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.

Chronic Pain
In the longer term the Trust is seeking to increase income from Chronic Pain services through obtaining National Specialist Commissioning Group status. More immediately, after a successful pilot in 2008/09, the Trust has established a complex in-hospital pain service to treat patients too severely affected by their condition to attend regular community or hospital based pain programmes. The Chronic Pain Service has also received agreement from a Bath-based charity to fund the development of a new service to treat pain in elderly patients.

Paediatric CFS/ME
The Trust is expanding its CFS/ME paediatric service to cope with increasing out-of-area referrals. Referrals overall are currently growing at 15% per annum despite capacity constraints which prevent active promotion of the service. As one of the few specialist services offering assessment and treatment for children with CFS/ME, the Trust is well placed to capture a significant share of this market. Detailed population studies estimate that a minimum of 1% of children in the UK are disabled by fatigue. Of these 0.1% of children (approximately 12,000) are severely affected and NICE guidelines state that all severely affected children must be offered assessment and treatment immediately by a specialist team. Only 15% of these children have access to a specialist service currently.

Capital expenditure plans focus on supporting the development of clinical services and improving the standard of accommodation and facilities for patients, particularly in ward and inpatient areas within the hospital site.

Competitive environment

The changing context of 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.

Whilst the specialist nature of the services provided at the Trust and its strong reputation for clinical excellence place it in an ideal position to benefit from the extension of Patient Choice. The Trust is however aware of Bath and North East Somerset PCTs intention to tender for the provision of community pain and musculoskeletal services at some stage during 2009/10. This initiative could provide both an opportunity for the Trust to work more directly in community service provision and/or prove a threat to patient referral levels into the hospital. The Trust will seek to play an active role in the development of this initiative in coming months.

Going Concern

After making enquiries, the Board of Directors has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, it 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 £38,900. This was for the statutory audit of accounts for the 12 months ending 31st March 2009 and services carried out in relation to this. Further fee payments of £10,000 were made to the external auditors in respect of a follow up from the 2007/08 Commercial management review and the statutory accounts audit, and a review of restated balances in relation to International Financial Reporting Standards (IFRS).

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

Annual Accounts

Full details of the Trust's 2008/09 financial position can be found in the Trust's audited annual accounts (pages 43 to 82 of this report).

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

Remuneration Report

In 2008 / 09 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 once during the year in November 2008. Present were:

- Brian Joakim, Chairman and Committee Chairman
- Kirsty Matthews, Non-executive Director
- Chris Johns, Non-executive Director
- Peter Spencer, Non-executive Director
- Julie O'Donnell, Non-executive Director

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

Statement of the policy on the remuneration of senior managers

The Remuneration of Directors was increased by 2.75% in April 2008 in line with the annual pay settlement given to the majority of NHS staff under the Agenda for Change pay framework. There were no performance pay elements.

Non Executive Directors

Brian Joakim, Chair
Brian Joakim was appointed as Chair of the RNHRD in December 2008. He resigned from the Trust in December 2008.

Kirsty Matthews Interim Chair
Kirsty was appointed as Non Executive Director in December 2007 for a term of four years. In December 2008, the Independent Regulator, Monitor appointed Kirsty as Interim Chair for a period of six months following the resignation of Brian Joakim. The notice period is three months.

Sir Peter Spencer KCB, Non-Executive Director, was appointed in September 2007 for a term of four years. The notice period is three months.

Julie O'Donnell, Non-Executive Director was appointed in September 2007 for a term of four years. The notice period is three months.

Chris Johns, Non-Executive Director was appointed in October 2007 for a term of four years. The notice period is three months.

Executive Directors

Nicola Carmichael was Chief Executive of the RNHRD from 1991 until August 2008.

Peter Hill, Interim Chief Executive is seconded to the RNHRD from Salisbury NHS Foundation Trust through a service contract with Salisbury Foundation Trust. The contract with Salisbury includes additional support from senior managers from Salisbury NHSFT. The contract with Salisbury runs until June 2009 and is subject to 1 month's notice.

Rod Barnes, was appointed as Director of Finance in March 2008. The notice period is 6 months.

Tim Jenkinson, was appointed as Medical Director in 2007. The notice period is 3 months.

Chris Fokke, Director of Clinical Practice/Nursing Professional Adviser left the Trust in March 2009 and was replaced by **Amanda Pacey** as Acting Director of Clinical Practice/Nursing Professional Adviser. Amanda's notice period is two months.

Hayley Sewell, Director of Governance and Performance was appointed to the Board in 2005. The notice period is 3 months.

Karen Kerley, Associate Director of HR and Membership was appointed to the Board in 2005. The notice period is one month.

With the exception of the Interim Chief Executive, for which the arrangement is 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.

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.

Signed: …… (Interim Chief Executive) Date: 5th June 2009

Pensions and Remuneration

Accounting policies for pensions and other retirement benefits are set out in note 1.9 to the accounts. Details of senior employees' remuneration can be found in page 61 .

Council of Governors

This Foundation Trust has a framework of local and national accountability through members and of governance through our Council of Governors (CoG) and Board of Directors. Our CoG 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.

Members of the Council of Governors are elected or appointed for a 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 three-year period. The maximum term for all members of the Council of Governors is six years.

The following Members were elected to the Council of Governors in March 2008:

Public Constituency

Judith BERESFORD-SMITH, Francis RING, Hilary ELMS, Peter MILES, Huw PONTING, Ben ROGERS
There are two vacant positions at the time of publication of this report.

Patient Constituency

John DE NORMANN, Donn BOYLAND, George ODAM, Judy COLES, Teresa EVANS, Tony BARBER, Elizabeth BREALEY, Brian JENKINS, Vivienne POZO, Ken BRAY

Staff Constituency

The following staff were uncontested: Caroline MAGGS, Lou GAY, Mary RICKETS, Jo EARLEY

Appointed Members

The following members are appointed representatives sitting on the Council of Governors:

Phil BAKER, Arthritis Care, Sara BROOKS, Action for ME, Lesley DONOVAN, University of the West of England, David LAVINGTON, National Ankylosing Spondylitis Society, Sue MEADOWS, National Osteoporosis Society, Connie WRIGHT, Patient and Public Involvement Forum, Prof. Steve WARD, University of Bath, Marylyn RESTARICK, Fibromyalgia Support Group, Peter HAINES Headway, Bath & Wilts, Councillor Alan HALL, Bath & North East Somerset Council.

There are two vacant positions at the time of publication of this report.

The CoG meets formally four times a year, and informally twice a year or 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 CoG 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 Members complete an annual declaration of interest. This information is available from the Membership Support Team:

FREEPOST SN1301
RNHRD NHS Foundation Trust
Upper Borough Walls
Bath
BA1 1RL
Telephone: 01227 787043, ext 201
Email: nhsft@rnhrd.nhs.uk
Website: 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 Members, as summarised below:

- To represent members and partner organisations from the local health economy;
- To feedback 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; and
- To regularly communicate the outcomes of their involvement within the Trust to members, including their impact and effectiveness.

The Board of Directors attend the Council of Governors' four formal meetings. The CEO 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, eg 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.

The following Governors are members of the appointments committee: Elizabeth Brealey (Chair), Ken Bray, Donn Boyland, Tony Barber, Francis Ring, John de Normann and Caroline Holcombe.

