Royal National Hospital for Rheumatic Diseases
NHS Foundation Trust

Annual Report & Accounts 06/07



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Presented to Parliament pursuant to Schedule 1 of the Health and Social Care (Community Health and Standards) Act 2003, Schedule 1, paragraph 25(4).

Contents	**Pages**

Chair's Statement

This year the Trust has risen to the challenge of its status as a Foundation Trust in a more competitive National Health Service. Since our authorisation in April 2005 we have continued to develop into a strong mutual benefit organisation. A key strategic direction is to provide excellent services, working with patients and their carers to support them in their management of their condition by providing access to information and education. This is especially important because many of our patients have complex, long-term health needs affecting all aspects of their life.

Over the year we have concentrated on consolidating and improving what we do best; providing leading edge specialist services in rheumatology, pain management, chronic fatigue and neuro-rehabilitation. In October 2006 the Healthcare Commission announced the 2005/06 Annual Healthcheck ratings. The Trust was awarded a rating of "Excellent" for patient services and "Good" on managing resources. We hope to maintain this high standard when the Healthcare Commission announces its ratings for 2006/07.

The Council of Members has made a strong contribution to developing our strategic direction and continues to work confidently and effectively with the Board. Council Members are in attendance at the open Board meetings and the Audit Committee. There have been detailed consultations with Council on the Annual Plan, providing support, innovative suggestions and constructive criticism. Council has also discharged its statutory duties in re-appointing the Auditors and they also participated in the selection through open competition of the Internal Auditors. Currently the Council's Appointments Committee has been involved in succession planning with the Board's Nominations Committee, with the planned recruitment and appointment of a new Chair and two non-executive directors due to take place soon. The enthusiasm and commitment of Council Members has proved to be invaluable throughout this year, and the translation of the idea of mutuality into a living reality is of real benefit to the Trust.

We have concentrated on developing our existing services to make them more appropriate for an increasingly competitive market. We have developed innovative approaches to what we do, including working closely with services in the community. At the same time new services have been incorporated, for instance the addition of a child and adolescent chronic fatigue service, transferred from the Royal United Hospital, Bath, increasing our portfolio of services for children and adolescents, alongside our well-developed adult Chronic Fatigue service. Another new development that fits well with specialist rehabilitation is a joint venture between the Trust and the British Association of Performing Arts to provide musculo-skeletal assessment for its members. It is also an example of how mutuality can support the Trust, as the collaboration was proposed by a Member of Council.

The Trust has met all its performance targets during the year, as well as achieving an Annual Healthcheck score that puts us in the top 4% of all

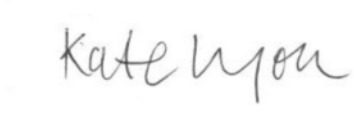
Trusts. Despite these excellent achievements, financial pressures throughout the South-West have had an impact, with a decrease in patients funded for pain management and neuro rehabilitation. This has meant that some of the activity targets that we set ourselves have not been achieved and as a result we end the year with a small financial deficit.

In the coming year we will work hard to be competitive while maintaining our position as a leading edge specialist hospital. We have produced a balanced business plan for the coming year. Research and development will continue to play a vital part in the further building of the Trust's reputation as an excellent specialist hospital, as will our commitment to education and training.

One of the enduring characteristics of this hospital is its flexibility and its innovative response to challenge. It is increasingly clear that staff at every level, with the support and guidance of the Council of Members and through them, of the membership, will strive to ensure that the Trust is in a good position to make the most of opportunities in a changing NHS.

In September the Trust was delighted to learn that Her Royal Highness the Duchess of Cornwall had agreed to be our Royal Patron. The Duchess of Cornwall has a particular interest in Osteoporosis, one of the many conditions treated in the RNHRD, and is President of the National Osteoporosis Society. The Society was founded by Professor Alan Dixon, then Senior Physician at the hospital. Her Royal Highness joins a long line of previous Royal patrons, and we are delighted that she has agreed to support our hospital in this way. The patronage will run until May 2011, and we hope soon to welcome Her Royal Highness on an official visit to the Trust.

Finally, as I will be leaving the Trust in November, I wish to say that it has been a great privilege and pleasure to have been involved with this unique hospital, its patients, its staff, and over the last two years, its members. I would like to thank formally, on behalf of the Board, all members of staff for their exceptional commitment and the Members of Council for their wise and supportive overseeing of the Trust. I wish you all well for the future and will take pleasure in the continuing success of the Min.



Kate Lyon
Chair

Chief executive's statement and management commentary

The Trust had a successful year, achieving growth in activity, improvement in its financial position and governance rating, and strong progress on strategic priorities.

The Trust Monitor risk rating improved from 2 to 3, and its governance rating improved from Amber to Green.

The Trust achieved a Healthcare Commission rating of "Excellent" for quality of services and "Good" for use of resources.

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.

Progress last year

The Trust's strategy aims to set standards for patient care, expand specialist services, and position the Trust as a specialist partner with evolving community and primary care based health services.

Last year was our second as a Foundation Trust, and as with last year, our Foundation Trust freedoms, flexibility and support from members helped us to make strong progress on our strategic priorities:

> We want to provide patient centred services, where each patient has the best support for their care and rehabilitation regardless of specialty or organisational boundaries.

- The Trust has continued working with local Primary Care Trusts on the development of care pathways for longer term conditions, which has resulted in improved outpatient and day-care arrangements for Neuro-rehabilitation patients resulting in earlier discharge.
- The Trust agreed to host a local group for the Arthritis and Musculoskeletal Alliance (ARMA), a UK umbrella association bringing together support groups, professional bodies and research organisations in the field the Arthritis and other musculoskeletal conditions. Meetings this year have been well attended, with very positive feedback.
- The Regional Paediatric Chronic Fatigue and ME service moved into the Trust in January 2007, with support from the local Primary Care Trust. The service brings together clinicians from across the local health services to deliver flexible, patient centred packages of care in a variety of locations across Bath, Swindon, Salisbury and Wiltshire.
- The Trust implemented a Picture Archiving and Communications system (PACS) for X-rays and scans as part of the National IT Programme.

