Royal National Hospital for Rheumatic Diseases
NHS Foundation Trust

Annual Report & Accounts 2007/08

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

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Contents

Chair's Statement

In this, my first Chairman's statement since I was appointed, I would like to reflect on my first five months at the Trust and then look to the future.

I took up the post as Chairman of the Royal National Hospital for Rheumatic Diseases (The Min) in December last year having spent time in the private sector. I soon became aware of, and was impressed by, the nature and scope of the work that the hospital does, on site, in the community and increasingly nationally. I am also aware of the incredible dedication of all of the staff throughout the whole Trust. In each of our medical specialities we are fortunate to have some of the most eminent consultants and clinicians in the country.

The Healthcare Commission again recognised the hospital's clinical care and safety record by awarding ratings of excellent and good for the 2nd year in succession. Patient safety and satisfaction are most important and we continue to develop ways of communicating with patients and their families to find out what they think about the hospital, the service that we provide and how we can improve it. Across our four main specialist services we have had great success in treating patients and improving their lives.

In rheumatology, The Min is now listed on the HMSA website as the regional centre for Hypermobility. Our Pain Management Unit has consolidated its position as an excellent provider of pain management services. It provides the only residential young adult pain management programme in the UK. In Neuro Rehabilitation our Young People's Neuro Rehabilitation service recently received a Royal visit by HRH The Duchess of Cornwall. This service is one of the few dedicated units for the rehabilitation of young people aged 14-25 in the country. Our CFS/ME services cater for both adults and children. The paediatric service is one of the leading services in the UK. Together, they are developing programmes which have been helping to reduce absenteeism in schools and the workplace.

Looking to the future, our hospital, as many others, faces challenges in the changing and dynamic world of medical care. Patients are being offered increasing levels of choice and we need to ensure that they are aware of the services of The Min. Not only do we need to adapt to changing market conditions but we also need to review and change our own culture and our approach to the market place in new ways so as to continue to make The Min the hospital of choice. We need to develop our referral base and also develop further the services that we provide both in the hospital and out in the community. It is imperative that we continue to work hard to consistently get our message across to GPs, the general public and stakeholders and to inform them about the specialist work of the hospital, the positive outcomes we achieve for patients, and the services and clinical excellence we provide.

Recently, the hospital has seen the appointment of new non executive directors. So, with a new Board in place, there is a new commitment to see the hospital thrive and develop. The Board and the consultants are coming together to review the hospital's future strategy to ensure that we provide even better patient care in a safe environment and that we stay at the forefront of providing clinical excellence and

communicate these messages clearly to the public and the relevant health communities.

Since achieving Foundation Trust status our Council of Members has been responsible for representing the interests of NHS foundation trust members and partner organisations in our health economy. Our Council of Members has been instrumental in bringing forward new initiatives and opportunities to The Min. Together with the 5,000 members of the hospital, we all need to ensure that more and more people know about The Min's clinical excellence, the services we provide and the positive outcomes we achieve for patients.

Brian Joakim
Chairman

Directors' Report

The Foundation Trust had a challenging year with pressures on income and expenditure, but it made good progress with its development plan and developed new services which will bring additional activity to the Trust in 2008/9. The Trust successfully delivered the first stage of a major savings programme which will deliver financial benefits in 2008/9. Overall, the Trust increased activity over the course of the year, positioning the Trust for growth in 2008/9.

Key issues and developments for the Trust during the year were:

Neurorehabilitation Services

Referrals to the Neurorehabilitation unit were lower in the first part of the year as PCTs reviewed costs and service level requirements. The Trust worked with PCTs to restructure prices and to continue development of outpatient support programmes. Towards the end of the year, referrals to the Service increased significantly and we start the new year with the Unit at full capacity.

The increase in patients also reflects service developments during the year:

- The Neurorehabilitation unit put in place new specialist assessment services to improve patient care. The new services were SMART assessments, a clinical tool for the assessment and rehabilitation of people in low awareness states, and FES (functional electrical stimulation), a technology to improve body functions through artificial electrical stimulation of the neuromuscular system.
- The Unit completed major schemes to improve accomodation for younger people in a specially designed Unit, and to upgrade the High Dependency Unit.
- The Unit implemented new "step-down" services, using self contained flats for patients to start living independently whilst still receiving support from the Neurorehabilitation unit.
- The new consultant in Neurorehabilitation, Dr, Roshni Beeharry, took forward development of outpatient spasticity management services

Plans for 2008/9 include a review of provision for ex-services patients to ensure that their needs are met in the most appropriate way, further extension of the day case therapy service, and participation in the NHS Southwest Strategic Health Authority Stroke service review. This review will give us the opportunity for expert assessment of our specialist stroke service for younger people, and a better understanding of its role in the overall provision of Stroke Services within the Southwest Region.

Complex Pain Services

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

Referrals for Complex Regional Pain Syndrome and Chronic Pain services remained consistent through the year, but although the PCTs agreed to fund a slightly higher proportion of Chronic Pain referrals than last year, continued pressure on funding meant that they did not meet their planned activity for the second year in succession.
For those patients who the Unit is able to treat, the Trust achieves excellent clinical outcomes and high patient satisfaction. It will continue to work with PCTs, to gain a better understanding of PCT treatment preferences for complex chronic pain patients. It will also maintain a focus on providing education on chronic pain and the benefits and limitations of different treatment approaches.
Developments during the year included:

- Individualised care packages for highly complex adult and young chronic pain patients.
- Collaborative working arrangements with secondary care providers such as Addenbrookes Hospital in Cambridge, Input at St Thomas's in London, and Great Ormond Street and the development of agreed care pathways to tertiary care treatment with PCTs such as Hants, B&NES, Devon and Gloucestershire for the care of patients with chronic pain.
- Increased work funded by Occupational Health Insurance.
- The first dedicated young adult chronic pain course.
- The appointment of Dr. Candy McCabe, Nurse Consultant in Complex Regional Pain Syndrome, to a post at Bath University.
- Several major research publications detailed in the Royal National Hospital for Rheumatic Diseases Annual Research report.
- A "Medicine at the Min" public lecture on complex regional pain syndrome.

Developments for 2008/9 will include:

- Increases in outpatient services for younger pain patients.
- Additional individual treatment of highly complex pain patient.
- Application for national specialist service funding for pain services unique in England (CRPS, In-hospital, young adult and adolescent programmes).
- Development of education products reaching primary and secondary care health professionals, as well as those already working in the field of Pain Management.
- New proposals for grant funded research.

Rheumatology

Rheumatology had a busy year, and treated more patients than originally planned. Financially, it was only slightly ahead of plan as an increase in the number of patients was largely offset by continued improvement in patient care, resulting in patients staying in Hospital for a shorter time. There were also significant additional costs for Rheumatology, primarily related to the need for temporary medical staff to cover absence and recruitment difficulties following changes to the national system for Medical Registrar appointments, and to price increases for clinical support services purchased from other Hospitals.

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

- A new flexible sigmoidoscopy service, and the appointment of a new consultant to lead the endoscopy service, Dr. Adrian Griffiths.
- Development of a specialist hypermobility service, which has been recognised by the Hypermobility Syndrome Association (HMSA).
- A new outpatient clinic for Performing Artists, in collaboration with the British Association of Performing Arts.
- A new physiotherapy led sports and exercise clinic.
- Achievement of the 18 week referral to treatment pathway ahead of national timetables.
- Appointment of Dr. Neil McHugh as an Honorary Professor at Bath University.
- A service review of the rapidly expanding anti-TNF therapy service.

During next year, Rheumatology plans to review the Ankylosing Spondylitis programme to recognise the important clinical role of physiotherapists, to continue work with local primary care partners on the musculoskeletal care pathway, further improvements in referral to treatment times and improvements to the Endoscopy Unit.

Chronic Fatigue Services

The Trust provides Chronic Fatigue services for children and adults in the local area, and nationally for specialist referrals. This includes the only paediatric service offering assessment and treatment for children with CFS/ME who do not have access in their local area to a specialist CFS/ME service.

The services were initially funded by Department of Health grants which were for a limited level of activity. Funding has now moved to Primary Health Care commissioners, and we are currently reviewing service requirements with them.

The nature of the funding meant that although both adult and children's services saw an increase in referrals during the year and were able to accommodate some additional activity through service efficiency, growth was not able to keep up with demand and waiting times for the service rose.

The services had a number of successes during the year:

- An article for AFME on Vocational Rehabilitation February 2008.
- A CFS/ME Study day for health and social care professionals June 2007.
- Increased levels of specialist referrals from outside the local area.
- Work in England and Sweden to advise on setting up CFS services.

For next year, the services plan to increase multi-agency models of care for complex patients that other providers cannot manage. It will also continue to work with local Primary Care Trusts to improve the efficiency and delivery of local services, and offer support in establishing new services.