There have been four formal meetings of the Council of Governors in April 2008 and March 2009. Attendance by Governors, Directors and Non Executive Directors is outlined below:

Public representatives
Judith Beresford Smith 4/4, Hilary Elms 4/4, Clive Howarth 2/4 (left 04.03.09), Peter Miles 4/4, Huw Ponting 3/4, Francis Ring 3/4, Ben Rogers 4/4, Steven Pike 0/2 (left 27.11.08), Patricia Wildblood 1/1 (left 05.02.09). There are currently 2 vacancies

Patient representatives
Tony Barber 4/4, Ken Bray 3/4, Elizabeth Brealey 4/4, Donn Boyland 4/4, Judy Coles 4/4, John De Normann 3/4, Teresa Evans 3/4, Brian Jenkins 2/4, George Odam 3/4, Viv Pozo 4/4

Appointed representatives:
P Nelson 1/4, Sara Brooks 4/4, Stephen Booth 1/4, Lesley Donovan 1/2 (left 27/10/08), Peter Haines 4/4, Allan Hall 0/4, David Lavington 4/4, Sue Meadows 2/4, Steve Ward 1/4, Lee Eborall 1/4, Yvonne Smith 0/1 (left 02/10.08). There are currently three vacancies

Staff representatives
Jo Earley 4/4, Caroline Maggs 3/4, Lou Gay 0/4, Mary Ricketts 2/4

Directors
Brian Joakim 2/2 (Chair left Dec 08), Peter Hill (CE) 3/3, Hayley Sewell 1/4, Karen Kerley 3/4, Tim Jenkinson 2/4, Rod Barnes 3/4, Chris Fokke 1/4, Stephen Cole 1/1

Non Executive Directors
Julie O'Donnell 2/4, Peter Spencer 2/4, Chris Johns 2/4, Kirsty Matthews 1/4

Board of Directors

The Board of Directors consists of Executive Directors and Non Executive Directors. An Associate Director attends the Board meetings but does not have any voting rights at the Board of Directors. 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 4 years. All the Non-Executive Directors are Independent Directors. The Trust holds a public Register of Interests which is available from the Chief Executive's Office.

The Board currently has a wide range of experience from both the public and private sectors. The Non Executive Directors have combined experience of marketing, social care, voluntary sector, management consultancy, armed forces and civil service. The Executive Directors have extensive experience in the NHS. Short biographies are detailed below.

The Board currently has two Non Executive Director vacancies. The Audit Committee and Board of Directors have highlighted a gap in the Board composition because none of the Non Executive Directors has an accountancy qualification, although the current Non Executive Directors have extensive budget management experience.

The Chair conducted appraisals of the Chief Executive and the Non-Executive Directors in 2008/09. The Executive Directors were appraised by the Chief Executive. The Audit Committee has completed an annual self-evaluation, taking account of any changes arising out of the Monitor Code of Governance. The Audit Committee revised its terms of reference in order to bring them into line with the Monitor Code of Governance and the Healthcare Financial Management Association recommended Terms of Reference.

There were 14 meetings of the Board during 2008/09.

Chair, Brian Joakim (resigned December 2008)
Brain was appointed in July 2007 for a period of four years as Chair-designate until taking over the role of Chair in December 2007. Brian had retired from a successful career in the telecommunications and media sectors.

Brian has attended 10 out of 11 Board of Directors meetings in 2008/09.

Kirsty Matthews, Interim Chair (December 2008 onwards)
Kirsty was appointed in December 2007 for a period of four years as a Non Executive Director. She was the Vice Chair and Senior Independent Director until assuming the role of Interim Chair on 18th December 2008. 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 currently working as a Business Consultant.

Kirsty has responsibility for the working of the board.

Kirsty has attended 13 out of 14 Board meetings in 2008/09

Christopher Johns, Non Executive Director

Chris was appointed in October 2007 for a period of four 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 has attended 11 out of 14 Board meetings in 2008/09.

Sir Peter Spencer KCB, Non Executive Director
Peter was appointed in December 2007 for a term of four 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.

Peter has attended 14 out of 14 Board meetings in 2008/09.

Julie O'Donnell, Non Executive Director
Julie O'Donnell was appointed in September 2007 for a term of four years. She was appointed to the position of Vice Chair 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 Candlelight Domiciliary Services, patron of Vital for Children and a Trustee of Bath Institute for Rheumatic Diseases (BIRD).

Julie has attended 11 out of 14 Board meetings in 2008/09.

Peter Hill (August 2008 onwards)
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.

Peter has attended 8 out of 8 Board meetings in 2008/09.

Nicola Carmichael, Chief Executive (resigned in August 2008)
Appointed as Chief Executive in 1993, Nicola had many years experience of strategic leadership in clinical health services.

Nicola has attended 6 out of 6 Board of Directors meetings in 2008/09.

Rod Barnes, Finance Director
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.

Rod has attended 14 out of 14 Board of Directors meetings in 2008/09.

Chris Fokke, Director of Clinical Practice/Nursing Professional Advisor (resigned in March 2009)
Chris Fokke qualified as both a Registered and District Nurse and has extensive nursing management experience at clinical nurse specialist and executive level. He also has an Honours degree in community healthcare and an MSc in Information Technology .

Chris has attended 9 out of 10 Board of Directors meetings in 2008/09.

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.

Tim has attended 9 out of 14 Board of Directors meetings in 2008/09.

Karen Kerley, Director of Human Resources and 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.

Karen has attended 12 out of 14 Board of Directors meetings in 2008/09.

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 into the role between August and October 2009. 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.

Amanda has attended 3 out of 3 Board of Directors meetings in 2008/09.

Hayley Sewell, Director of Performance and Governance 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. She has 21 years experience in the NHS and completed the NHS Clinical Strategist Programme at INSEAD in 2003, an MSc in Research Methods in 1994 and began her NHS career as a Chartered Physiotherapist.

Hayley has attended 12 of 14 Board of Directors meetings in 2008/09.

Audit Committee

Audit Committee Membership: Sir Peter Spencer is Chair of the Committee. Julie O'Donnell (nee Cingoz-Spencer), and Kirsty Matthews. Kirsty was a member of the Audit Committee during her period as a Non Executive Director and before she became interim Chair of the Trust in December 2008.

There were four meetings of the Audit Committee in 2008/09. Peter Spencer has attended all meetings, Julie O'Donnell attended three meetings and Kirsty Matthews attended one meeting.

During 2008/09 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:

- 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;
- introducing a software tool for tracking the implementation of a consolidated list of all audit recommendations. This is now reported at every meeting of the Audit Committee; and
- reviewing and updating our Terms of Reference.

Following the market testing of the internal audit service late in 2006-07 the Board accepted a recommendation from the committee for a change in the provider and Bentley Jennison took up the appointment on 1st April 2007, and they remained the internal auditor during 2008/09. 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 2008/09.

Appointments Committee of Council of Governors

The Appointments Committee of the Council of Governors is responsible for the appointment and remuneration of the chairman 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.

There has not been an appointments committee meeting in 2008/09. Kirsty Matthews was appointed Interim Chair of the Trust in December 2008. This followed the departure of the previous chair Brian Joakim and an intervention by the Independent Regulator Monitor. This appointment was approved by the full Council of Governors in January 2009.