We want to work as partners with patients and their carers and support them in their management of their condition by providing access to information and education. We think this is especially important because many of our patients have complex and long-term health needs affecting all aspects of their life.

- The Council of Members has worked with the Trust to review and improve patient information and to support the Trust with development of its website.
- The Council of Members has established a programme of public lectures, Medicine at the Min, bringing the work of the Trust to a wider public audience.
- We have a close dialogue with our patients and people close to them through the Council of Members and members, helping the Trust maintain focus on service improvements. This support has helped shape our service development plans for next year.

We want to provide fair and easy access to appropriate services for all who need them, and work with other health partners to reduce inequalities.

- The Trust continued to meet targets for inpatient and outpatient waiting times and to support achievement of the 18 week patient pathway.
- Waiting times for the Pain Management programme have reduced as a result of improvements in capacity, and remain low in other specialties.

- The Trust developed plans to achieve 18 week patient pathway milestones for 2007/8.

We want to provide excellent local services that are high quality and appropriate for the needs of our local population.

- The Trust launched a Rheumatology Outpatient Coping skills programme which has had a very positive response from patients.
- The Trust reviewed inpatient admission and discharge protocols for rheumatology to achieve improvements in length of stay and quality of care for 2007/8.
- The Trust expanded outpatient and day-care options for patients discharged from the Neuro-rehabilitation Unit.

We want to be at the leading edge in our specialised services.

- The Trust recruited a new consultant Rheumatologist, Dr. Elli Korendowych specialising in Psoriatic Arthritis/Connective Tissue Disease and has improved waiting times for clinics in this area.
- The Trust is developing programme bids in Chronic pain and Rheumatology for new NHS research programme grants.
- The Trust worked with the British Association of Performing Arts Medicine and will host a specialist assessment clinic for them starting in July 2007.

We want to provide the best possible working environment for staff to enable them to use and develop their skills to the maximum.

- The Trust upgraded accommodation for younger patients on the Neuro-rehabilitation unit.
- The Trust jointly with the Bath Academy opened a new learning centre with e-learning facilities on the Hospital site

The Trust also improved its marketing capability and capacity, introducing a new department of Marketing and Communications. It launched an initiative to look at the name of the Trust in preparation for new National Patient Choice systems.

Overall, the Trust continued to show growth in activity. However, despite our positive progress with development objectives, this has been a challenging year for the Trust with pressures on activity and cost.

The Trust experienced problems with completion of the external audit of accounts for 2005/6 within the required timescale, and the audit identified some accounting issues which exposed an overall deficit position for that year. Problems were also identified with financial assumptions underpinning the annual plan, and as a result there were significant revisions to the plan resulting in late submission.

As a result of the deficit and late submission of the Annual Plan, the Trust started the year with a risk rating of 2 and an amber governance rating. Over the course of the year the Trust's risk rating has improved to 3, and the Governance rating returned to green at the end the first quarter.

There was some continuing impact on the Trust this year from last year's problems and pressures that arose in year:

- pressure on cash, reflecting a combination of the income and expenditure position, a high level of debtors, and the payment regime for non-contract activity which results in inherent payment delays.
- outstanding invoices from previous years for which no provision had been made.
- the Department of Health unexpectedly top sliced funding for educational and support costs mid year.
- increases above inflation for core support services (pathology, pharmacy, radiology) contracted from the Royal United Hospital.
- costs of implementing Agenda for Change, the new NHS pay structure
- a number of problems with established posts omitted from the baseline budgets.
- growth slower than planned for Pain Management and Neuro-rehabilitation.

Led by a new Finance Director appointed in June 2006, the Trust has invested significantly in the finance function during the year, and achieved improvements to financial management and resilience for future years. Short term improvements included increased staffing levels, improved debtor and creditor management, improved reporting and improved budget analysis and management. At the end of the year, the Trust tendered the internal audit function and new internal auditors were appointed with effect from 1 April 2007. The Trust implemented a new Finance system (SBS) from 1 April 2007.

The Trust is now confident it has robust financial systems and procedures in place, with excellent leadership. Cash management has improved significantly and the Trust is now maintaining a positive cash balance.

Plans for next year

For next year, the Trust has a review programme to make sure it is as cost effective as possible by having appropriate specialist staff teams, shifts to match patient requirements, and streamlined working arrangements.
Overall, the Trust is committed to continuing improvements to its patient services and to maintaining its specialisation, and the review programme will support this objective.

Although this is a period of unprecedented growth in funding for the NHS, the Trust recognises that at a time of change in the NHS with new independent sector, primary and community services coming on stream, there is unlikely to be significant growth in funding for our services. The Annual Plan for next year therefore concentrates on making sure that we do lead the way in efficient working practices, and in some new "added value" services that will make the most of our existing skills and resources.

Key service developments for next year are:

- A new specialist outpatient service for performing artists in the Southwest and Wales, in partnership with the British Society for Performing Arts Medicine. This is the first dedicated assessment clinic outside London.
- New specialised technical assessments including SMART assessments and Functional Electro Stimulation as part of the portfolio of interventions delivered in Neuro-rehabilitation.
- Provision of lower dependency beds to minimise the need to transfer Neuro-rehabilitation patients to hospitals outside the area for transitional care for a period following the acute rehabilitation phase of their treatment.
- Continued work with local Health Communities on chronic care management including the development of outpatient spasticity management services.
- Development of the Endoscopy service with the addition of flexible sigmoidoscopies.
- Increasing Paediatric Rheumatology Outpatient clinics in new children's accommodation from August 2007.
- Partnership with other local paediatric and pain service providers to review care pathways for the management of Pain in Children.
- Offering a limited Pain Management inpatient service for younger people with exceptional needs

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

Performance against key patient targets

The Trust met all national out patient and inpatient access targets in 2006/07.