Clinical Measurement

The Clinical Measurement department increased services over the year to meet the 18 week referral to treatment pathway. Other important developments during the year included:

- Implementation of Digital Imaging (PACS) and electronic reporting of Bone Densitometry results. This means that X-ray and other images taken at the RNHRD or other hospitals connected to the system are easily available to medical staff on computers throughout the hospital.
- Development of an Electrophysiology Service provided by the Consultant Clinical Scientist, and one session each month from a Consultant Neurophysiologist. The service has developed a clinical pathway for Carpal Tunnel Syndrome, in consultation with PCT Commissioners and Orthopaedic Surgeons. The development of this service means that all patients with entrapment neuropathies are now seen by the RNHRD team.
- Further work on an established research collaboration with Philips Research to develop home rehabilitation systems for people with acquired brain injury.
- A partner on a new 2 year Research for Patient Benefit grant with Care of the Elderly and Wiltshire PCT.

Developments for next year include:

- Improvements to the fracture liaison service provided at the RUH which reviews patients who have a fractured bone to help identify if the patient may need treatment to improve bone density, including new computer software at the RUH which will automatically identify 'at risk' patients from clinic and discharge letters.
- A pilot project to develop Biomechanics services, to carry out in-shoe pressure measurements for Rheumatology and Sports Injury patients.

Operations and Finance

The lower activity levels in Pain Management and Neurorehabilitation meant that the Trust did not meet its income plan in year, and towards the end of the year it identified significant cost pressures which resulted in a year end deficit of £420k, compared to a planned surplus of £120k. The Trust also identified problems with financial assumptions underpinning in-year financial reporting and the 2006/07 annual accounts and has made a prior period adjustment of £583k to the accounts for 2006/07. This resulted in the Trust's risk rating by the independent regulator, Monitor, reducing from a 3 to a 2. More information is given in the Financial Overview later in this report.

The Trust also had pressure on its private patient cap during the year. This resulted in an amber governance rating from Monitor at the end the year, while the Trust took action to restrict private patient admissions and review the level of NHS patient income which determines the cap figure, These measures were successful, and the Trust ended the year with a private patient income within the required cap.

The pressures on activity and income in 2007/8 are a challenge for the Trust, but it is confident it can achieve the improvements in activity and financial performance to deliver a significantly better result in 2008/9. The service developments achieved in

2007/8 have already resulted in an increase in the number of patients being treated in the Trust, and the savings plans developed in 2007/8 are now in place to deliver additional savings during next year. The Trust has a review in place to identify further saving opportunities that will not have an adverse impact on the quality of patient care or on our staff's working environment, and will take these forward during 2008/9.

In 2007/8, the Trust made good progress in developing services and working practices that would enable it to thrive in a competitive NHS environment. We look forward to building on this, and seeing the benefit of those developments in 2008/9.

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.

Nicola Carmichael
Chief Executive

Background Information

History / Context

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust was founded in 1742. Locally, the RNHRD is still known as the “the Min”, a reference to its original name The Mineral Water Hospital.

From its foundation the hospital has had an interest in the treatment of patients suffering from rheumatic diseases, and in rehabilitation and research. In the 20th century, the interest in rehabilitation led to the development of specialist services in Neuro-rehabilitation and Pain Management which integrate with our specialist Rheumatology services. These three 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 Trust has a strong tradition of innovation. In the first part of the last century, with the arrival of Dr George Kersley, it was one of the first places to recognise Rheumatic Diseases as an area of medical specialisation in its own right. In 1991 the hospital became one of the first wave of NHS Trusts, and in 2005 it became one of the first wave of NHS Foundation Trusts.

Performance against Key Patient Targets

The Trust met all national out patient and inpatient access targets in 2007/08.
All patients had an initial out-patient appointment within 11 weeks of receipt of their referral and by 31 March 2008 there was no-one waiting longer than 5 weeks. No patient waited longer than 18 weeks to commence treatment following referral.

- All patients were admitted for in-patient treatment within 5 months of decision to admit, by 31 March 2008 no patient waited longer than 11 weeks for admission, which is next year’s target
- By the end of 2007/08 no patients were waiting more than 13 weeks for diagnostic tests. The waiting time has now reduced (as at 31 March 2008) to 6 weeks

The Board is informed of progress against key national and local targets in regular Board Performance Reports.

Healthcare Commission Annual Healthcheck

In October 2007 the Trust was rated as Excellent for Quality of Services by the Healthcare Commission.

The Trust is required to produce a declaration of its compliance against the Healthcare Commission Annual Healthcheck core standards during 2007/08. The

core standards cover the areas of safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities and public health. Compliance against the standards was reviewed by the Trust Clinical Governance Committee, the Council of Members, the PPI forum, the Local Overview and Scrutiny Committee, Internal Audit and the Board. The Board agreed that it had reasonable assurance that the Trust complied with the Healthcare Commission Annual Healthcheck core standards during the period April 1st 2007 to March 31st 2008.

Patient Safety

The Trust has been able to reduce it's previous year's C-diff incidence from 7 in 2006/7 to only 2 cases in 2007/8. There has been no case of MRSA bacteraemia since January 2007. The new statutory requirements for infection control (2006) are fully implemented and the Board is regularly briefed on matters relating to infection control and prevention. The Director of Infection Prevention and Control and the infection control team conduct monthly audits on hand hygiene and infection control training and advice is provided on a continuing basis. The vital aspect of Clinical Safety system provides assurances and predicts any potential risks to patients in advance and now includes the nursing- and physiotherapy function. The Trust has finished its deep clean and improved the patient environment through innovations such as using anti-microbial paints in high risk areas (Diagnostics suite and HDU) and the introduction of an in-house developed Infection Control Surveillance system.

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 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), the Chronic Fatigue Syndrome Guidelines published during this year and the Arthritis and Musculoskeletal Alliance (ARMA), and structures are in place to ensure that we audit against any guidelines relevant to this Trust.

Several evidence-based integrated care pathways have been developed with input from patients and a clinical audit component built into them in order to achieve continuous monitoring and routine auditing.

Information Governance

In March 2008 we completed the 2007/08 Information Governance Toolkit Assessment. The assessment included 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 59 requirements relevant to this Trust and the Trust scored 90% compliance against the requirements. This

demonstrates the high standards in Information Governance across the Trust. An action plan has been developed by the Information Governance lead and is derived from all the requirements for which the Trust did not achieve the highest score.

National In-patient Survey 2007

The Trust recognises that the excellent result in the 2007 national in-patient survey is directly due to the hard work and dedication of our staff.

The Inpatient Survey is required of all Acute NHS Trusts by the Healthcare Commission. The results will contribute to the Annual Healthcheck ratings for 2007/08.

Patients discharged from January to August 2007, were sent a questionnaire and up to 2 reminders. Overall 296 responded (67%).

The results are quite stable, with one significant change since last year, more patients reported that they receive copies of letters sent to their GP than previously. There have been no other significant changes since the last survey. The Trust is above average for 36 questions. Of these it is in the top 20% for 21 questions. The Trust was below average for 2 questions but was not ranked in the bottom 20% for any question.

Complaints

The Trust received 8 written complaints in 2007/08 which is less than the 12 received in 2006/07. All complainants received a written acknowledgement within 2 working days and 7 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 2007/2008.

Action taken as a result of Complaints

- If a PCT requests transfer of a patient's care, arrangements to be communicated to patient and G.P.
- Notices in lifts updated

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 provide information about the hospital, the NHS, and organisations and support groups outside the NHS. They help resolve concerns when patients are using hospital services and work with patients to improve hospital services, by listening to their experiences and ensuring that staff who deliver the services are aware of and address any issues raised.

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 50 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.

Emergency Preparedness

As a result of the civil contingencies act 2004, the Trust has plans in place in the event of 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 and these are available both in hard copy and on the local intranet to ensure 24/7 coverage. Our emergency broadcasting system (PageOne) is linked to our local PCT and regional resilience group. The lead for emergency planning has regular contact with the local and regional emergency planner in the Strategic Health Authority.

Research and Development

As a specialist hospital it is essential that the Trust promotes involvement in research by its staff and patients. With an excellent track record, the Trust is able to attract high quality clinicians who are always striving to improve patient treatments, diagnosis and care through the process of research, innovation and the implementation of new evidence.

A varied programme of research includes projects in all the specialty areas, including rheumatology, pain, chronic fatigue syndrome and neuro-rehabilitation in adults, adolescents and children. We undertake a wide range of research, such as laboratory based research, clinical measurement, commercial and non-commercial clinical trials, clinical research and qualitative research. Trust researchers attracted over £1m of external grants in 2006/7 and have again topped the £1m again in 2007/08. Funding includes grants from funding bodies such as the Arthritis Research Campaign, Economic and Social Research Council (ESRC) and the Engineering, Physical Sciences Research Council (EPSRC) and other medical charities.

Our research consistently receives a high rating from the Department of Health. The Department's comment on our most recent R&D Annual Report was *'The report covers all the key areas and includes some good examples of impacts demonstrating that research is having a positive impact on NHS policy and services. We note that*

in 2005/06 the Trust's publication output increased by 30% to 61 publications. This year, the number has fallen slightly to 53 publications, but is still a 12% rise over 2004/05 (47 publications). We also note that the total value of new grants awarded was over £1m. Of this sum, £370k was received in 2007/08, which represents a marginal reduction in external funding received compared with the previous year. We are pleased to see four higher degrees awarded during the period covered by the report.'