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 2009, the RNHRD had 4,632 members, with 3,678 patient and carer members, 956 public members and 424 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' (CoG) 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 CoG 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; and
- 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 were invited to attend our Annual Members Day in July 2008. This was an opportunity to provide information on the work of the Trust and its accounts and gather feedback from members, sessions included:

- Members shaping our services: "What would your ideal journey be, from visiting your GP, through referral to your first appointment?"
- Meeting the clinicians and specialty leads: The clinicians provided information about their service and asked for members views on key issues.

We also invited Members to:

- attend CoG meetings,
- join the CoG Membership Sub-group,

- apply for volunteer roles,
- attend the Medicine at the Min lectures,
- attend the Trust's AGM, and
- 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.

Public Interest Disclosures

Communication and Consultation

Staff were 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. The Trust has a joint staff management committee which meets monthly. Any member of staff is able to attend a monthly pre-meeting if they would like items raised. Matters are then discussed by the joint committee. This process is supported by a written communication which is issued monthly to staff.

The Chief Executive gives a monthly face-to-face briefing open to all staff and followed up by a written briefing.

There were no formal consultations in 2008/9. A formal consultation of RNHRD stakeholders is planned for the coming year as part of the process of merger with another Trust.

Equalities (Policies applied to Staff with Disabilities)

The Trust has individual Race, Gender and Disability Equality Schemes and underpinning action plans. The Trust is recognised as a "two-ticks" disability friendly employer. During the 2008-9 financial year, we re-deployed 5 members of staff on health grounds. We also used access to work funding to support a staff member to stay in post and another member of staff received support from Remploy.

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.

The Trust has no current health and safety enforcement notices.

Sickness Absence Data

Sickness absence for the year April 2008 to March 2009 was 5.53%. This figure is over the Trust's internal target of 4.7% sickness and reflects an unusually high incidence of long term sickness. Health promotion and sickness absence management are key priorities for the year ahead.

Period	**% sickness absence**
April 08	5.29
May 08	4.98
June 08	6.22
July 08	7.11
August 08	5.99
September 08	4.09
October 08	5.02
November 08	4.40
December 08	6.00
January 09	6.08
February 09	6.76
March 09	4.53
April 08-March 09	*5.53*

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.

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.

Awards and Community Involvement

Food Hygiene Award
The catering team at the RNHRD received a Food Hygiene Award following a routine inspection from BANES Environmental Health. 1700 organisations in the BANES area were inspected. Only 2% met the high standards required for the award, of these the Min was one of only seven organisations to achieve a merit.

This is the third time in a row that the team at the RNHRD have been successful in achieving this award in recognition for their high standards in food safety and cleanliness.

Clinical Research Fellowship Awarded
Dr John Pauling, Specialist Registrar in rheumatology at the RNHRD, has been awarded the Dorothy Dando Fellowship. Dr Pauling was awarded the fellowship and research grant of 150k for his proposal to investigate anti-platelet agents in patients with Raynaud's and Scleroderma. This will lead to a better understanding of blood flow and mechanisms regulating circulation for patients with this complicated condition.

The award is funded by the Raynaud's and Scleroderma Association and the Royal College of Physicians.

New area of research into chronic childhood condition secures prestigious fellowship
The National Institute of Heath Research has awarded the Clinician Scientist Fellowship to Dr Esther Crawley, Consultant Paediatrician at the RNHRD.

Dr Crawley will develop a new area of ground-breaking research to provide a better understanding of the cause, treatment and prevention of Chronic Fatigue Syndrome/ME in children, and has secured funding of £730,000. The project will be carried out over five years and began March 2009. It will be the first study to look at CFS/ME in children in such detail.

International Fellowship at a leading centre for pain research awarded to clinician at the RNHRD

Dr Jenny Lewis, Clinical Research Occupational Therapist for the Complex Regional Pain Syndrome (CRPS) team at the RNHRD, has been awarded the 2009 Ronald Melzack Pain Research Fellowship at McGill University, Montreal, Canada, by the Louise and Alan Edwards Foundation.

Jenny secured the award with her research proposal to investigate a new area in pain research which will explore the relationship between the brain and a phenomenon known as 'body perception disturbance' in the chronic pain condition CRPS.

Complex Regional Pain Syndrome Conference (CRPS) a success
A three-day national CRPS Conference took place at the RNHRD from 15 – 17th October 2008.

Conference was attended by over 100 people and featured international guest speakers which included; Dr Christian Maihöfner from the University Erlangen-Nürnberg, Germany, Prof Dr Bob van Hilten from Leiden University Medical Centre, Netherlands and Prof Patrick Haggard from the University College, London. These experts presented their latest research in this cutting edge scientific field of CRPS.

Rheumatology team receive award for services to patients living with Rheumatoid Arthritis
Consultant Rheumatologist Dr Ashok Bhalla and his rheumatology team at the RNHRD, have been presented with a Healthcare Champions Award by the National Rheumatoid Arthritis Society (NRAS) in recognition of the excellent support and care they have provided to people living with rheumatoid arthritis (RA) in Bath.

Dr Bhalla is just one of twenty health professionals across the UK to receive a Healthcare Champions Award, which was presented by the Rt. Hon Theresa May MP, NRAS Patron and Shadow Leader of the House of Commons at an awards ceremony hosted by the All Party Parliamentary Group on Inflammatory Arthritis at the Houses of Parliament in Westminster.

A new partnership between the RNHRD and the Royal United Hospital Bath is helping women at risk of osteoporosis to get help earlier.

A new £16,000 investment from NHS Bath and NE Somerset, has enabled specialists from the two hospitals to work together to provide a falls and fracture liaison service for patients who attended clinics following a fracture, or the A&E department with a fall. This new service will scan patients for early signs of osteoporosis and identify patients who have problems with balance or walking and might be at risk of falling.

Public lectures
Medicine at the Min is a series of public lectures which aim to provide an informative, accessible update on different areas of work and treatment within the hospital, and encourage the involvement of the public and patients in the Trust. There have been two lectures in 08/09 which were; 'Rheumatology – more than just arthritis', by Professor Neil McHugh, and 'Arthritis and Exercise', by Dr T Jenkinson. These are popular events which are well attended by members of the public.

Coffee mornings
The RNHRD Council of Governor's have continued to organise coffee mornings to gain feedback and comments from patients and the public and also to promote the

membership at the Min. The Coffee Mornings take place twice a month and any feedback gained is sent on to the patient and public involvement lead. They are well received by the public and are a good way for members to meet the Governors that represent them.

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 "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);

- The names of the chairman, the deputy chairman, the chief executive, the senior independent director and the chairmen and members of the nomination, audit and remuneration committees (A.1.2);

- The number of meetings of the board of directors and those committees and individual attendance by directors (A.1.2);

- The names of the non-executive directors whom the board determines to be independent, with reasons where necessary (A.3.1);

- A description of each director's balance, completeness and appropriateness (A.3.4);

- The names of the governors and details on their constituency, whether they are elected or appointed and the duration of their appointments (B.1.3);

- The number of meetings of the board of governors and individual attendance by governors and directors (B.1.3);

- The other significant commitments of the chairman and any changes to them during the year (C.1.6);

- The work of the nomination 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.1.12);

- How performance evaluation of board of directors, its committees and its directors has been conducted (D.2);

- 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);

- 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);

- A statement from the directors that the business is a going concern, with supporting assumptions or qualifications as necessary (F.1.2);

- A report that the board has conducted a review of the effectiveness of the group's system of internal controls (F.2.1);

- A separate section describing the work of the audit committee in discharging its responsibilities (F.3.3)

- 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 had taken a different position (F.3.5)

- An explanation of how, if the auditor provides non-audit services, auditor objectivity and independence is safeguarded (F3.7);

- Contact procedures for members that wish to communicate with governors and/or directors (G.1.4); and

- The steps the board has taken to ensure that members of the board, and in particular the non-executive directors, develop and understanding of the views of governors and members about their NHS foundation trust (G.1.5).

Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

Annual Accounts

Year Ended 31st March 2009

ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FOUNDATION TRUST

2008/2009 ANNUAL ACCOUNTS

CONTENTS

DIRECTORS' STATEMENTS

Statement of the Chief Executive's responsibilities as the Accounting Officer of the Royal National Hospital for Rheumatic Diseases

The National Health Service Act 2006 ("2006 Act") states that the chief executive is the accounting officer of the Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the accounting officers' memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the 2006 Act, Monitor has directed 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 the 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 Financial 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 financial 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 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 Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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.

A resolution to reappoint PricewaterhouseCoopers LLP as auditors to the Trust was made by the Council of Members at a meeting in January 2009.

Signed…….

Kirsty Mathews - Interim Chief Executive
Date: 5 June 2009

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 Disease NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Royal National Hospital for rheumatic Diseases NHS Foundation Trust for the year ended 31 March 2009 and up to the date of approval of the annual report and accounts.

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.

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 Committee meets every other month. The Risk Management Committee Chair is a Non-Executive Director. Other members of the Risk Management Committee include the Chief Executive, Medical Director, Finance Director, Director of Human Resources and Membership, Director of Nursing and Director of Governance & Performance;

· The Risk Management Committee 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 Committee reviews all incidents rated moderate and above and ensures that appropriate actions are taken and controls are in place to minimise risk;
Safety Agency;

· The Executive Directors led on the NHSLA assessment against the Clinical Negligence Scheme for Trusts during 2008/09 with achievement of level 1;

· Staff are trained or equipped to manage risk in a way appropriate to their authority and duties;

· External auditors presentation to the Board on Risk;

· All staff trained at induction on risk management policy and processes, staff responsibilities and duties;

· Further training is provided for senior managers relating to their responsibilities and duties of risk assessment and managing risks and incidents;

· Monitoring of staff attendance at risk management training;

· Regular briefs for the Senior Manager 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, through identifying, prioritising and managing all aspects of risk. The key elements of the Risk Management Strategy aim to ensure that:

· Management processes are in place to minimize risks
· Patient safety is maintained
· The cost of risk is reduced
· Safe practices exist
· Safe systems at work exist
· Premises are safe
· Awareness of dangers and liabilities exists

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.

The Risk management procedure comprises six elements

· Identify hazards
· Analyse and evaluate risk
· Risk Treatment
· Resource
· Communicate risk
· Monitor and Review Risk

The first stage in the implementation of the Trust strategy is to identify and categorise hazards, whether or not they are within the control of the Trust. The responsibility is on line managers and staff at every level to identify the hazard in their area of work

The Trust has established a Trust-wide Risk Register and Incident Reporting system that includes risk registers for each speciality.

Risks are evaluated as specified in the Trust Risk Management procedures and evaluation involves consideration of the sources of hazards, their consequences and the likelihood that those consequences may occur. The Trust uses the NHS Standard matrix for quantifying risk and assigns a score to each risk.

The Trust Risk Management Strategy and procedures identify actions and reporting requirements for newly identified or reviewed risks depending on the score. If a risk is evaluated as moderate, high or significant, line managers are responsible for recommending and implementing a risk treatment plan that will reduce the level of risk to low/acceptable.

The Risk Management Committee considers all new or revised, serious and high risks at each meeting, and regularly reviews the risk register. The Risk Management Committee discusses any concerns relating to risks identified, evaluation or treatment plans with the line manager responsible immediately following this review.

Specialties and departments are required to review their risk register at least annually, and to incorporate management action to address key risks in their annual business plan. Any development proposals or business cases must include a risk assessment.

The Trust encourages all staff to be involved in identifying and reporting risk, and this is reflected in the high level of entries in the Trust's risk register. The Trust Board has developed an Assurance Framework which covers all of the organisations main activities. The Assurance framework identifies significant risks to the Trust's delivery of its major strategic objectives and the controls that the Trust has in place to manage these risks. The Assurance Framework also identifies any gaps in controls or assurance, and action agreed by the Board to address those gaps.

The Assurance Framework informs the Statement of Internal Control, clearly identifying any gaps in control or assurance in key risks to the Trust. The Trust Board has reviewed the Board Assurance Framework and updated it to reflect current strategic objectives and the changing risk profile of the Trust

· Two Governors are members of the Audit Committee which reviews risks rated moderate and above at every meeting and the assurance framework every 6 months.
· Two Governors attend the Board meetings where risk management committee minutes, risks and incidents are reviewed.
· The Trust Patient Environment Action Team (PEAT) inspection team involves members of the public.
· Two members attend the Clinical Governance Committee which receives the risk management committee minutes.
· Members attend the infection control committee which reviews infection risks.
· Member attends the education committee which reviews education and training in risk.
be involved in managing risks which might impact on them.
· The Trust reports all incidents to the National Patient Safety Agency through the National Reporting and Learning System.
· The Trust reports Serious Untoward Incidents to the host PCT should they occur.
· The Trust reports all risks rated moderate and above to the host PCT in quarterly quality reports.
internal control and risk management, across the whole of the organisation's activities (both clinical and non-clinical) that
· The Risk Management Committee, chaired by a Non-Executive Director, reports to the Board every two months
· The Clinical Governance Committee, chaired by a Non-Executive Director, reports to the Board every two months

· The Trust completed the Annual Information Governance Toolkit Assessment in 2008/09 and achieved a green rating with a score of 90% and meets the requirements of the Information Governance Statement of Compliance.

· The Director of Governance and Performance leads on the annual Information Governance Toolkit Assessment which is reviewed by the board. The Board approves the annual Information Governance Plan.

· The Board has reviewed the systems and procedures for securing personal data, including patient data in transit and confirms that it is satisfied that these have been and remain compliant with relevant information governance guidance and the Data Protection Act 1998.

· During 2008/09 there have been no material breaches in data security (including personal data in transit) resulting in actual data loss.

· The Board reviews the minutes of the Audit Committee, Clinical Governance Committee and Risk Management Committee.

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 towards 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 to comply with Condition 2 of its Authorisation by which it is required 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 asked the Board to prepare and present a detailed recovery plan to the Monitor Board.

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

Action

During the summer of 2008 the Trust developed a detailed financial recovery plan to address these concerns. This plan focuses on measures to improve financial controls and reduce costs, without compromising the quality of patient care provided. The implementation of the first stages of this plan has supported the Trust in the delivery of an operating surplus for 2008/09, an improvement in the Trust's financial risk rating to 2, and an expected surplus and further improvement in its financial risk rating for 2009/10.

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 has decided to seek to merge with another NHS organisation. During 2009/10 the Trust will identify a merger partner and consult with stakeholders on the merger plans.

At the end of 2008/09 Monitor continues to be concerned with the vulnerability of the Trust's financial position and the Trust remains on a red rating to facilitate close scrutiny of its liquidity, trading position and the on-going delivery of its Short and Medium Term Recovery Plan. As a consequence the Trust remains in significant breach of its terms of Authorisation on the basis of failure of financial governance, in particular that the Trust has failed to comply with Condition 2 of its Authorisation by which it is required at all times to exercise its functions "*effectively, efficiently and economically"*.