- All patients had an initial out-patient appointment within 13 weeks of receipt of their referral.
- All patients were admitted for in-patient treatment within 6 months of referral.
- There was a reduction in the number of patients waiting more than 13 weeks for diagnostic tests.

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

Healthcare Commission Annual Healthcheck

The Trust is required to produce a declaration of its compliance against the Healthcare Commission Annual Healthcheck core standards during 2006/07. 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, Directors, 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 there have been no significant lapses in meeting the Healthcare Commission Annual Healthcheck core standards during the period April 1st 2006 to March 31st 2007.

Patient Safety

The Trust reviews all aspects of patient safety through the risk management steering group. The Trust has continued to maintain high standards in infection control but did report one case of MRSA bacteraemia in 2006/07. Following a successful application for capital funds for infection control use, we were awarded a grant of £300,000 to improve facilities for patients.

We continued to develop our in house system, Vital Aspects of Patient Safety, for measuring the quality of patient care and patient safety. The scores remained consistently above the benchmark set by the Trust.

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) 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 a clinical audit component built into them in order to achieve continuous monitoring and routine auditing.

Information Governance

In March 2007 we completed the 2006/07 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 87% 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 2006

The Trust recognises that the excellent result in the 2006 national in-patient survey is directly due to the hard work and dedication of our staff.

Questionnaires were posted at the end of September 2006 to all adult inpatients discharged from this Trust during April to 31 August 2006. Patients were asked about various aspects of their experiences including their admission, the quality of care, pain management, communication with doctors and nurses, information, medicines, involvement in their care, hospital food and cleanliness and discharge arrangements.

Every NHS hospital trust in England participated in this survey as part of the commitment, set out in the NHS Plan, to design a health service around the needs of patients.

When our results are compared with the results for all other trusts nationally our scores are in the top 20% of trusts for 80% (39) of the questions, the middle 60% for 16% (8) questions and the bottom 20% for 2 questions which asked patients about operations and procedures. Patients do attend the Trust for endoscopies but no other operations are carried out. Our own in house surveys of patients attending for endoscopy give consistently very good results for the service.

Charter Mark Award – In September 2006 we successfully met the Charter Mark Standard. Charter Mark, is the Government's national standard for excellence in customer service. Charter Mark is a registered certification mark, owned by the Government Communications Group in the Cabinet Office. It is a positive force for change and customer service improvement. The award recognises the excellent work of Trust staff delivering a high quality service.

Complaints

The Trust received 12 written complaints in 2006/07 which is less than the 14 received in 2005/06. All complainants received a written acknowledgement within 2 working days and 58% received a response within the timeframes set out in the complaints policy.

The Trust had no requests for an Independent Review by the Healthcare Commission during 2006/2007.

Action taken as a result of Complaints

- Patients to receive information directly on policy changes of a PCT
- Patient offered appointment with another therapist
- Audit of time taken to send letters to patient/GP, introduction of digital dictation and restructuring of medical secretary working to reduce time taken to send letters after clinic appointments.
- Staff reminded to communicate appropriate timescales for investigations
- Staff reminded to treat all patients with dignity and respect.

Catering Award

For the second year running BANES Environmental Health Department has awarded the catering team at our hospital with a Food Hygiene Award for Safety 2006.

This is a really difficult award to achieve. Only a few hundred of the thousands of those judged successfully meet the high standards required, and for the Catering team to do this two years running is a fantastic achievement, and fair recognition of their professionalism.

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, interruption and/or disruption to the continuity of any of its services. This is more commonly known as business continuity planning and is in addition to planning for those situations that are more commonly known as rising tide events such as an influenza pandemic.

The Trust practices these emergency plans through national exercises such as “Winter Willow” which took place in 2007 and local emergency planning exercises.

Research and Development

Research and development underpins and informs the care the Trust provides and promotes the Trust’s reputation as a specialist hospital. As a research active Trust, we are able to attract the very best staff and encourage innovation and an openness to new ways of thinking, as we continually strive to improve methods for the diagnosis and treatment of patients.

Staff are engaged in research across all specialty areas, including rheumatology, pain management, rehabilitation, paediatrics and head injury. 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. The Trust attracts funding from major funding bodies, such as the Arthritis Research Council and the Engineering and Physical Sciences Research Council.

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 ‘This programme continues to have all the key elements of a strong programme and has been rated as strong again this year. We are pleased to note the significant increase in publication output, and the award of five higher degrees.’

The Trust continues to work closely with the University of Bath. The appointment of a new Head of School for Health at the University in 2006 has provided an opportunity to strengthen the research collaboration at strategic level between the two organisations.

Human Resources

The Trust recognises that its success over the year is directly due to the hard work and dedication of our staff.

2006 saw the launch of our new LINKS communication and partnership working arrangements. LINKS; liaison, information, knowledge, solution and satisfaction, draws together existing communication channels and aims to allow every member of staff to access the decision making processes of the Trust.

It followed from our NHS Foundation Trust application and new governance arrangements based on principles of mutuality, that we wanted to give all staff, whether union or non-union, an active voice in the running of the Trust. It was also important to develop new language to replace the old staff and management "sides".