The Trust faces ongoing challenges with a changing Department of Health funding structure for research in the NHS and is developing a new R&D Strategy for the hospital to ensure it secures adequate external funding to meet the costs of research activities going forward. This strategy will be brought back to the Board for ratification during 2008.

The Trust continues to work closely with local universities, particularly the University of Bath School for Health, in its endeavour to produce both high quality research and well trained, excellent researchers for the future.

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 Members from an approved list recommended by the Board of Directors. The total cost of audit services for the year was £36,981. This was for the statutory audit of accounts for the 12 months ending 31st March 2008 and services carried out in relation to this. Further fee payments of £8,000 were made to the external auditors in respect of reviewing the Trust's Commercial Management arrangements during this period.

Pensions and Remuneration

Accounting policies for pensions and other retirement benefits are set out in note 1.10 to the accounts. Details of senior employees' remuneration can be found in page 58.

Financial Review

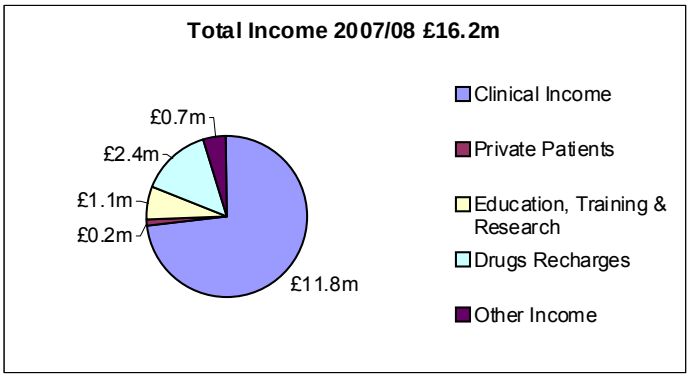
Financial Performance in 2007/08

The last 12 months have proved to be challenging for the Trust with the delivery of an in year deficit for the third year in succession. Pressures on finances within the local health economy leading to lower levels of patient referrals and reductions in levels of funding for medical training and research have had an adverse impact on the income received by the Trust and, whilst significant measures have been taken to deliver cost improvements the full year benefit of these will not be seen until 2008/09. As a result of these issues the Income & Expenditure Account position for 2007/08 was a deficit of £420k, compared to a planned surplus of £120k.

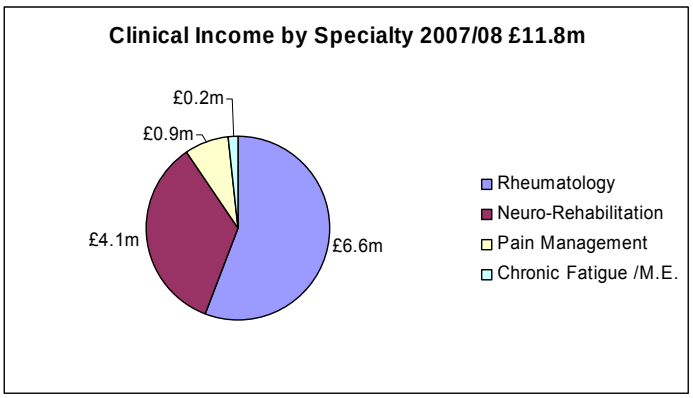
Towards the end of the financial year problems were also identified with financial assumptions underpinning in-year financial reporting and the 2006/07 annual accounts. As a result of these issues the Trust has made a prior period adjustment of £583k to the accounts for 2006/07. Further detail is provided on page 47.

Funding Overview

The Trust earned £16.2m in income during 2007/08. This is primarily from clinical activities, but the Trust also receives a significant amount of income from education, training and research.



The largest proportions of clinical income received by the Trust relate to Rheumatological, Neuro-rehabilitation and Pain Management services. Overall clinical income was £604k below the targets set in our annual plan for 2007/08. Whilst income in Rheumatology was in line with expectations activity and income for both Pain management and Neuro-rehabilitation failed to meet planned levels.



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 outpatient treated at national tariff rates. Because of the specialist nature of the Trust's activities, the remainder of the Trust's patient-related income falls outside of the scope of Payment by Results and was received based on locally set prices and a small number of fixed price agreements, where the Trust receives a set amount of income for providing specific services.

The Payment by Results system presents the Trust with particular challenges as 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 as the 'Min' as we tend to have a higher proportion of complex patients requiring more intensive and higher cost treatment. It is therefore even more important that we focus on delivering services efficiently and effectively.

Expenditure Overview

During the year the Trust experienced significant cost inflation in relation to charges for diagnostic tests and procedures carried out by external organisations. In addition the Trust also incurred unusually high levels of unplanned medical staff expenditure to cover long-term sickness and maternity leave. Both of these issues contributed to the Trust's deficit for financial year.

The Trust is committed to providing the best possible healthcare within available resources and therefore aims to ensure that it delivers value for money across all of it's services. During 2007/08, the Trust undertook reviews in several key service areas to ensure staffing levels and skill mix were appropriate for the numbers and complexity of patients seen within the hospital. This work will continue into 2008/09 as part of our ongoing financial strategy which includes the use of benchmarking information and collaboration with other NHS bodies to the maximise value delivered from contracts with external suppliers.

Capital Developments in 2007/08

During 2007/08, the Trust carried out capital projects with an in year cost of £297k. The major item of spend was the completion of the Bath Neuro-Rehab High Dependency Unit at a cost of £200k. The new unit provides a brighter environment for up to six patients with improved hygiene facilities and reduced noise whilst giving nurses a better visibility of patients.

Our Financial Objectives as an NHS Foundation Trust

The Trust's financial performance is monitored by the Independent Regulator of NHS Foundation Trusts (Monitor), assigning a risk rating to the Trust and using a scorecard system to compare key financial metrics on a consistent basis across all NHS Foundation Trusts. As a result of the current year's financial deficit the Trust has been assigned a risk rating of 2, out of a possible maximum of 5 (the lowest risk). This means that the Trust is at risk of a significant breach of it's Terms of Authorisation in the medium term, e.g. 9 to 18 months, if remedial action is not taken.

A number of measures have already been taken to ensure the Trust delivers an improved financial performance in 2008/09 these are described in more detail below.

Managing Risks

The Trust continues to face a number of operational and strategic risks related to the clinical delivery of services and the management of capacity within the hospital. In addition the Trust is also exposed to a number of financial risks such as the risk of losing income under payment by results, if activity plans are not delivered or if demand for services is adversely affected as a result of increased contestability and patient choice. In managing these risks the Trust needs to: deliver the levels of clinical activity agreed with ours commissioners and achieve planned levels of non-contract activity within agreed waiting times; ensure we continue to provide care in safe and hygienic surroundings and meet targets for infection control and achieve efficiency savings of c£0.8m. Achievement of these objectives would improve the risk rating assigned by Monitor to a minimum rating of 3 by the end of the 2008/09 financial year and ensure ongoing financial viability and sound financial governance.

Looking Ahead

Competitive environment

With 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 hospitals and community healthcare providers.

Looking forward, the specialist nature of the services provided at the Min and its strong reputation for clinical excellence place it in an ideal position to benefit from the extension of Patient Choice. The Trust has also identified potential to expand the scope of several relatively new services which could lead to significant income growth over the next two to three years. Coupled with these plans to increase activity is the need to continue to deliver cost savings in order that the Trust lives within its means.

Future Spending Plans

The Trust has developed a financial strategy which presently includes financial projections up to and including 2010/11. During this period the Trust expects further investment in developing new services and improving the standard of accommodation and facilities for patients. In order to deliver these objectives the Trust will need to build cash surpluses and explore opportunities for external fundraising. As with all NHS Trusts and NHS Foundation Trusts, the ability to spend capital funding to improve buildings, equipment and infrastructure will be dependent upon the affordability of the revenue cost of the capital and make any loan repayments against borrowed sums. The delivery of greater financial headroom is therefore a key element in our ability to achieve these objectives. In order to improve the level of financial return the Trust makes, a number of actions have already been taken to improve financial performance in the coming financial year and beyond. These include:

- The identification of cost improvement schemes and income generation to deliver £0.8m in 2008/09 with additional savings already identified for future years

- Reviewing productivity and efficiency of services to ensure they continue to meet the needs of patients whilst delivering value for money
- Changes in processes to improve the efficiency with which the Trust manages its working capital (cash, debtors, creditors and stock)
- Reviewing services and income to ensure the Trust is recovering all income due to it under Payment by Results and NHS commissioning guidance.

Annual Accounts

Full details of the Trust's 2007/08 financial position can be found in the Trust's audited annual accounts (pages 35 to 74 of this report).