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, 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 and
· the risk management committee including all organisation risks rated as moderate or above.
· The information governance assessment action plan
· Assurance framewok
· 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.

management across the organisation, to identify, assess, decide on responses to and report on opportunities and threats that affect the achievement of the organisation's objectives. The internal auditors concluded that significant assurance exists that there is a generally

Conclusion

The Board has taken appropriate action in year to clear with the internal control issues which have been identified in terms of financial governance. The Trust has implemented a robust action plan to address these and the Board and its regulator, Monitor receive regular reports detailing progress against the Trust's Short and Medium Term Recovery Plan and actions taken to address any variances as they arise. Positive progress in delivering these improvements is reflected in the opinion provided by the Trust's internal auditors that a sound system of control exists.

Signed… 

Kirsty Mathews

Interim Chief Executive

Date: 5th June 2009

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 2009 which comprise the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement, the Statement of Total Recognised Gains and Losses, and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Financial 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 the Chief Executive's responsibilities as the accounting officer of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (set out on page 45) 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 Financial Reporting Manual, of the state of the NHS Foundation Trust's affairs as at 31 March 2009 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 Financial Reporting Manual.

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

In our opinion

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Financial 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 trusts 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 46. 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 Financial 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
8 June 2009

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2009 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.

The Royal National Hospital For Rheumatic Diseases achieved Foundation Trust status on 1 April 2005.

Signed…….…….

Kirsty Mathews - Interim Chief Executive

Date: 5th June 2009

INCOME AND EXPENDITURE ACCOUNT

for the year ended
31st March 2009

	NOTE	2008/09 £000	Restated 2007/08 £000
Income from activities	3-4	17,559	14,452
Other operating income	5	1,496	1,785
Operating expenses	6-7	(18,695)	(16,449)
OPERATING SURPLUS / (DEFICIT)		360	(212)
Net financing expenditure	8	(10)	25
SURPLUS / (DEFICIT) FOR THE FINANCIAL YEAR		350	(187)
Public Dividend Capital dividends payable	9	(296)	(326)
RETAINED SURPLUS / (DEFICIT) FOR THE YEAR		**54**	**(513)**

The notes on pages 57 to 82 form part of the accounts.

All activities are classed as continuing.

BALANCE SHEET
as at
31st March 2009

	NOTE	31st March 2009 £000	Restated 31st March 2008 £000
FIXED ASSETS			
Intangible assets	13	71	50
Tangible assets	14	7,957	7,968
		8,028	**8,018**
CURRENT ASSETS			
Stocks and work in progress	15	31	6
Debtors	16	2,336	2,326
Cash at bank and in hand		327	523
		2,694	**2,855**
CREDITORS: Amounts falling due within one year	17	**(3,801)**	**(4,049)**
NET CURRENT LIABILITIES		**(1,107)**	**(1,194)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**6,921**	**6,824**
CREDITORS: Amounts falling due after more than one year	17	**(29)**	**0**
PROVISIONS FOR LIABILITIES AND CHARGES	18	**(9)**	**(14)**
TOTAL ASSETS EMPLOYED		**6,883**	**6,810**
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital		6,015	6,015
Revaluation reserve	20	748	745
Donated asset reserve	20	367	351
Income and expenditure reserve	20	(247)	(301)
TOTAL TAXPAYERS' EQUITY	25	**6,883**	**6,810**

These accounts have been approved by the Board of Directors on 5 June 2009 and signed on its behalf by:

Kirsty Mathews - Interim Chief Executive
5 June 2009

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES
for the year ended
31st March 2009

	2008/09	Restated 2007/08
	£000	£000
Surplus / (deficit) for the financial year before dividend payments	350	(187)
Unrealised surplus /(deficit) on fixed asset revaluations	4	(922)
Increase in donated asset reserve due to receipt of donated assets	7	0
Increase / (Decrease) in the donated asset reserve due to the depreciation, impairment and disposal of donated assets	8	(48)
Total recognised gains and losses for the financial year	**369**	**(1,157)**
Prior period adjustment recognised since last annual report	(1,274)	
Total losses recognised in the financial year	**(905)**	**(1,157)**

CASH FLOW STATEMENT
for the year ended
31st March 2009

	NOTE	2008/09 £000	2007/08 £000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	21.1	**572**	**485**
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		22	25
Interest paid		(28)	0
Net cash inflow from returns on investments and servicing of finance		**(6)**	**25**
CAPITAL EXPENDITURE			
Payments to acquire tangible fixed assets		(419)	(292)
Payments to acquire intangible assets		(31)	(22)
Net cash outflow from capital expenditure		**(450)**	**(314)**
DIVIDENDS PAID		**(296)**	**(326)**
Net cash outflow before financing		**(180)**	**(130)**
FINANCING			
Capital element of finance lease rental payments		**(16)**	**0**
Net cash inflow from financing		**(16)**	**0**
Increase / (Decrease) in cash		**(196)**	**(130)**

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 Financial Reporting Manual which has been agreed with HM Treasury. Consequently, the financial statements have been prepared in accordance with the 2008/09 NHS Foundation Trusts Financial Reporting Manual issued by Monitor. The accounting policies contained in the manual follow UK generally accepted accounting practice for companies (UK GAAP) 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.

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

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. NHS foundation trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the FRS 3 requirements to report "earnings per share" or to prepare a reconciliation between current cost and historical cost surpluses and deficits.

1.2 Income recognition

Income is accounted for by applying the accruals convention. The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.3 Intangible fixed assets

Intangible assets are capitalised when they are capable of being used in the Trust's activities:

for more than one year;
they can be valued
and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis. 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.

1.4 Tangible fixed assets

Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or
- are for 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.

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are restated to current value using professional valuations in accordance with FRS15 every five years. A three yearly interim valuation is also carried out.

Professional valuations are carried out by the District Valuers of the Inland Revenue Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. The last asset valuations were undertaken in April 2009 as at the prospective valuation date of 31 March 2009.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

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

Assets in the course of construction are valued at current cost and are valued by professional valuers as part of the 5 or 3-yearly valuation or when they are brought into use.

Operational equipment is valued at cost. Equipment surplus to requirements is valued at net recoverable amount.

Change in Accounting policies in year

The Foundation Trust FReM requires all foundation trusts to prepare their accounts in accordance with UK GAAP 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 modern equivalent asset (MEA) basis values assets by estimating the costs to create a modern equivalent of the existing asset, taking into account modern materials and building techniques.
This differs from the approach previously used , which would value assets based on the cost to recreate an exact replica of the existing asset.

The Trusts only specialised asset is the main hospital building. This has thefore been revalued on this basis and prior year figures relating to this asset have also been restated to account for the impact of this change in accounting policy.

1.4 Tangible fixed assets (continued)

Depreciation, amortisation and impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land and assets surplus to requirements.
Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term.

Fixed asset impairments resulting from losses of economic benefits are charged to the income and expenditure account. All other impairments are taken to the revaluation reserve and reported in the statement of total recognised gains and losses to the extent that there is a balance on the revaluation reserve in respect of the particular asset.