The LINKS Partnership Committee encompasses the old Joint Negotiating Committee but also includes Staff Council of Members Representatives and other staff nominees and meets with management on a monthly basis. Before this formal partnership meeting staff members meet with nominated staff representatives from all areas of the Trust at the "LINK UP" meeting, which is open to any member of staff to attend. LINK UP hears any issues of concern or comment to take to the partnership meeting and feedbacks or answers questions about the previous month's partnership meeting with management. A formal LINKS Brief newsletter, issued once a month, supports the whole process.

There has been an active programme of briefings with staff across the year with the Chief Executive holding regular open meetings with staff. In addition the Chief Executive and Finance Director held a suite of sessions updating staff about the Trust's financial position and identifying the contribution expected of staff. The Trust is currently engaged in a Trust-wide consultation with staff about how we stay "fit for the future". Communication is supported by management briefings, the LINKS infrastructure, together with open meetings and a healthy debate on the Intranet Cafe. The aim is to learn from staff at the frontline, as to what will really make us more efficient and effective and help us to prosper in the future. When staff ideas and suggestions have been gathered this will feed into a three year plan for change.

Work on the equalities agenda has progressed well throughout the year. The Minority Ethnic Group has met to consider issues relevant to them and to oversee our Race Equality Action Plan. We involved staff, patients and public, with experience or knowledge of disability in a highly successful consultation event, which fed into our Disability Equality Scheme and Disability Action Plan, which was approved by the Board in December 2006. Our thanks go to all those who responded so constructively and helped us put this in place. Consultation on our gender equality scheme completed our year. Next year we will work to bring these three strands together under a Single Equality Steering Group.

Other work on equalities involved the development of Knowledge and Skills Framework competency standards in equality for our entire staff, roll out of equality training to staff across the Trust and work ensuring all our policies and procedures were age proof following age legislation in October 2006.

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. We regularly assist members of staff who become disabled, for instance by the purchase of equipment that can help them in their roles, by making adjustments to work if required or if necessary by efforts to assist with redeployment.

The education and Training Executive Committee oversee training within the Trust. Staff have personal development plans agreed at appraisal and the Trust has provided a programme of clinical and non clinical training to staff to meet training needs.

Another positive step forward regarding training, involved us achieving accreditation as a City and Guilds Awards Centre. This will allow us to provide our own NVQs in healthcare in the coming year and pave the way for further accredited courses in the future.

The Trust aims to ensure that it is seen as a good employer by the local community and promotes model employment practices through open events. In autumn 2006 the Trust held a successful NHS volunteers and careers day with attendance from local schools.

The Trust works in partnership with the Bath Crime Reduction Unit to support crime reduction in Bath.

Staff surveys show a high level of awareness of the Occupational Health and employee assistance services available to staff.

There have been no major Health and Safety Incidents over the year and no enforcement notices from the Health and Safety Executive or any other enforcement agency. The Health and Safety Executive assessed work related stress in the Trust and the findings were satisfactory and improvements identified have been put in place.

The Trust is committed to preventing and detecting fraud and corruption in the NHS and in accordance with national guidelines has policies and procedures in place to deal with this. In addition, the Trust employs the services of a Local Counter Fraud Specialist to assist with this.

The Trust has an Environment Policy in place and during the year there was a significant increase in recycling.

Board of Governors

This is our second year of operation since becoming an NHS Foundation Trust in April 2005. As a Foundation Trust we are democratic and the principle of mutuality is well embedded. Our Members directly elect representatives to serve on the Council of Members. The Council of Members (CoM) works with the Board of Directors – responsible for day-to-day running of the Trust – to ensure that the NHS Foundation Trust acts in a way that is consistent with its terms of authorization. In this way, the Council of Members plays a role in helping to set the overall strategic direction of the organisation.

Relationships between Board and Council are now more established with Board members including CEO and FD regularly attending CoM meetings and a member of Council attending open Board meetings and feeding back to Council as a whole. While the Board of Directors takes the lead in setting the strategic direction of the Trust, the Council contributes to the planning process, feeding in direct to specialties on their emerging business plans and contributing in response to regular updates from the CEO as the plans are developed. Feedback from Council in January 2006 has since been developed into a new service initiative (performing arts) to be launched in summer 2007.

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, (the date for the next Annual Members Day is 20th June 2007).

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 3 membership constituencies in the RNHRD membership and the criteria are:

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.

The vision of the Membership team at the Trust is:

'To achieve and maintain an actively engaged and representative membership of the Royal National Hospital for Rheumatic Diseases as an NHS Foundation Trust'.

This vision is outlined in our Membership Strategy, which:

- Defines the membership community and describes how the Trust will establish systems to manage the new culture and the challenges that will come with establishing and maintaining an active membership;
- Identifies the aims and objectives to ensure the success of membership at the Trust; and
- Outlines how the Trust will evaluate the success of the Membership Strategy.

Board of Directors

Meetings of the Board of Directors

Meetings of the Board of Directors are held monthly on the third Thursday of each month in the Board Room of the Trust Headquarters, Trim Street, Bath. Public meetings are held every other month and members of the public are very welcome to attend. A schedule of dates and meeting details and declarations of interest can be obtained from info@rnhrd-tr.swest.nhs.uk

Non-Executive 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 Board currently has three non-executive directors with experience of Board membership and operational responsibilities in large organisations, one of whom has experience largely in the public sector. The fourth non-executive director has a background in manufacturing, design and design consultancy, academia and as a local authority councillor. The chair is a former academic with six years experience as a non-executive director in two NHS Trusts before taking up her current role.

The chair conducted appraisals of the Chief Executive and the non-executive directors. 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 and Nominations Committees revised their terms of reference in order to bring them into line with the Monitor Code of Governance. In addition, the Board undertook a facilitated away-day in order to examine whole Board working.