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

Going Concern

After making enquiries, the Board of Directors has a reasonable expectation that Royal National Hospital for Rheumatic Diseases NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Council of Members

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

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

On 17th March 2008, the Trust completed a successful election for the patient and public seats on the Council of Members. The following members were successful in election to the Council of Members:

Public Constituency

Judith BERESFORD-SMITH, Francis RING, Hilary ELMS, Peter MILES, Huw PONTING, Clive HOWARTH, Ben ROGERS, Steven PIKE

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

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 CoM meets formally four times a year, and informally twice a year. Council Members are requested to attend all of these meetings each of which run between 10am and 3.30pm. In addition to this time commitment for CoM meetings, the Trust holds an Annual Members Day, which the Council are asked to attend. Council Members 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 Members or request information on Council of Members meetings and attendance by Council Members 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
- 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 Members' 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 have the opportunity to put questions to the Finance Director and feed-in their views and opinions. Representatives from the non-exec directors attend the Council of Members' four formal meetings. In addition a representative from the Council of Members attends open board meetings. NEDs sits on committees along-side the Council Members, 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, to find out members' views of the hospital's services.

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 Council, ratified by a two-thirds majority. 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 media and 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 one Non Executive Director vacancy. 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 2007/08. 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, while the Remuneration Committee revised their terms of reference in order to bring them into line with the Monitor Code of Governance.

There has been no change to the commitments of the chair during the year.

There were 13 meetings of the Board during 2007/08.

The Trust's Board

Chair, Kate Lyon (term of office completed November 2007).

Kate Lyon was reappointed in 2003 for a term of four years until November 2007. Kate Lyon has previously worked in the Home Office Research Unit in London and the Universities of Bath and Bristol as a senior academic lecturer. Kate had responsibility for the Board and the overall organisation.

Kate attended 10 out of 10 Board of Directors meetings in 2007.

Chair, Brian Joakim (December 2007 onwards)

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 has recently retired from a successful career in the telecommunications and media sectors. He has held senior board/management positions with some of the world's foremost newspapers, magazines and TV Broadcasters.

Brian has responsibility for the working of the board and the overall organisation.
Brian has attended 7 out of 8 Board of Directors meetings in 2007/08.

Richard Darch, Non Executive Director

Richard was appointed to the Board in 2004 for a period of four years until January 2008. He has a background in health economics and has worked in the NHS as a freelance consultant for strategy and operations improvement in health and social care, both in this country and abroad. Richard Darch has been a member of the Foundation Trust Financing Facility since 2005.

Richard has attended 4 out of 11 Board of Directors meetings in 2007/08.

Vincent Harral, Non Executive Director

Vincent was reappointed in 2003 for a period of four years until November 2007. He agreed to extend his contract until March 2008. Vincent Harral spent thirty years in senior administrative posts within the NHS, retiring as Chief Officer of what is now the United Bristol Healthcare NHS Trust. Since retiring from the NHS he founded a trading company and ran one of the major medical charities in Bristol.

Vincent has attended 13 out of 13 Board of Directors meetings in 2007/08.

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 4 out of 5 Board of Directors meetings in 2007/08.

Kirsty Matthews, Non Executive Director, Vice Chair

Kirsty was appointed in December 2007 for a period of four years. She is the Vice Chair and Senior Independent Director. 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 attended 3 out of 3 Board of Directors meetings in 2008.

Peter Metcalfe, Non Executive Director

Peter was reappointed in 2002 for a period of four years, re-appointed for a further year until November 2007 and then extended his contract until March 2008. Peter Metcalfe has spent many years as a designer in the manufacturing industry before later establishing a design and management consultancy in Bath. In parallel, he became a part time lecturer at the London College of Furniture and eventually led the College until 1990. He served as Mayor of the City of Bath in 2005/06.

Peter has attended 11 out of 13 Board of Directors meetings in 2007/08.

David Rogers, Non Executive Director (Resigned July 2007)

David was appointed in 2005 until September 2009, David Rogers has significant and extensive experience at Board level, in both Executive and Non Executive roles within a variety of industries, including consumer electronics and telecommunications. He has a degree in business management and is a registered Corporate Representative of the Financial Authority.

David has attended 5 out of 5 Board of Directors meetings in 2007.

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 this year. 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 3 out of 3 Board of Directors meetings in 2008.

Julie Spencer-Cingoz, Non Executive Director

Julie Spencer-Cingoz was appointed in September 2007 for a term of four years. 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 has just stepped down after eight years 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 and she currently chairs the charity board.

Julie has attended 5 out of 6 Board of Directors meetings in 2007/08.

Appointment of the Chief Executive and Board of Directors

The Chief Executive is appointed by the Board of Directors, as a substantive appointment that may be terminated by application of the Trust's Disciplinary or other appropriate procedures. The Executive Directors are appointed by the Chief Executive and Non-Executive members of the Board as substantive appointments that may be terminated by application of the Trust's Disciplinary or other appropriate procedures.

Nicola Carmichael, Chief Executive

Appointed as Chief Executive in 1993, Nicola has many years experience of strategic leadership in clinical health services. During her time with the Trust she has successfully led the organisation and has facilitated the introduction of new services.

Nicola has attended 11 out of 13 Board of Directors meetings in 2007/08.

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 1 out of 1 Board of Directors meetings in 2008.

Paul Dodd, Finance Director (Resigned February 2008)

Paul Dodd joined the Trust in May 2006 and was appointed to the post of Finance Director in July 2006. He has extensive experience of the NHS having previously worked for the Strategic Health Authority, the Department of Health, and numerous Trusts throughout England, Wales and Northern Ireland including serving as Director of Finance for two NHS Trusts. Prior to joining the NHS in 1990 he worked in Local Government.

Paul has attended 10 out of 12 Board of Directors meetings in 2007/08.

Chris Fokke, Director of Clinical Practice/Nursing Professional Advisor

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 8 out of 13 Board of Directors meetings in 2007/08.

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 4 out of 13 Board of Directors meetings in 2007/08.

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 11 out of 13 Board of Directors meetings in 2007/08.

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, 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 13 out of 13 Board of Directors meetings in 2007/08.

Audit Committee

Audit Committee membership: Vincent Harral was the Chair for the Committee meetings up to and including the 28th January; Sir Peter Spencer joined the Committee on 28th January and chaired the meeting on 27th March 2008. Sir Peter will be the chair of the Committee during 2008-09.

There were four meetings of the Committee in 2007-08. Vincent Harral attended all meetings, Peter Metcalfe attended three meetings, Richard Darch, a member until 30th September 2007 attended one meeting and Brian Joakim, who was a member of the Committee during his period as a Non-Executive Director and before taking the Chair of the Trust, attended the one meeting that occurred during that period.

During 2007-08 the Audit Committee 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 Committee would note:-

- The monitoring and testing of the annual accounts, including the Trust's charitable fund annual accounts, the financial systems and systems of internal control that exist within the Trust, including those for risk assessment.

- Monitoring the work, including the work plans, of both external and internal auditors, meeting with them, considering their progress and recommendations and implementing these where appropriate.

- Monitoring the introduction of revised systems of working within the department of the Director of Finance, receiving reports on these, liaising with the external and internal auditors about the effect of those changes on their work and reporting on all aspects of the change to the Board.

- The maintenance of timely and adequate reporting arrangements with the Board of Directors and, where appropriate, with the Council of Members. Reviewing those reports made direct to the Board by the Director of Finance relating to the financial performance and cash position and commenting on these where required.

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. During the year Council accepted a recommendation of the Committee, made via the Board of Directors, for the re-appointment of the existing external auditors for 2008-09. There were no additional (non-audit) services provided by the external auditors during 2007-08.

The Committee would wish to place on record its appreciation of the ready assurance and guidance given by both the external and internal auditors during 2007-08 and

also the contribution made to work of the Committee by the two representatives of the Council of Members who have been in attendance at its meetings.

Appointments Committee of Council of Members

The appointments committee of the Council of Members is responsible for the appointment and remuneration of the chairman and other non-executive directors of the Board. During 2007-8 the committee met once formally to agree the forthcoming appointment process and to set the remuneration levels of chair and non-executive directors.

The appointments committee commissioned an independent report from consultants to review the market and advise on appropriate levels of remuneration for chair and non-executive directors and set levels accordingly at £30k for chairman and £9k for non-executive directors.

The appointments committee then oversaw the appointment of a new chair and four non-executive board members with the committee fully involved in the national advertising campaign, interview and selection process. One non-executive vacancy still remains to be filled.

The committee meeting was attended by Tony Barber, Don Boyland, Elizabeth Brearly and John De-Norman from the appointments committee. Phillip Waite, from Inventures Consultants, Richard Darch, then Chair of the Board's Remuneration Committee, Nicola Carmichael, Chief Executive, and Karen Kerley, HR and Membership Director, were in attendance for relevant parts of the meeting. (Richard Darch left the meeting prior to discussion about non-executive remuneration.)

Membership

Membership is free, there are no obligations if you sign up as a member. On the registration form there are 3 levels of membership:

Level 1 All members receive a regular newsletter and information.

Level 2 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 For further active membership involvement some members attend working groups and meetings or stand for election to the Council of Members. 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 2008, the RNHRD had 5163 members, with 3805 patient members, 938 public members and 420 staff members.

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

Membership Strategy

A group consisting of representatives from the Council of Members and some active members has reviewed the Trust's Membership Strategy. This strategy 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 Member's accountability and responsibility and how the Trust will work in partnership with the CoM 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 bi-annual Minformation newsletter, with increased feedback from members in response to April and October editions and increased email correspondence with members to reduce mailing costs.