The Trust depreciates its fixed 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:

	Years
Freehold buildings	13 - 60
Freehold dwellings	36 - 52
Plant and machinery	5 - 15
Transport equipment	7 - 10
Information technology	5
Furniture & fittings	10
Software licences capitalised as part of an IT asset	5

1.5 Donated fixed assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed 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 income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the value of the sale proceeds is transferred from the donated asset reserve to the income and expenditure reserve.

1.6 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress; they are accounted for as accrued income.

1.7 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to:
  - its technical feasibility;
  - its resulting in a product or service which will eventually be brought into use;
- adequate resources exist, or are reasonably expected to be available to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account 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 income and expenditure account separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

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.
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 18.

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.

External Auditors Liability

There is a limitation on the external auditors liability of £1m

1.9 Pension Costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk. 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. 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, based on a five year revaluation cycle), and a FRS17 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 accounts its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determines current contribution rates was undertaken as at the 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. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008 the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending upon total earnings.

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 income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

b) FRS17 Accounting valuation

In accordance with FRS17, a valuation of the scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date 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 2009 is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2009 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.

1.9 Pension Costs (continued)

Scheme provisions as at 31 March 2009

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. 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. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

The scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement, the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

Scheme provisions from 1 April 2008

From 1 April 2008 changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website www.pensions.nhsbsa.nhs.uk

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 fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.11 Foreign exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Income and Expenditure Account.

1.12 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 29.

1.13 Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. The interest element of the finance lease payment is charged to the income and expenditure account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the income and expenditure account on a straight-line basis over the term of the lease.

1.14 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, including those for achieving three star status, 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 Income and Expenditure account to match the expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to the income and expenditure account over the life of the asset on a basis consistent with the depreceation charge for that asset.

1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance, based on the excess of assets over liabilities ie the net assets of a public benefit corporation.

A charge, reflecting the forecast cost of capital utilised by the Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for assets in the course of construction, donated assets and cash with the Office of the Paymaster General. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year, see Note 9.

1.15 Cash, bank and overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Trust's bank account belonging to patients. Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded as "interest receivable" and "interest payable" respectively in the periods to which they relate. Bank charges are recorded as operating expenditure in th eperiods to which they relate.

1.16 Expenditure

Expenditure is accounted for applying the accruals convention, and is recognised in the financial period that it is incurred, not in the period that it is paid.

1.17 Financial instruments

FRS 25, 26 and 29, Financial Instruments, requires disclosure of the roler that financial instruments have had during the period in creating or changing the risks that an entity faces in undertaking its activities.

Financial instruments are carried on the balance sheet at their fair value or amortised cost (book value). The fair value is the amount for which a financial asset could be exchanged, or a financial liability settled, between knowledgeable willing parties. If an active market exists, the market price is applied. If an active market does not exist, which is the case for a number of financial assets and liabilities, generally accepted estimation and valuation techniques based upon market conditions at the balance sheet date are used instead, including the discounted cash flow method.

Financial assets and financial liabilities which arise from contracts for the purchase 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.

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.

At the balance sheet date, the Trust assesses whether any financial assets are impaired. Where financial assets are impaired, impairment losses are recognised 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.

Provision for bad debts is calculated based upon individual/collective outstanding balances which are unlikely to be recoverable.

2. Segmental analysis

All income and activities are for the provision of health and health related services in the UK.

3. Income from activities	**2008/09**	**Restated 2007/08**
	£000	£000
Elective income	5,772	4,834
Non-elective income	5,116	4,483
Outpatient income	2,850	2,278
Block contract income	326	256
Private patient income	136	189
Other clinical income from mandatory services	3,359	2,412
	17,559	**14,452**
Income from mandatory services	17,423	14,263
Income from non-mandatory services	136	189
	17,559	**14,452**

4. Private patient income

	2008/09	**2007/08**	**2002/03**
	£000	£000	£000
Private patient income	136	189	128
Total patient related income	17,559	14,442	9,748
Proportion (as a percentage)	**0.77%**	**1.31%**	**1.31%**

Section 15 of the 2003 Act requires that the proportion of private patient income to the total patient related income of NHS Foundation Trusts should not exceed the proportion whilst the body was an NHS Trust in 2002/03 the base year. For the Trust this is 1.31%

The Trust has treated income from PCTs for high cost drugs as patient related income. This is consistent with the classification used by the Trust when the private patient cap was set in 2002/03.

	2008/09	**Restated 2007/08**
PCT Income	14,064	11,851
High Cost Drugs Income	3,359	2,412
Private Patient Income	136	189
Total Patient Related Income	**17,559**	**14,452**

5. Other operating income	**2008/09**	**Restated 2007/08**
	£000	£000
Research and development	350	364
Education and training	1,001	864
Transfers from donated asset reserve	(8)	48
Charitable and other contributions to expenditure	67	8
Other income	86	501
	1,496	**1,785**

6. Operating expenses

6.1 Operating expenses comprise:	2008/09 £000	Restated 2007/08 £000
Services from NHS Foundation Trusts	2	0
Services from NHS Trusts	922	672
Services from other NHS bodies	143	241
Executive directors costs	417	428
Non-executive directors' costs	39	42
Staff costs	10,643	9,757
Drug costs	3,628	2,635
Supplies and services - clinical (excluding drug costs)	353	401
Supplies and services - general	139	139
Establishment	202	254
Transport	99	19
Premises	864	839
Bad debts	(32)	67
Depreciation and amortisation	459	548
Audit fees	38	37
Internal audit fees	56	0
Other auditor's remuneration	10	8
Other	713	362
	18,695	**16,449**

6.2 Operating leases

6.2.1 Operating expenses include:-

	2008/09 £000	2007/08 £000
Other operating lease rentals	59	59
	59	**59**

6.2.2 Annual commitments under non - cancellable operating leases are:

	Land and buildings	
	2008/09 £000	**2007/08** £000
Operating leases which expire:		
Between 1 and 5 years	0	59
	0	**59**

6.3 Salary and pension entitlements of senior managers

Remuneration

Name and Title	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Golden hello / compensation for loss of office (bands of £5000)	Benefits in kind (Rounded to the nearest £100)
2008/09	£000	£000	£000	£
Nicola Carmichael, Chief Executive (left August 2008)	30-35	0	0	0
Peter Hill , Interim Chief Executive (from September 2008)	45-50			
Dr T Jenkinson, Medical Director	0	120-125	0	0
Rod Barnes, Finance Director	70-75	0	0	0
Karen Kerley, Director of Human Resouces & 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 Mathews - 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.

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.

Costs for Dr T Jenkinson are funded from Clinical Excellence income.