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

There were 12 meetings of the Board during 2006/07, Kate Lyon attended all 12 meetings, Nicola Carmichael, Hayley Sewell and Vincent Harral gave their apologies for 1 meeting, Paul Dodd, Sue Gray, Karen Kerley, Mike Bowden, Peter Metcalfe gave their apologies for 2 meetings, Chris Fokke and Richard Darch gave their apologies for 3 meetings, Dr A K Clarke and David Rogers gave their apologies for 5 meetings and Steven Haynes attended all meetings until his resignation in May 2006.

The Trust's Board

Chair, Kate Lyon.

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 has responsibility for the Board and the overall organisation.

Richard Darch, Non Executive Director

Richard Darch 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.

Vincent Harral, Non Executive Director

Reappointed in 2003 for a period of four years until November 2007. 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.

Peter Metcalfe, Non Executive Director

Reappointed in 2002 for a period of four years, and then re-appointed for a further year until November 2007. 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 is an elected Councillor of the Bath & North East Somerset Council and served as Mayor of the City of Bath in 2005/06.

David Rogers, Non Executive Director

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.

Mike Bowden, Non Executive Director (Resigned October 2006)

Appointed in 2005, Mike Bowden has a range of experience from within the energy sector as an Executive Director with a wide range of responsibilities including legal, health and safety and Human Resources. Mike Bowden is also a qualified solicitor.

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. Most recently she has led the Trust successfully through its Foundation Trust application.

Dr A K Clarke, Medical Director (Retired March 2007)

Dr Clarke held the post since the Trust's inception. He is well respected by his colleagues and throughout the Trust, and has consistently innovated to improve standards in advance of central guidance.

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 and Marketing. She has 20 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.

Paul Dodd, Finance Director (From May 2006)

Paul Dodd joined the Trust in May 2006 and was appointed to the post of Finance Director in July 2006. In addition to Finance, he also has overall responsibility for Facilities and Estates. 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.

Steven Haynes, Finance Director (Resigned May 2006)

Steven Haynes was appointed as Finance Director in May 2004 and left the Trust in May 2006 having made a valuable contribution to our success in becoming a Foundation Trust.

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 Matron level. He also has an Honours degree in community healthcare.

Sue Gray, Director of Clinical Services (resigned October 2006)

Sue Gray had previously successfully managed the Head Injury Unit. Sue is educated at degree level in Physiotherapy and at Masters level in

Rehabilitation Counselling. Sue has extensive practical experience both clinically and managerially and has completed the King's Fund Senior Managers Programme.

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 and brings with her extensive public sector knowledge including that gained from the civil service.

Audit Committee

Audit Committee Chair: Vincent Harral, Non-Executive Director, Committee Members; Non-Executive Directors Richard Darch and Peter Metcalfe

There were 5 meetings of the Audit Committee in 2006/07, Vincent Harral and Peter Metcalfe attended all meetings, and Richard Darch did not attend 5 meetings.

During 2006/07 the Audit Committee has continued to discharge its responsibilities in accordance with its Terms of Reference and the requirements of the Code of Governance and the Audit Code for NHS Foundation Trusts, in particular relation to;

- The monitoring and testing of the annual accounts and the financial systems and systems of internal controls existing within the Trust.

- Monitoring the work, including the work plans, of both external and internal auditors and the implementation of their recommendations within the Trust.

- The reviewing of staffing levels and operational systems within the department of the Director of Finance and recommendation to the Board relating to changes in these.

- The reviewing of the content and adequacy of reports made to the Board by the committee and also of those made to the monthly meetings of the former by the Director of Finance and relating to the financial performance and cash position of the Trust.

- The monitoring of systems within the Trust for the assessment of perceived risks, including receiving the minutes of the Risk Management Committee.

- The maintenance of good reporting arrangements with the Board of Directors and, where appropriate, with the Council of Members. In this latter context the Committee has been assisted by the presence of two members of the Council at its meetings.

- Reviewing the arrangements for the routine work of the committee including its terms of reference and the completion of a self-assessment exercise.

- The establishment of effective criteria for the market testing of audit services.

During the year the Council accepted a recommendation of the Committee, made via the Board of Directors, for the re-appointment of the existing external auditors for 2007-08. There were no additional (non-audit) services provided by the external auditors during 2006-07 but the committee would wish to place on record its appreciation for the ready assistance and guidance given by the auditors in establishing changed staffing and working practice arrangements within the Trust's finance function.

Nomination Committee

The members of the Nomination Committee are Richard Darch (Chair), Vincent Harral, Kate Lyon, Peter Metcalfe and David Rogers, all non-Executive Directors. There was one meeting in 2006/07 attended by all members.

The objective of the Nomination Committee is to assist the Board to discharge its responsibilities to the Council of Members and other stakeholders for ensuring that the Board regularly reviews its structure, size and composition and that there is appropriate succession planning. Its terms of reference follow closely the Monitor Code of Governance.

It has been actively engaged this year in planning for the vacancies later in the year for chair and two non-executive directors and its chair has worked closely with the Council of Members Appointments Committee. Job descriptions and person specifications for Board appointments are agreed by the Nominations Committee, reported to the Board, and then proposed to the Council's Appointment Committee. After detailed discussion between the chair of the Nomination Committee and members of Council's Appointments Committee the recruitment process is put in place, with final approval of appointments resting with the Council of Members.

It was agreed by both the Board and the Council that one non-executive director be re-appointed until November 2007 without either an external search or open advertising. The reason for this course was because the Council of Members felt strongly that it would be more effective and economical to complete the recruitment process for a chair designate, followed closely by that of two non-executive directors. In the meantime, with an already existing non-executive vacancy due to resignation at short notice, the re-appointment of the current non-executive was deemed necessary in order to maintain the presence of independent non-executive directors on the Board.

Membership in 2006/07

The Trust will strive to maintain and develop membership.