Members were invited to attend our Annual Members Day in June 07. This was an opportunity to provide information on the work of the Trust and its accounts and gather feedback from members that influenced the work of the Trust in developing patient information, the infection control service at the Min and the development of the purpose of membership.

We also invited members to:

- become involved in the development of our equality schemes and action plans,
- attend CoM meetings,
- vote for their representatives on the CoM,
- become an elected member of the CoM,
- join the CoM Membership Sub-group,
- apply for volunteer roles,
- attend the Medicine at the Min lectures, to attend the Trust's AGM,
- feedback in the re-branding and re-naming consultation, and
- join the Friends of the Min.

The Trust aims to have a diverse and representative membership. We are working towards a system which informs all new patients about membership opportunities. Our Council of Members 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 monthly coffee mornings at the hospital to communicate with members and patients. We have also provided information on the hospital and membership of

the hospital to minority groups, such as The Bath and Bristol Race Equality Councils, across the South West area.

Public Interest Disclosures

Communication and Consultation

The Trust continues to communicate and consult with staff at many levels and using different methods and media.

The Trust's "Executive Committee" of middle managers meets monthly for discussion and information sharing. Managers then cascade information from the meeting to their staff groups.

The Links Partnership Committee meets monthly with manager and staff representation. Staff representatives on the partnership committee meet with nominated staff representatives and other interested staff at monthly "Link Up" meetings to hear issues of concern and feedback on management actions. The communication process is supported by a formal "Links Brief" newsletter issued once a month.

The Chief Executive holds regular open meetings with staff throughout the year. Additional open briefings have been held with the Chief Executive and Directors to support particular consultation issues, for instance our "Keeping Ahead of the Game" consultation which involved briefing on the economic position of the Trust and consultation about ways in which the Trust could position itself for the future. This consultation lead to the development of proposed changes to working practices in some areas of the Trust and formal consultation was held on those issues affecting particular staff groups in accordance with the Trust policy on Organisational Change.

Good use is also made of the Trust's internal intranet based "Mintranet Café" to support discussion around any issue of concern to staff and to hear staff suggestions and comments about ongoing issues.

Equalities (Policies applied to Staff with Disabilities)

The Trust has developed a gender equality scheme within the last year and continues to take forward actions within its current disability and race equality schemes.

The Trust uses the "two ticks" logo to recognise our working practices for the full and fair consideration to applicants for employment by disabled employees and for training, development and promotion. A questionnaire has been issued to all staff aimed at identifying any issues and concerns of those staff with disabilities. We regularly assist members of staff who become disabled, for instance by the regular purchase of equipment that can help them in their roles, by making adjustments to work or if necessary by assisting with redeployment to alternative roles.

Countering Fraud and Corruption

The Trust's counter fraud arrangements 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 Countering Fraud and Corruption Policy.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all valid non NHS invoices within 30 days of receipt or the due date whichever is the latter. The Trust has made improvements in 2007/08 and hopes to continue this improvement in 2008/09.

Better Payment Practice Code - measure of compliance

	2007/08		2006/07	
	Number	£000	Number	£000
Total bills paid in the year	5,755	6,659	6,708	5,565
Total bills paid within target	3,106	1,887	1,210	1,232
Percentage of bills paid within target	53.97%	28.34%	18.04%	22.14%

No payments were made arising from claims made by businesses under the Late Payment of Commercial Debts (Interest) Act 1998.

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.

Remuneration Report

Remuneration Committee Chair: Richard Darch to January 2008, Brian Joakim from February 2008. Members: Trust Chair and all non-executive directors.

The Remuneration Committee is responsible for determining remuneration of the Executive Directors. 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.

In 2007/8, the Remuneration Committee commissioned an independent report from NHS Partners to review the market and advise on levels of Remuneration. During 2007/8, the Remuneration Committee met three times. The meetings were attended as follows:
11th September 2007: Richard Darch.(in the Chair), Brian Joakim, Kate Lyon, Peter Metcalfe. P. Waite (Inventures), Nicola Carmichael, Paul Dodd, Dr. Tim Jenkinson were in attendance for part of the meeting. Paul Dodd and Tim Jenkinson left the meeting prior to discussions about Executive Directors salaries, and Nicola Carmichael left the meeting prior to discussions about Chief Executive remuneration.
22nd November 2007: Vincent Harrall (in the Chair), Brian Joakim, Kate Lyon, Peter Metcalfe. Nicola Carmichael was in attendance.
11th March 2008. Brian Joakim (in the Chair). Peter Spencer, Kirsty Matthews. Nicola Carmichael was in attendance.

Remuneration and terms and conditions of service for the Chair and non-executive Directors are decided by the Council of Members Appointments Committee. The Appointments Committees reviewed Chair and non-executive Director remuneration in 2006/07.

Salary and pension entitlements of senior managers are detailed in note 6.3 of the Accounts. Details of Pension Costs are given in note 1.9 of the Accounts.

No compensation was payable to former senior managers during the year 2007/8.

No payments subject to performance conditions were made in 2007/8, and the Remuneration Committee did not have a policy in place to award payments subject to performance conditions.

No non-cash benefits (benefits in kind) were awarded or given.

The Remuneration Committee has a policy of offering substantive contracts of employment. Previously, all contracts have been subject to 3 months notice, and in 2005/6 the Remuneration Committee reviewed this policy and increased the period of notice to 6 months for all future Executive appointments.

The Remuneration Committee policy on termination payments is that executive director posts are subject to Agenda for Change terms and conditions of service and to all relevant Trust policies and procedures, including the policy for Organisational Change which specifies termination payments where termination is as a result of organisational change.

Name	Role	Date of Contract	Unexpired term	Notice period
Nicola Carmichael	CEO	1999	N/A	6 months
Rod Barnes	Dir Finance	25.2.08	N/A	6 months
Hayley Sewell	Dir Gov &Perf	07.07.03	N/A	3 months
Chris Fokke	Dir Clinical Prac	01.08.05	N/A	3 months
Karen Kerley	Dir HR and Mbrship	01.10.05	N/A	1 month
Brian Joakim	Chair	01.12.07	30.11.10	3 months
Chris Johns	Non Exec	01.10.07	01.10.10	3 months
Kirsty Mathews	Non Exec	01.12.07	30.11.10	3 months
Peter Spencer	Non Exec	03.12.07	02.12.10	3 months
Julie Spencer Cingoz	Non Exec	05.09.07	04.09.10	3 months

Accounting policies for pensions and other retirement benefits are set out in note 1.9 to the accounts and the details of senior employees' remuneration can be found in note 6.3 of accounts.

Nicola Carmichael
Chief Executive

Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

Annual Accounts

Year Ended 31st March 2008

ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FOUNDATION TRUST

2007/2008 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

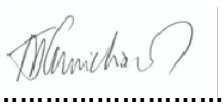
- prepare the financial statements on a going concern basis.

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 a director 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 on 22 October 2007.



Signed……

Nicola Carmichael - Chief Executive

Date: 13 June 2008

ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FOUNDATION TRUST

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 Royal National Hospital for Rheumatic Diseases NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Royal National Hospital for Rheumatic Diseases NHS Foundation Trust for the year ended 31 March 2008 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 Board developing and agreeing the Assurance Framework
- Accountability of the Risk Management Steering Group to the Trust Audit Committee.
- Monthly meetings of the Risk Management Steering Group, which is chaired by the Chief Executive. Other members of the committee include the Trust Chair, the Director of Finance, Medical Director, the Director of Governance and Performance, and Facilities Manager.
- Board review of the work of the Risk Management Steering Group.
- The regular production, implementation and monitoring of risk assessment and management plans through the Risk Management Steering Group, the Audit Committee and the Board.

All staff in the Trust are trained and equipped to manage risk in a way appropriate to their authority and duties. Action taken by the Trust in 2007/8 included:

- A review of the Trust Risk Register and action plans to reduce levels of risk.
- Training in risk management for all staff at induction and mandatory training updates. This training included the use of the risk management system and a clear explanation of their responsibilities and duties
- Training in root cause analysis
- Monitoring of staff attendance at mandatory training
- Regular briefs on risk management issues and practice produced by the Risk Management Committee at each meeting

The Risk Management Steering Group regularly reviews hazard and incident reports, formal and informal complaints and other patient feedback, health and safety and good practice guidance and examples.

Learning from experience within the Trust and from outside, is disseminated through staff induction and training and the monthly Risk Management brief.

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, including clinical risk. The key elements of the Risk Management Strategy aim to ensure that:

- management processes are in place to minimise 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.

Trust 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 hazards in their area of work. Appointed 'Competent Persons' assist in the identification and evaluation process.

The Trust has established a Trust wide Risk Register using the Datix risk management 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 action 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 organisation's 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 identifies the systems of assurance that these controls are in place and effective. 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 on Internal Control, clearly identifying any gaps in control or assurance in key risks to the Trust.

The Trust Board regularly reviewed the assurances identified in the Framework during the year 2007/08 to ensure that internal controls identified in the Board Assurance Framework were in place and effective.
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. The Council of Members and annual Member's day provide a forum where public stakeholders can identify, question and be involved in managing risks which might impact on them. Representatives of the Council of Members are in attendance at the Trust audit committee, and open Board Meetings where the Assurance framework is reviewed. Members have contributed to identifying risks for inclusion in the Trust's Assurance framework.