2007/08

Nicola Carmichael, Chief Executive	85-90	0	0	0
Dr T Jenkinson, Medical Director	0	85-90	0	0
Paul Dodd, Finance Director (until Feb 2008)	60-65	0	0	0
Rod Barnes, Finance Director (from Feb 2008)	0-5	0	0	0
Karen Kerley, Director of Human Resouces & Membership	55-60	0	0	0
Chris Fokke, Director of Clinical Practice/Nursing Professional Advisor	55-60	0	0	0
Hayley Sewell, Director of Governance & Performance	55-60	0	0	0
Kate Lyon - Chairperson (until Nov 2007)	15-20	0	0	0
Brian Joakim - Chairperson (from August 2007)	10-15	0	0	0
David Rodgers - Non Exec (until July 2007)	0-5	0	0	0
Richard Darch - Non Exec (until Sept 2007)	0-5	0	0	0
Peter Metcalfe - Non Exec (until March 2008)	5-10	0	0	0
Vincent Harral - Non Exec (until March 2008)	5-10	0	0	0
Julie O'Donnell nee Spencer-Cingoz (from Sept 2007)	5-10	0	0	0
Christopher Johns (from Oct 2007)	0-5	0	0	0
Peter Spencer (from Dec 2007)	0-5	0	0	0
Kirsty Mathews (from Dec 2007)	0-5	0	0	0

6.3 Salary and pension entitlements of senior managers

Pension Benefits

Name and Title	Real increase in pension and related lump sum at age 60 (bands £2,500)	Total accrued pension and related lump sum at age 60 at 31 March 2009 (bands of £2,500)	Cash Equivalent Transfer Value at 31 March 2009	Cash Equivalent Transfer Value at 31 March 2008	Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000
Nicola Carmichael, Chief Executive	0-2.5	120-122.5	591	442	35
Dr Tim Jenkinson, Medical Director	5.0-7.5	75-77.5	373	264	72
Rod Barnes, Finance Director	2.5-5.0	60-62.5	233	171	41
Karen Kerley, Director of Human Resouces & Membership	2.5-5.0	15-17.5	79	53	17
Chris Fokke, Director of Clinical Practice/Nursing Professional Advisor (until March 2009)	2.5-5.0	45-47.5	203	147	34
Hayley Sewell, Director of Governance & Performance	2.5-5.0	35-37.5	144	104	26
Amanda Pacey, Acting Director of Clinical Practice/Nursing Professional Advisor and DIPC (from March 2009)	(0-2.5)	30-32.5	122	82	2

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.

7. Staff costs and numbers

7.1 Staff costs

	2008/09	2007/08
	£000	£000
Salaries and wages	**8,856**	**8,326**
Social Security costs	**627**	**595**
Employer contributions to NHSPA	**991**	**929**
Agency and contract staff	**586**	**335**
	11,060	**10,185**

7.2 Average number of persons employed

	2008/09			2007/08
	Total Number	Permanently Employed	Other	**Total Number**
Medical and dental	**15**	15	0	**15**
Administration and estates	**114**	114	0	**112**
Healthcare assistants & other support staff	**0**	0	0	**0**
Nursing, midwifery & health visiting staff	**105**	105	0	**95**
Scientific, therapeutic and technical staff	**64**	64	0	**63**
Bank and agency staff	**110**	0	110	**75**
Total	**408**	**298**	**110**	**360**

7.3 Employee benefits

There were no employee benefits during the year.

7.4 Retirements due to ill-health

There were no retirements due to ill health in 2008/09.(Nil 2007/08)

8. Net financing income	**2008/09**	**2007/08**
	£000	£000
Interest Payable	(32)	0
Interest Receivable	22	25
	(10)	**25**

9. Public Dividend Capital dividend		
	£000	£000
Actual public dividend capital dividend incurred during the year	**296**	**326**
	%	**%**
The actual dividend rate is	3.41%	3.41%
The forecast dividend rate was	3.50%	3.50%
Difference between actual and forecast rate	**-0.09%**	**-0.09%**

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

Opening and closing relevant net assets excludes donated assets and cash held in paymaster accounts.

10. Public Sector Payment Policy

Better Payment Practice Code - measure of compliance

	2008/09		2007/08	
	Number	£000	**Number**	£000
Total bills paid in the year	4,614	5,989	5,755	6,659
Total bills paid within target	1,786	883	3,106	1,887
Percentage of bills paid within target	38.71%	14.74%	53.97%	28.34%

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 £30k included within Interest Payable arising from claims made by businesses under this legislation.

12. Losses and special payments

There were no losses or special payments in the year.

13. Intangible fixed assets

	31st March 2009 Software Licences £000	31st March 2008 Software Licences £000
Gross cost at 1 April	203	181
Additions	31	22
Gross cost at 31 March	**234**	**203**
Accumulated amortisation at 1 April	153	149
Provided during the year	10	4
Accumulated amortisation at 31 March	**163**	**153**
Net book value		
- Purchased assets at 1 April	50	32
- Purchased assets at 31st March	**71**	**50**

14. Tangible fixed assets

14.1 Tangible fixed assets 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 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
Other revaluations	(16)	20	0	0	0	0	0	4
Disposals	0	0	0	0	0	0	0	0
At 31 March 2009	**2,292**	**6,503**	**1,543**	**48**	**637**	**73**	**48**	**11,144**
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
Accumulated depreciation at 31 March 2009	**0**	**1,356**	**1,123**	**34**	**620**	**54**	**0**	**3,187**
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**

14.2 Analysis of tangible fixed assets

Net book value								
Protected assets at 31 March 2009	2,292	5,147						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 Foundation Trust FReM requires all foundation trusts to prepare their accounts in accordance with UK GAAP 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 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. This differs from the approach previously used, which would value assets based on the cost to recreate an exact replica of the existing asset.

The Trust's only specialised asset is the main hospital building. This has therefore been revalued on this basis and prior year figures relating to this asset have also been restated to account for the impact of this change in accounting policy.

The impact of this adjustment on the opening revaluation reserve and income & expenditure reserve is shown in Note 20.

14.3 Tangible fixed assets (contd)

Of the totals at 31 March 2009, there was £1,045k of assets valued at open market value (Nil 2007/08)

There were assets held under Finance Leases or Hire Purchase contracts with a NBV of £39k at the balance sheet date.(Nil 2007/08)

15. Stocks and Work in Progress

	31 March 2009	31 March 2008
	£000	£000
Raw materials and consumables	**31**	**6**

16. Debtors

	31 March 2009	31 March 2008
	£000	£000
Amounts falling due within one year:		
NHS trade debtors	**1,766**	**1,349**
Provision for irrecoverable debts	**(93)**	**(125)**
Other prepayments and accrued income	**55**	**110**
Other debtors	**608**	**992**
	2,336	**2,326**

17. Creditors

Creditors at the balance sheet date are made up of:	**31 March 2009** £000	**Restated 31 March 2008** £000
Amounts falling due within one year:		
NHS trade creditors	**2,059**	**2,037**
Non - NHS trade creditors - revenue	**1,384**	**1,470**
Non - NHS trade creditors - capital	**16**	**63**
Tax and social security costs	**192**	**187**
Other creditors	**0**	**27**
Accruals and deferred income	**150**	**265**
	3,801	**4,049**
Amounts falling due after more than one year:	**29**	**0**
	3,830	**4,049**

NHS creditors include:

£100k outstanding pensions contributions as at 31 March 2009.

In accordance with UK GAAP and HM Treasury's FReM The Trust has made an accrual of £120,000 for cost of untaken leave at 31 March 2009. Inclusion of this liability represents a change in accounting policy and therefore a prior period adjustment has been made to restate the comparative figures in the accounts to include a provision for untaken leave of £168,000 at 31 March 2008.

The impact on the brought forward income and expenditure reserve at 1 April 2007 is a reduction of £168,000. The full impact of this adjustment is shown in Note 20.

18. Provisions for liabilities and charges

£9k has been included in the provisions of the NHSLA at 31st March 2009, in respect of LTPS (Liabilities to Third Parties Scheme) Provisions for the Trust. (31st March 2008 was £14k in respect of Clinical Negligence)

19. 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 five 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 thewebsite of Monitor, the independent Regulator of Foundation Trusts.