Feedback from members assisted the Membership Support Service to discover what motivates people to become a member. We used this information to develop our membership interest pack, keeping the message simple and adapting the literature depending on the target audience, develop our marketing methods and regularly mail-shot literature for specific communities, for example nursing and therapy students.

We have used our bi-annual membership newsletter to promote membership, the importance of our membership base and involvement opportunities.

Patient membership

We have developed systems in all service areas to provided information about membership to all new patients. This method is being audited.

Staff membership

We have provided staff with accurate and up-to-date information about membership and Foundation Trust governance through induction and orientation. There is evidence of increased staff involvement through a successful staff election to the Council of Members. All Bank staff have been invited to become members. Only one member of staff has opted out of membership over the last 2 years. HR staff promote membership to new staff and staff leavers

The Trust will build a diverse and representative membership

The Trust is focusing on the diversity of members and the Council of Members has developed a promotional pack to assist them to promote the hospital and membership to the wider community. The membership newsletter has evolved to provide members with information about all aspects of the services we provide. Mail shots are sent to local minority groups and volunteer and community groups to promote the hospital and membership.

Members were involved in the Disability Equality Scheme workshops to assess patients' and members' disability equality needs and how we can address them.

PALS has developed a database of translation services in order to translate membership literature into different languages and formats dependent on requirements.

Our target during 2006 - 2007 to increase membership was 10%. We exceeded this and increased our membership by 16%. We also reviewed and updated our website pages and saw an increase of 600% in membership recruitment via the website.

A summary has been provided below to indicate the number of members in each constituency.

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Patients	3387	3386	3335	3332	3837	3903	3914	3924	3896	3900	3901	3907
Carers	54	54	53	53	64	66	67	67	67	68	68	68
Public	756	756	751	749	846	872	887	897	897	901	904	914
Staff												
Total	**4197**	**4196**	**4139**	**4134**	**4747**	**4841**	**4868**	**4888**	**4860**	**4869**	**4873**	**4889**

All membership promotional material and information includes correspondence details for the Membership Support Service. The members can contact their representatives on the Council of Members through the:

Membership Support Service
FREEPOST SN1301
RNHRD NHS Foundation Trust
Upper Borough Walls
Bath
BA1 1RL
Telephone: 01225 787043, ext 201
Email: nhsft@rnhrd.nhs.uk

Members can also request information on Council of Members meetings and attendance by Council Members at these meetings from the Membership Support Service.

Council of Members

Patient Members: Elizabeth Brealey, Vice-chair. George Odam, Judy Coles, Ken Bray, Tony Barber, Terri Tee, Don Boyland, John de Normann, Howell Hughes Jones and John Haigh.

Public Members: Joan Davies, Philip Edwards, Richard Mishra, Vincent Okafor, Steven Pike, Huw Ponting, Francis Ring and Bob Williams.

Staff Members: Laura Davies, Caroline Maggs, Jan Williams and Lou Gay

Organisations with appointed representatives to the Council of Members

Peter Redfern	University of Bath
Sue Meadows	National Osteoporosis Society
Marylyn Restarick	Fibromyalgia Support Group
Dr Sarah Webb	Bath & North-East Somerset Council
Andy Newton	BANES PCT
Lesley Donavon	University of the West of England
Phil Baker	Arthritis Care
Allan Trinder	Care Network
Peter Haines	Headway, Bath & Wilts
Kate Mountford	RNHRD PPI Forum

There are 2 vacant positions at the time of publication of this report.

Terms of office of the Council of Members

Public and 10 Patient Members:

- are elected by members of their constituency
- may hold office for a period of three years;
- are eligible for re-election at the end of that period;
- may hold office for a maximum of six years;
- cease to hold office if they cease to be a member of the constituency by which they were elected.

4 Staff Members:

- are elected by members of their constituency
- may hold office for a period of four years;
- are eligible for re-election at the end of that period;
- may hold office for a maximum of eight years;
- cease to hold office if they cease to be a member of the constituency by which they were elected

Appointed Members:

- may hold office for a period of 3 years or 2 years in the case of Other Partnership Governors
- are eligible for reappointment at the end of that period or any subsequent period;
- cease to hold office if the sponsoring organisation withdraws its sponsorship of them by notice in writing to the Trust.

Council Members have a duty to disclose details of company directorships or other material interests in companies held by members where those companies or related parties are likely to do business with the Royal National Hospital for Rheumatic Diseases. A full register of members interests is available for public inspection and can be obtained by contacting the Membership Support Service on 01225 787043, ext. 201.

Involvement Opportunities 2006/07

Our membership and involvement work is the key channel for the social and community activities in the Trust. Involvement is well-developed within the hospital's delivery and governance structures. The culture and values of the organisation emphasise involvement and open, honest communication to improve patient experience.

Structures and opportunities for involvement during 2006/07 include:

Council of Members

- Input to Trust Annual Business Plans
- Input to Annual Healthcheck Declaration

- Council assisted in developing the agenda and organising Annual Members Day for the Trust. Excellent feedback was received from Members and Staff, the day was very successful
- Annual Members Day
- Hospital re-development consultation
- Disability Equality Scheme (DES) involvement workshops
- Patient and Public Involvement Forum
- Seminar on Osteoporosis
- Volunteer Programme

Patient Literature and Information Group established to ensure:

- Information for patients is constantly improved
- Literature produced within the Trust is monitored
- There is an up-to-date catalogue of all literature produced for the benefit of patients and carers/ families
- All literature is reviewed annually, and
- All literature is accessible and provided in an appropriate format.