The Trust uses the Information Governance Toolkit to ensure that risks are identified and managed. In 2007/08, there were no serious untoward incidents involving data loss or confidentiality breach. The Trust's self-assessment of Information Governance risk resulted in a score of 90%; no major risks were identified. This information is reviewed by the Information Governance Committee which is chaired by the Director of Governance and Performance.

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

The Trust Strategy was developed by the Trust Board with key internal and external stakeholders and members of the public. The Strategy sets strategic objectives for the organisation which will be reviewed in 2008. The Trust's Annual 3 year plan agreed by the Board sets out operational objectives for delivery of the Trust's strategy, including expenditure proposals and productivity improvement objectives. The Annual plan objectives are used to prioritise capital expenditure plans.
Implementation of the operational objectives is taken forward through Executive Directors' Specialty Reviews, where any variance against objectives is reported and remedial action agreed where necessary. Progress with implementation and action to address variance is regularly reviewed by the Trust Board.
The Trust Board also monitors progress with implementation through regular financial and activity reports compared to plan, and through clinical and information governance reports.
The Trust Board is has established an Audit Committee which identifies key risks to achievement of the Trust's strategic business and operational objectives and agrees an assurance framework which identifies controls and assurances on the effectiveness of controls which are regularly reviewed by the Board. Independent assurance is provided to the Board by internal auditors, and the Audit committee regularly reviews risks, controls and assurance including assurance provided by the Trust's internal and external auditors. The Audit committee reviews recommendations made by the Trust's auditors and receives reports on progress with their implementation within the Trust. Independent assurance is also provided by the Commission for Health annual rating and by periodic assessments including the NHS litigation scheme.
The Trust has specific objectives to manage and improve value for money which are agreed by the Trust board. Progress with implementation is overseen by the Trust Board by review of Financial and Executive Director reports. The Trust Board and the Audit committee approve policies, procedures and systems that are designed to promote and ensure probity and propriety in the conduct of the Trusts business.
The Trust maintains an asset register and plans to upgrade this facility in 2008/9.
The Trust's Council of Members, the Annual member's day and the Patient Advise and Liaison officer are channels of communication with patients and their representatives, and other stakeholders.

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 risk management committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.
The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- Clinical Governance reviews
- Feedback on quarterly reports from Monitor.
- Healthcare Commission Annual Healthcheck Assessment
- Clinical Negligence Scheme for Trusts (CNST)
- PEAT reviews and inspections
- Patient reviews – National and local satisfaction surveys, patient forum
- Health and Safety Executive
- Benchmark data including NHS Estates and Information Governance Assessment
- Work of the Risk Management and Health and Safety Committees
- Outcome of internal and external audit of practice and control systems and procedures

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee, Clinical Governance Committee, Information Governance Committee, and the Risk Management Committee.

The Trust's Head of Internal Audit has advised that 2007/08 audit work included one report for which a limited assurance opinion was given: IT Disaster Recovery. Internal auditors raised one fundamental and two significant recommendations in respect of IT Disaster Recovery. These related to:

- Management should ensure that a documented disaster recovery plan is developed, approved by management and circulated to key staff.
- Roles and responsibilities of staff should be included within the plan to identify the key tasks to be undertaken following an incident.
- Management should ensure that the IT Disaster plan is periodically tested.

A documented disaster recovery plan has been developed and a plan to address weaknesses and ensure continuous improvement of the system is in place.

However, the recently appointed Director of Finance has identified weaknesses in the way in which the Trust accrues for income and expenditure, and in control accounts which appear to have a significant effect on the financial position of the Trust. This weakness may also impact significantly on the Trust's ability to achieve its objectives for 2007/08. An initial plan to address weaknesses and achieve improved control has been approved by the Board and is in place, and further work will be undertaken to ensure continuous improvement of the system.

The Board, Executive Team, Clinical Governance Committee and the Audit Committee continue to regularly review and take action to maintain the effectiveness of the system of internal control. Heads of department review key risks and controls measures as part of their Annual Planning

process, and where relevant these are incorporated into personal objectives and reviewed in Personal Development reviews.

The Healthcare Commission assesses Trust performance in key risk areas. The Trust has completed a self-assessment against those standards, and has not identified any significant areas of weakness. The self-assessment has been reviewed and approved by the Board.

Conclusion

The Trust's Head of Internal Audit has identified one fundamental and two significant control issues in relation to I.T. disaster recovery and a plan to address weaknesses and ensure continuous improvement of the system is in place. In addition, in 2008/09 the Trust has identified weaknesses in the way in which the Trust accrues for income and expenditure, and in control accounts which appear to have a significant effect on the financial position of the Trust. This weakness may impact significantly on the Trust's achievement of its objectives for 2007/08. An initial plan to address weaknesses and achieve improved control has been approved by the Board and is in place, and further work will be undertaken to ensure continuous improvement of the system.

Nicola Carmichael
Chief Executive

13 June 2008

INDEPENDENT AUDITORS' REPORT TO THE COUNCIL OF MEMBERS 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 2008 which comprise the Income and Expenditure Account, the Balance Sheet, the Statement of Total Recognised Gains and Losses, the Cashflow Statement and the related notes. These financial statements have been prepared in accordance with the accounting policies set out therein. We have also audited the information in the Directors' Remuneration Report that is described as having been audited.

Respective Responsibilities of Directors and Auditors

The Foundation Trust is responsible for preparing the Annual Report, the Directors' Remuneration Report and the financial statements in accordance with directions issued by the Independent Regulator of Foundation Trusts ("Monitor") under the National Health Service Act 2006. Our responsibility is to audit the financial statements and the part of the Directors' Remuneration Report to be audited in accordance with relevant statute, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (UK and Ireland).

This report, including the opinion, is made solely to the Council of Members of the Royal National Hospital NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and for no other purpose. We do not, in giving this opinion, 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.

We report to you our opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the directions issued by Monitor under the National Health Service Act 2006. We also report to you whether in our opinion the information given in the Directors' Report and Financial Review is consistent with the financial statements.

We review whether the Accounting Officer's statement on internal control is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the Accounting Officer's statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the NHS Foundation Trust's corporate governance procedures or its risk and control procedures.

We read other information contained in the Annual Report, and consider whether it is consistent with the audited financial statements. This other information comprises only the Director's report, Financial Review, Background Information, Chair's Statement, the unaudited elements of the Directors' Remuneration Report, the Board of Governors, Board of Directors, Membership and Public Interest Disclosures. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any other information.

In addition we report to you if, in our opinion, the NHS Foundation Trust has not kept proper accounting records, if we have not received all the information and explanations we require for our audit, or if information specified by law regarding directors' remuneration and other transactions is not disclosed.

Basis of audit opinion

We conducted our audit in accordance with section 62 and Schedule 10 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with relevant auditing standards issued by the Auditing Practices Board.

An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgements made by the NHS Foundation Trust in the preparation of the financial statements, and of whether the accounting policies are appropriate to the NHS Foundation Trust's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements and the part of the Remuneration Report to be audited are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinion

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 affairs of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust as at 31 March 2008 and of its income and expenditure for the year then ended;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and the directions made thereunder by Monitor; and
- the information given in the Directors' Report and Financial Review is consistent with the financial statements.

Certificate

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.

Signature:... PricewaterhouseCoopers LLP

Date:…16 June 2008…….

PricewaterhouseCoopers LLP
31 Great George Street
Bristol
BS1 5QD

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2008 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……

Nicola Carmichael - Chief Executive

Date: 13 June 2008

INCOME AND EXPENDITURE ACCOUNT

for the year ended
31st March 2008

	NOTE	2007/08 £000	Restated 2006/07 £000
Income from activities	3-4	12,040	11,981
Other operating income	5	4,197	3,755
Operating expenses	6-7	(16,356)	(16,087)
OPERATING DEFICIT		(119)	(351)
Net financing income	8	25	7
DEFICIT FOR THE FINANCIAL YEAR		(94)	(344)
Public Dividend Capital dividends payable	9	(326)	(284)
RECORDED DEFICIT FOR THE YEAR		**(420)**	**(628)**

The notes on pages 49 to 74 form part of the accounts.

All activities are classed as continuing.