	Total £000
Prudential borrowing limit set by Monitor	0
Actual borrowing in the year	0

The Trust had a £1,000,000 approved working capital facility in place from 1st November 2008 until February 2009

	2008/09			**2007/08**	
Financial Ratios	**Actual PBL Ratios**	**Approved PBL Ratios**		**Actual PBL**	**Appro PBL**
Maximum Debt/Capital	0	0		0	0
Minimum Dividend Cover	2.7x	4.0x		1.7x	3.3x
Minimum Interest Cover	0	0		0	0
Minimum Debt Service	0	0		0	0
Maximum Debt Service to	0%	0%		0%	0%

20. Movements on reserves

Movements on reserves in the year comprised the following:

	Revaluation reserve	Donated Asset reserve	Other	Income and Expenditure reserve	Other reserves	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2008 Restated	745	351		(301)	0	**795**
Transfer from the Income and Expenditure account	0	0		54	0	**54**
Surplus/(deficit) on revaluations of fixed assets and current asset investments	3	1		0	0	**4**
Transfer to the I & E Account for Depreciation, impairment, and disposal of donated assets	0	8		0	0	**8**
Receipt of donated assets	0	7				**7**
At 31 March 2009	**748**	**367**	**0**	**(247)**	**0**	**868**

Prior year adjustments

The Trust has changed its accounting policies this year as follows:

- to account for the its liability in respect of untaken leave at the balance sheet date; and
- to value specialised assets on the modern equivalent asset basis.

Prior year adjustments have been made to account for both these changes. The impact on the income and expenditure reserve and revaluation reserve are as follows.

	Revaluation Reserve	**I&E Reserve**
As at 1st April 2007	**894**	**566**
Prior year adjustments		
Holiday pay accrual		(168)
Modern Equivalent Asset va	773	(186)
As at 1st April 2007 Restat	**1,667**	**212**
Transfer from the income and expenditure account		(420)
Surplus/(deficit) on revaluations of fixed assets and current asset investments	678	
Prior year adjustment:		
Modern Equivalent Asset va	(1,600)	(93)
As at 31st March 2008 Res	**745**	**(301)**

21. Notes to the cash flow statement

21. 1 Reconciliation of operating surplus to net cash flow from operating activities:

	2008/09	**Restated 2007/08**
	£000	£000
Total operating surplus / (Deficit)	360	(212)
Depreciation and amortisation charge	459	548
Transfer from donated assets reserve	8	(48)
Decrease/(Increase) in debtors	(11)	(646)
(Decrease)/Increase in creditors	(214)	829
(Decrease)/Increase in provisions	(5)	14
Increase in stocks	(25)	0
Net cash inflow from operating activities	**572**	**485**

21.2 Reconciliation of net cash flow to movement in net debt

	2008/09	**2007/08**
	£000	£000
Increase / (Decrease) in cash in the period	(196)	(130)
Change in net funds resulting from cashflows	**(196)**	**(130)**
Net funds at 1 April 2008	523	653
Net funds at 31 March 2009	**327**	**523**

21.3 Analysis of changes in net debt

	At 31 March 2009	Cash flows	At 1 April 2008
	£000	£000	£000
OPG cash at bank	**325**	(156)	481
Commercial cash at bank and in hand	**2**	(40)	42
	327	**(196)**	**523**

22. Capital commitments

The Trust had no capital commitments at 31 March 2009. (£8k at 31 March 2008)

23. Post balance sheet events

There were no post balance sheet events having a material effect on the accounts for 2008/9
On the 30th April 2009 the Trust sold 11Trim Street realising sale proceeds before expenses of £495k'.

24. Contingent liabilities

The Trust had £4k Contingent Liabilities at 31 March 2009.

25. Movements in Taxpayers' equity

	£000
Surplus for the financial year	**350**
Public dividend capital dividends	**(296)**
Surplus from revaluations of fixed assets and current asset investments	**4**
Additions of donated assets	**7**
Transfers to the donated asset reserve	**8**
Net increase in Taxpayers' equity	**73**
Opening Taxpayers' equity at 1st April 2008	**6,810**
Closing Taxpayers' equity at 31st March 2009	**6,883**

26. 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 totalling £66,000 from Funds Held on Trust in 2008/9. The Trust processed payments totalling £69,479 in 2008/09

Funds Held on Trust owed the Trust £0 as at 31st March 2009 in respect of invoices paid by the Trust on its behalf. The Trust owed Funds Held on Trust £0 as at 31 March 2009.

The Trust also had significant transactions with the following NHS organisations during 2008/09:

	Income	Expenditure
	£000's	£000's
Bath and North East Somerset Primary Care Trust	3,670	38
Wiltshire Primary Care Trust	3,791	98
Somerset Primary Care Trust	1,510	_
Hampshire Primary Care Trust	2,454	_
The Royal United Hospital, Bath NHS Trust	23	1,847

27. Public private partnership transactions

The Trust has had no Private Finance Initiative or public private partnership schemes.

28. 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. FRS 25, Financial Instruments Disclosure and Presentation, 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.

28.1 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 NHS Foundation 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 respectt of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy foe leases described above.

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

28.2 Financial instruments & financial liabilities derecognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the NHS Foundation 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 NHS Foundation 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 negligible foreign currency income or expenditure.

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.

28.1 Financial Assets	**Book value £000**	**Fair value £000**
At 31 March 2009		
Sterling	2,608	2,609
Other		-
Gross financial assets	**2,608**	**2,609**
At 31 March 2008		
Sterling	2,849	2,849
Other	-	-
Gross financial assets	2,849	2,849

As the Trust's financial assets are predominantly short term, the book value is considered to be the fair value of the asset.

28.2 Financial liabilities	**Book value £000**	**Fair value £000**
At 31 March 2009		
Sterling	3,488	3,488
Other	-	-
Gross financial liabilities	**3,488**	**3,488**
At 31 March 2008		
Sterling	4,049	4,049
Other	-	-
Gross financial liabilities	4,049	4,049

The book value of the Trust's short term liabilities are considered to be the same as the fair value.

28.3 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 Debtors (net of provision for irrecoverable debts)	1,673	-	-	-	**1,673**
Accrued income	0	-	-	-	**0**
Other debtors	608	-	-	-	**608**
Cash at bank and in hand	327	-	-	-	**327**
Total at 31 March 2009	2,608	-	-	-	**2,608**
NHS Debtors (net of provision for irrecoverable debts)	1,224	-	-	-	**1,224**
Accrued income	110	-	-	-	**110**
Other debtors	992	-	-	-	**992**
Cash at bank and in hand	523	-	-	-	**523**
Total at 31 March 2008	2,849	-	-	-	**2,849**

Ageing of Debtors	**31 March 2009** £000	**31 March 2008** £000
Up to three months	471	112
In three to six months	104	-
Over six months	295	605
Not yet due	1,466	1,609
	2,336	**2,326**

28.4 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 creditors	2,059	-	**2,059**
Other creditors	1,429	-	**1,429**
Accruals		-	**0**
Total at 31 March 2009	3,488	-	**3,488**
NHS creditors	2,037	-	**2,037**
Other creditors	1,747	-	**1,747**
Accruals	265	-	**265**
Restated total at 31 March 2008	4,049	-	**4,049**

£29k of financial liabilities mature in one to five years.

29. Third party assets

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