Other opportunities for involvement have been through:

- Patient Advice and Liaison Service (PALS)
- NHS Complaints procedure
- Bi-annual membership newsletter 'Minformation'
- Marketing and re-branding consultation
- Gender Equality Scheme consultation
- Review of Patient Feedback Surveys
- Expert Patient Programme

To facilitate member, patient and public involvement in all aspects of the hospital, the following have been put in place:

- Staff guidelines and toolkits and information sessions for involving members, patients and the public
- Inclusion of PPI in the NHS staff Knowledge and Skills Framework to improve patients' experiences
- PPI Adviser sits on the local PCT, BANES, PPI Development and Implementation Group
- Partnership working with volunteer and community groups and partner organisations through involvement events and the Council of Members.

Income and Expenditure Account

The year end Income & Expenditure Account position was a deficit of £45k, compared to a planned surplus of £210k. Earnings Before Interest Tax Depreciation and Amortisation (EBITDA) and dividends was £654k giving an EBITDA margin of 4.1%.

The main reasons for the shortfall against plan was under performance of £185k against the planned PCT income target of £12,051k, expenditure of £145k that should have been accounted for in 2005/06, and a reduction in funding from the Department of Health in relation to education and training, This was partly offset by additional non-recurrent income.

In Neuro-Rehabilitation, the underperformance was 10% below plan, with 6,868 patient bed days delivered against a plan of 7,635 patient bed-days. In Pain Management the under-performance was 20% below plan, with 164 inpatients treated against a plan of 204. This was partly offset by an over-performance against plan in Rheumatology, where the specialty was above plan by 17 inpatient spells (2.6%) and 1,374 outpatient attendances (8.8%).

Income from private patients was £147k, which equates to 1.22% of total patient related income. This is within the private patient cap for the Trust of 1.31%.

There were no exceptional items included within the income & expenditure account.

Our performance in respect of other key financial indicators is set out in notes 10 and 19 to the accounts.

Capital

Capital expenditure during the year was £646k. The main areas of investment were the hospital redevelopment, control of infection improvements, and the Patient Archiving System. The Trust did not borrow any sums against its £1.8m Prudential Borrowing Limit set by Monitor.

Cash

Due to the issues outlined above with regards the Income and Expenditure position, and also due to delays in the Trust receiving cash from PCTs for patient services because of the way the national payment system works, the Trust experienced a downward pressure on its cash position from the middle of the financial year. Positive action was taken to manage this and the Trust delivered a strong cash position at the year end with a positive cash balance of £653k at 31st March 2007. This compared favourably with the planned level of cash of £430k at the year end.

Annual Accounts

Full details of the Trust's 2006/07 financial position can be found in the Trust's audited annual accounts (pages 32 to 72 of this report).

The Trust's accounting policies are set out in note 1 of the annual accounts. The Trust's accounting policies for pensions and other retirement benefits are set out in note 1.10 to the annual accounts.

The Trust received contributions to expenditure during 2006/07 from the Royal National Hospital for Rheumatic Diseases Funds Held on Trust, which are disclosed in note 5 to the accounts. The Trustees of the Funds Held on Trust are members of the NHS Trust Board.

Going Concern

After making enquiries, the directors have a reasonable expectation that the 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.

2007/08 Financial Position

As a result of the 2006/07 performance and increased competition from other local providers, the Trust is restructuring its price tariff and consulting on ways to improve efficiency. The Board has reviewed its planning assumptions for 2007/08 and agreed that the plan should be based on moderate risk. As a result of this, the Trust is planning for a surplus of £120k in 2007/08. The planned level of PCT income for 2007/08 is set at £12.4m, and the Trust is facing cost pressures of £329k and a cost improvement programme of £594k in 2007/08.

The key risks to the delivery of the financial plan mainly relate to PCT income. The South West remains a financially challenged area and a number of PCTs have significant financial problems to address. In addition, there are increasing risks from competitors as PCTs become more cost driven, particularly with regards to neuro-rehabilitation services and Independent Sector Treatment Centres. It should be noted that although most contracts have been agreed with PCTs, the figures included within contracts are indicative values only and are not guaranteed income.

The Trust is committed to ensuring it receives value for money in relation to all of its activities, in order to obtain the maximum benefit to our patients from the resources available to the Trust. The Trust has an annual cost improvement programme that delivers a minimum of 2.5% savings in each year. In 2007/08 the cost improvement programme will deliver £494,000 of savings, which is equivalent to 3.4% of the Trust's total cost base. In addition to this, the Trust is consulting with staff to identify further areas where the Trust can be more

efficient through improved ways of working and it is anticipated that savings of £100,000 will be achieved in 2007/08.

The Trust has an annual capital investment programme which for 2007/08 will allow for £700,000 of investment in the Trust's capital assets. The main areas of investment in 2007/08 are:

- replacement of the existing nurse call system to provide an effective and efficient communication system
- refurbishment of the neuro-rehabilitation high dependency unit to improve the patient environment and maximise the control of infection
- a rolling programme of replacing and upgrading the Trust's information management and technology systems and equipment to provide for critical and efficient information systems
- refurbishment of specific hospital areas to enhance the patient environment

In addition to the above, the Trust has an annual maintenance budget to cover repairs to the Trust's buildings.

Remuneration Report

Remuneration Committee Chair: Richard Darch. 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 2006/7, the Remuneration Committee commissioned an independent report from NHS Partners to review the market and advise on levels of Remuneration. During 2006/7, the Remuneration Committee met once. The meeting was attended by Richard Darch, (in the Chair), Mike Bowden, Kate Lyon, Vincent Harral, Peter Metcalfe, and Nicola Carmichael. J Langren (NHS Partners) was in attendance. Nicola Carmichael left the meeting prior to discussions about Chief Executive remuneration.

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 Committee did not meet to consider Chair or non-executive Director remuneration in 2005/6 and no awards were made.

Salary and pension entitlements of senior managers are detailed in note 6.3 of the Accounts. Details of Pension Costs are given in note 7.5 of the Accounts.

No compensation was payable to former senior managers during the year 2006/7.