BALANCE SHEET
as at
31st March 2008

	NOTE	31st March 2008 £000	Restated 31st March 2007 £000
FIXED ASSETS			
Intangible assets	13	50	32
Tangible assets	14	9,074	8,550
		9,124	**8,582**
CURRENT ASSETS			
Stocks and work in progress	15	6	6
Debtors	16	2,326	1,680
Cash at bank and in hand		523	653
		2,855	**2,339**
CREDITORS: Amounts falling due within one year	17	**(3,895)**	**(3,047)**
NET CURRENT LIABILITIES		**(1,040)**	**(708)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**8,084**	**7,874**
PROVISIONS FOR LIABILITIES AND CHARGES	18	0	0
TOTAL ASSETS EMPLOYED		**8,084**	**7,874**
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital		6,015	6,015
Revaluation reserve	20	1,572	894
Donated asset reserve	20	351	399
Other reserves	20	0	0
Income and expenditure reserve	20	146	566
TOTAL TAXPAYERS' EQUITY	25	**8,084**	**7,874**

These accounts have been approved by the Board of Directors on 13 June 2008 and signed on its behalf by:

Nicola Carmichael - Chief Executive
13 June 2008

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES
for the year ended
31st March 2008

	2007/08	Restated 2006/07
	£000	£000
Surplus for the financial year before dividend payments	(94)	(344)
Unrealised surplus on fixed asset revaluations	678	0
Reductions in the donated asset reserve due to the depreciation, impairment and disposal of donated assets	(48)	(52)
Total recognised gains for the financial year	**536**	**(396)**
Prior period adjustment	(583)	0
Total gains and losses recognised in the financial year	**(47)**	**(396)**

In finalising the accounts for the year ended 31 March 2008, the directors became aware of certain matters which were incorrectly reported in the 2006/07 financial statements. Prior year adjustments have been incorporated into these financial statements in respect of those items. The restated items are indicated by reference in all other places in these financial statements.

The adjustments relate to invoices received prior to and during 2006/07 but not accrued in the 2006/07 accounts and credit notes relating to underperformance in 2005/06 which had not been carried forward into the 2006/07 balance sheet, an overstatement of private patient income in 2006/07 and an overstatement of Education and Training income.

The impact of these adjustments on the affected 2006/07 figures is set out below:

	2006/07 as reported	Income adjustments	Unrecognised liabilities	2006/07 restated
	£000	£000	£000	£000
Income & expenditure account				
Income from activities	12,013	(32)	-	11,981
Other operating income	3,848	(93)	-	3,755
Operating expenses	(15,629)	-	(458)	(16,087)
Operating surplus / (deficit)	232	(125)	(458)	(351)
Net financing income	7	-	-	7
Surplus/(deficit) for the financial year	239	(125)	(458)	(344)
Public dividend capital dividend payable	(284)	-	-	(284)
Recorded (deficit) for the year	(45)	(125)	(458)	(628)

CASH FLOW STATEMENT
for the year ended
31st March 2008

	NOTE	2007/08 £000	2006/07 £000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	21.1	**485**	**775**
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		25	7
Interest paid		0	0
Net cash inflow from returns on investments and servicing of finance		**25**	**7**
CAPITAL EXPENDITURE			
Payments to acquire tangible fixed assets		(292)	(693)
Receipts from sale of tangible fixed assets		0	0
Payments to acquire intangible assets		(22)	0
Net cash outflow from capital expenditure		**(314)**	**(693)**
DIVIDENDS PAID		**(326)**	**(284)**
Net cash outflow before financing		**(130)**	**(195)**
FINANCING			
Public dividend capital received		0	343
Net cash inflow from financing		**0**	**343**
Increase / (Decrease) in cash		**(130)**	**148**

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 2007/08 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.

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 2008 as at the prospective valuation date of 31 March 2008.

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.

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, respectively.

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

	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.

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 determine 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 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 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 2008

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 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

The Trust has adopted FRS 26 Financial Instruments: Recognition and Measurement and FRS 29 Financial Instruments Disclosure for the first time this year. This adoption represents a change in accounting policy. There is no prior period adjustment to reserves resulting from adoption of these standards as there is no material impact.

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	**2007/08**	**Restated 2006/07**
	£000	£000
Elective income	4,834	4,731
Non-elective income	4,483	4,550
Outpatient income	2,278	2,709
Other types of activity income	256	111
PBR clawback	0	(235)
Private patient income	189	115
	12,040	**11,981**
Income from mandatory services	11,851	11,866
Income from non-mandatory services	189	115
	12,040	**11,981**

4. Private patient income	**2007/08**	**Restated 2006/07**	**2002/03**
	£000	£000	£000
Private patient income	189	115	128
Total patient related income	14,442	14,048	9,748
Proportion (as a percentage)	**1.31%**	**0.82%**	**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.

	2007/08	**2006/07**
PCT Income	11,841	11,856
High Cost Drugs Income	2,412	2,077
Private Patient Income	189	115
Total Patient Related Income	**14,442**	**14,048**

5. Other operating income	**2007/08**	**Restated 2006/07**
	£000	£000
Research and development	364	697
Education and training	864	356
Transfers from donated asset reserve	48	52
Charitable and other contributions to expenditure	8	54
Drugs income	2,412	2,077
Other income	501	519
	4,197	**3,755**

6. Operating expenses

6.1 Operating expenses comprise:

	2007/08	Restated 2006/07
	£000	£000
Services from NHS Trusts	672	0
Services from other NHS bodies	241	175
Executive directors costs	428	474
Non-executive directors' costs	42	40
Staff costs	9,757	9,807
Drug costs	2,635	2,144
Supplies and services - clinical (excluding drug costs)	401	836
Supplies and services - general	139	209
Establishment	254	225
Transport	19	150
Premises	839	614
Bad debts	67	(16)
Depreciation and amortisation	455	422
Audit fees	37	55
Other auditor's remuneration	8	0
Clinical negligence	0	0
Other	362	952
	16,356	**16,087**

6.2 Operating leases

6.2.1 Operating expenses include:-

	2007/08	Restated 2006/07
	£000	£000
Hire of plant and machinery	0	0
Other operating lease rentals	59	59
	59	**59**

6.2.2 Annual commitments under non - cancellable operating leases are:

	Land and buildings	
	2007/08	Restated 2006/07
	£000	£000
Operating leases which expire:		
Within 1 year	0	0
Between 1 and 5 years	59	59
After 5 years	0	0
	59	**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)
2007/08	£000	£000	£000	£
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	5-10	0	0	0
Vincent Harral - Non Exec	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
2006/07				
Nicola Carmichael, Chief Executive	80-85	0	0	0
Dr Anthony K Clarke, Medical Director	95-100	55-60	0	0
Steven Haynes, Finance Director (until May 2006)	5-10	0	0	0
Paul Dodd, Finance Director (from May 2006)	60-65	0	0	0
Karen Kerley, Director of Human Resouces & Membership	45-50	0	0	0
Sue Gray, Director of Clinical Services (until October 2006)	25-30	0	0	0
Chris Fokke, Director of Clinical Practice/Nursing Professional Advisor	45-50	0	0	0
Hayley Sewell, Director of Governance & Performance	45-50	0	0	0
Kate Lyon - Chairperson	15-20	0	0	0
David Rogers - Non Exec (from October 2006)	0-5	0	0	0
Richard Darch - Non Exec	5-10	0	0	0
Peter Metcalfe - Non Exec	5-10	0	0	0
Vincent Harral - Non Exec	5-10	0	0	0
Michael Bowden - Non Exec (until October 2006)	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 2008 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2008	Cash Equivalent Transfer Value at 31 March 2007	Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000
Nicola Carmichael, Chief Executive	2.5-5.0	115-120	442	401	31
Dr Tim Jenkinson, Medical Director	15.0-17.5	65-70	264	188	71
Paul Dodd, Finance Director (until Feb 2008)	0-2.5	35-40	143	119	21
Rod Barnes, Finance Director (from Feb 2008)	0-2.5	55-60	171	140	28
Karen Kerley, Director of Human Resouces & Membership	2.5-5.0	15-20	53	37	15
Chris Fokke, Director of Clinical Practice/Nursing Professional Advisor	5.0-7.5	40-45	147	118	26
Hayley Sewell, Director of Governance & Performance	5.0-7.5	30-35	104	82	20

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

	2007/08	2006/07
	£000	£000
Salaries and wages	**8,326**	**8,559**
Social Security costs	**595**	**570**
Employer contributions to NHSPA	**929**	**915**
Agency and contract staff	**335**	**237**
	10,185	**10,281**

7.2 Average number of persons employed

	2007/08 Total Number	Permanently Employed	Other	2006/07 Total Number
Medical and dental	**15**	15	0	**18**
Administration and estates	**112**	112	0	**91**
Healthcare assistants & other support staff	**0**	0	0	**44**
Nursing, midwifery & health visiting staff	**95**	95	0	**115**
Scientific, therapeutic and technical staff	**63**	63	0	**14**
Bank and agency staff	**75**	0	75	**41**
Total	**360**	**285**	**75**	**323**

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 2007/08.

8. Net financing income

	2007/08	2006/07
	£000	£000
Interest receivable	25	7
	25	**7**

9. Public Dividend Capital dividend

	£000	£000
Actual public dividend capital dividend incurred during the year	**326**	**284**
	%	**%**
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

	2007/08		2006/07	
	Number	£000	**Number**	£000
Total bills paid in the year	5,755	6,659	6,708	5,565
Total bills paid within target	3,106	1,887	1,210	1,232
Percentage of bills paid within target	53.97%	28.34%	18.04%	22.14%

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 were no amounts 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

	2007/08 Software Licences £000	2006/07 Software Licences £000
Gross cost at 1 April 2007	181	181
Additions	22	0
Gross cost at 31 March 2008	**203**	**181**
Accumulated amortisation at 1 April 2007	149	145
Provided during the year	4	4
Disposals	0	0
Accumulated amortisation at 31 March 2008	**153**	**149**
Net book value		
- Purchased at 1 April 2007	32	36
- Purchased at 31st March 2008	50	32

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	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2007	2,165	6,716	1,390	48	596	62	10,977
Additions - purchased	0	288	3	0	6	0	297
Impairments	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Other revaluations	643	(1089)	0	0	0	0	643
Disposals	0	0	0	0	0	0	0
At 31 March 2008	**2,808**	**7,004**	**1,393**	**48**	**602**	**62**	**11,917**
Accumulated depreciation at 1 April 2007	0	809	1,036	24	506	52	2,427
Provided during the year	0	315	77	2	52	5	451
Impairments	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Other revaluations	0	(1,124)	0	0	0	0	(1,124)
Disposals	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2008	**0**	**0**	**1,113**	**26**	**558**	**57**	**1,754**
Net book value							
- Purchased at 1 April 2007	2,165	5,567	295	24	90	10	8,151
- Donated at 1 April 2007	0	340	59	0	0	0	399
Total at 1 April 2007	**2,165**	**5,907**	**354**	**24**	**90**	**10**	**8,550**
- Purchased at 31 March 2008	2,807	5,529	255	22	44	5	8,662
- Donated at 31 March 2008	1	386	25	0	0	0	412
Total at 31 March 2008	**2,808**	**5,915**	**280**	**22**	**44**	**5**	**9,074**

14.2 Analysis of tangible fixed assets

Net book value							
Protected assets at 31 March 2008	2,808	5,915					8,723
Un-protected assets at 31 March 2008	0	0	280	22	44	5	351
	2,808	**5,915**	**280**	**22**	**44**	**5**	**9,074**

14.3 Tangible fixed assets (contd)

Of the totals at 31 March 2008, there were no assets valued at open market value.

There were no assets held under Finance Leases or Hire Purchase contracts at the balance sheet date.

15. Stocks and Work in Progress

	31 March 2008 £000	31 March 2007 £000
Raw materials and consumables	**6**	**6**

16. Debtors

	31 March 2008 £000	Restated 31 March 2007 £000
Amounts falling due within one year:		
NHS trade debtors	**1,349**	**1,387**
Provision for irrecoverable debts	**(125)**	**(58)**
Other prepayments and accrued income	**110**	**134**
Other debtors	**992**	**217**
	2,326	**1,680**

17. Creditors

Creditors at the balance sheet date are made up of:	**31 March 2008**	**Restated 31 March 2007**
	£000	£000
Amounts falling due within one year:		
NHS trade creditors	**2,037**	**1,435**
Non - NHS trade creditors - revenue	**1,484**	**1,182**
Non - NHS trade creditors - capital	**63**	**58**
Tax and social security costs	**187**	**191**
Other creditors	**27**	**0**
Accruals and deferred income	**97**	**181**
	3,895	**3,047**

1. There were no amounts falling due after more than one year.

2. NHS creditors include:

£112k outstanding pensions contributions as at 31 March 2008.

18. Provisions for liabilities and charges

£14k has been included in the provisions of the NHSLA at 31st March 2008, in respect of Clinical Negligence Provisions for the Trust. (31st March 2007 was £7k)

19. Prudential Borrowing Limit

	Total £000
Prudential borrowing limit set by Monitor	1,800
Actual borrowing in the year	0

The Trust had a £1,000,000 approved working capital facility in place.

	2007/08		2006/07	
Financial Ratios	**Actual PBL Ratios**	**Approved PBL Ratios**	**Actual PBL Ratios**	**Approved PBL Ratios**
Maximum Debt/Capital Ratio	0	0	0	0
Minimum Dividend Cover	1.7x	0.0	2.3x	3.3x
Minimum Interest Cover	0	0	0	0
Minimum Debt Service Cover	0	0	0	0
Maximum Debt Service to Revenue	0%	0%	0%	0%

20. Movements on reserves

Movements on reserves in the year comprised the following:

	Revaluation reserve	Donated Asset reserve	Income and Expenditure reserve	Other reserves	**Total**
	£000	£000	£000	£000	**£000**
At 1 April 2007	894	399	1,149	0	**2,442**
Prior Period Adjustments	0	0	(583)	0	**(583)**
At 1 April 2007, as restated	894	399	566	0	**1,859**
Transfer from the Income and Expenditure account	0	0	(420)	0	**(420)**
Surplus/(deficit) on revaluations of fixed assets and current asset investments	678	0	0	0	**678**
Transfer to the I & E Account for Depreciation, impairment, and disposal of donated assets	0	(48)	0	0	**(48)**
Movements on other reserves	0	0	0	0	**0**
At 31 March 2008	**1,572**	**351**	**146**	**0**	**2,069**

21. Notes to the cash flow statement

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

	2007/08	Restated 2006/07
	£000	£000
Total operating deficit	(119)	(351)
Depreciation and amortisation charge	455	422
Transfer from donated assets reserve	(48)	(52)
Decrease/(Increase) in debtors	(646)	(381)
Increase in creditors	843	1,137
Decrease in provisions	0	0
Decrease in stocks	0	0
Net cash inflow from operating activities	**485**	**775**

21.2 Reconciliation of net cash flow to movement in net debt

	2007/08	2006/07
	£000	£000
Increase / (Decrease) in cash in the period	(130)	148
Change in net funds resulting from cashflows	**(130)**	**148**
Net funds at 1 April 2007	653	505
Net funds at 31 March 2008	**523**	**653**

21.3 Analysis of changes in net debt

	At 31 March 2008	Cash flows	At 1 April 2007
	£000	£000	£000
OPG cash at bank	**481**	79	402
Commercial cash at bank and in hand	**42**	(209)	251
	523	**(130)**	**653**

22. Capital commitments

The Trust had capital commitments of £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 2007/8.

24. Contingent liabilities

There are no contingent liabilities.

25. Movements in Taxpayers' equity

	£000
Surplus for the financial year	**(94)**
Public dividend capital dividends	**(326)**
Surplus from revaluations of fixed assets and current asset investments	**678**
New public dividend capital	**0**
Public dividend capital repaid	**0**
Public dividend capital repayable	**0**
Transfers from the donated asset reserve	**(48)**
Net increase in Taxpayers' equity	**210**
Opening Taxpayers' equity at 1st April 2007	**8,457**
Prior period adjustments	**(583)**
Restated opening Taxpayers' equity at 1st April 2007	**7,874**
Closing Taxpayers' equity at 31st March 2008	**8,084**

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 £8,290 from Funds Held on Trust in 2007/8. The Trust processed payments totalling £69,479 in 2007/8.

Funds Held on Trust owed the Trust £10,948 as at 31st March 2008 in respect of invoices paid by the Trust on its behalf. The Trust owed Funds Held on Trust £0 as at 31 March 2008.

During the year P Metcalfe, a non-executive director of the Trust, was also a councillor at Bath and North East Somerset Council. There were transactions between the Trust and Bath and North East Somerset Council for non-domestic rates totalling £62,747 for 2007/08 (2006/7 £59,757). No money was owed by the Trust to the Council at 31st March 2008.

The Trust also had significant transactions with the following NHS organisations during 2007/8:

Bath and North East Somerset Primary Care Trust
Wiltshire Primary Care Trust
Somerset Primary Care Trust
Hampshire Primary Care Trust
The Royal United Hospital, Bath NHS Trust

27. Public private partnership transactions

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

28. Financial instruments

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.

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

8% 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 2008		
Sterling	2,849	2,849
Other	**-**	**-**
Gross financial assets	**2,849**	**2,849**
At 31 March 2007		
Sterling	2,333	2,333
Other	-	-
Gross financial assets	2,333	2,333

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 2008		
Sterling	3,895	3,895
Other	-	-
Gross financial liabilities	**3,895**	**3,895**
At 31 March 2007		
Sterling	3,047	3,047
Other	-	-
Gross financial liabilities	3,047	3,047

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)	1,349	-	-	-	**1,349**
Accrued income	110	-	-	-	**110**
Other debtors	867	-	-	-	**867**
Cash at bank and in hand	523	-	-	-	**523**
Total at 31 March 2008	2,849	-	-	-	**2,849**
NHS Debtors (net of provision for irrecoverable debts)	1,387	-	-	-	**1,387**
Accrued income	134	-	-	-	**134**
Other debtors	159	-	-	-	**159**
Cash at bank and in hand	653	-	-	-	**653**
Total at 31 March 2007	2,333	-	-	-	**2,333**

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: -			
Loans	-	-	**0**
NHS creditors	2,037	-	**2,037**
Other creditors	1,761	-	**1,761**
Accruals	97	-	**97**
Total at 31 March 2008	3,895	-	**3,895**
Loans	-	-	**0**
NHS creditors	1,435	-	**1,435**
Other creditors	1,431	-	**1,431**
Accruals	181	-	**181**
Total at 31 March 2007	3,047	-	**3,047**

Financial liabilities all mature in less than one year.

29. Third party assets

The Trust held £0 cash at bank and in hand at 31 March 2008 which relates to monies held by the NHS Foundation Trust on behalf of patients.