No payments subject to performance conditions were made in 2006/7, 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
Paul Dodd	Dir Finance	01.09.06	n/a	6 months
Hayley Sewell	Dir Gov & Perf	07.07.03	n/a	3 months
Chris Fokke	Dir Clinic Prac	01.08.05	n/a	3 months
Karen Kerley	Dir HR	01.10.05	n/a	1 month
Kate Lyon	Chair	01.12.99	30.11.07	*Not available
Mike Bowden	Non-Exec	01.10.05	12.11.06	1 month
Richard Darch	Non-Exec	01.02.04	31.01.08	3 months
Vincent Harral	Non-Exec	01.12.99	30.11.07	*Not available
Peter Metcalfe	Non-Exec	01.12.98	03.11.07	*Not available
David Rogers	Non-Exec	01.10.05	01.10.10	*Not available

* appointments pre-date the requirement for a notice period.

Accounting policies for pensions and other retirement benefits are set out in note 1.12 to the accounts and the details of senior employees' remuneration can be found in note 6.2 of accounts.

Nicola Carmichael
Chief Executive

Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

Annual Accounts

Year Ended 31st March 2007

ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FOUNDATION TRUST

2006/2007 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 Health and Social Care (Community Health and Standards) Act 2003 ("2003 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 2003 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 him/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.

Signed…….

Nicola Carmichael - Chief Executive

Date: 8th June 2007

STATEMENT OF DIRECTOR'S RESPONSIBILITY IN RESPECT OF 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 2007 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership is given to the risk management process through:

- The involvement of the Board in 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 group include the Trust Chair, the Director of Finance, Medical Director, the Director of Governance and Performance, the Associate Director for Clinical Services (until September 2006) 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.

The Trust's Risk Management Strategy identifies the responsibility for risk management throughout the Trust.

The Trust Board is responsible for pursuing the aims and objectives of risk management.

The Chief Executive is the Executive Director with responsibility for the management of corporate risk and all risks within the Trust.

The Medical Director is responsible for clinical risk management and clinical governance within the Trust, advising on clinical risk and is a member of the Risk Management Steering Group.

The Director of Finance is responsible for management of financial risk within the Trust and is a member of the Risk Management Steering Group.

The Director of Governance and Performance is responsible for co-ordination of risk management meetings, management of CNST standards, management of complaints and co-ordinating the management of clinical negligence claims and is a member of the Risk Management Steering Group.

The Trust has also restructured risk management arrangements including the appointment of a Trust Director with responsibility for Performance and Governance, including risk management, and a risk management system administrator.

These posts have responsibility for ensuring that a comprehensive risk management training programme is in place.

The Facilities Manager is responsible for environmental risk and co-ordinating the management of liability to third parties and property claims and is a member of the Risk Management Steering Group.

The Chief Executive is the Director having responsibility for Assurance and Organisational Risk and is the Chair of the Risk Management Steering Group.

Each Specialty Director/Head of Department is responsible for ensuring compliance with the Risk Management Policy within their Specialty or department.

The Risk Management Strategy details key responsibilities for all staff, which include hazard and incident reporting, safe clinical practice in diagnosis and treatment, statutory duty to take reasonable care for their own safety and the safety of others who may be affected by the Trust's business, compliance with health, safety and welfare requirements, familiarity with the Trust's Risk Management Strategy and awareness of emergency procedures.

The Trust's Risk Management Strategy is available to all staff through the Trust's intranet.

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 2006/7 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 Risk Management brief.

The Trust has reviewed its arrangements for risk management and has implemented further improvements to the risk management system to improve facilities for incident and hazard report follow up and action planning at
specialty/department manager level.

The Risk Management Steering Group reports to the Trust's Audit Committee.

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.

The Trust's 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.

As part of the NHS Foundation Trust application process in 2004/05, the Trust undertook a detailed SWOT and PEST analysis. This exercise included a complete review of potential risks to the Trust over the next five years and forms the basis for the risk management plan over this period. The SWOT and PEST analyses are reviewed and updated annually as part of the Business Planning process.

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 identified that there is a need to rationalise the risk register to address duplication of risks by different departments and instances of inconsistency in evaluation where the same risk is recorded by different departments and work to consolidate the risk register continued through 2006/07.

The Trust Board has developed an Assurance Framework which covers all of the organisations main activities. The Assurance Framework identifies significant risks to the Trust's delivery of its major strategic objectives and the controls that the Trust has in place to manage these risks. The Assurance Framework 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 of 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 2006/07 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. These have been addressed during 2006/07. The Council of Members and annual Members 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.

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

The Trust Board approves annual cost improvement plans and budget allocations to ensure that resources are used economically, efficiently and effectively. The Board uses national tariff information to assess whether the Trust's costs are above or below average. The Trust uses a number of mechanisms and processes to maintain cost economy, efficiency and effectiveness:

- Tendering and contracting procedures to test costs for contracted goods and services
- Use of nationally negotiated PASA and NHS Logistics contracts
- Benchmark information including Estates, VfM audit reports and Pay comparison which is reviewed by the Board
- Board panel review meetings to oversee expenditure compared to performance by specialty
- Business planning processes
- Internal and National Audit including value for money studies
- Business planning processes to assess the financial impact of any proposed developments.

The Board monitors economy, efficiency and effectiveness of the use of resources through the annual plan review, its Audit Committee and Board Performance reports.

Internal Audit and National Audit studies review value for money in specified areas and test the robustness and application of Trust systems and processes.

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

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work.

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
- Accreditation reviews including Investors in People, Chartermark, Improving Working Lives and clinical peer review
- 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. A plan to address weaknesses and ensure continuous improvement of the system is in place.

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.

Signed……..

Nicola Carmichael - Chief Executive

Date: 8th June 2007

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 2007 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.

Respective Responsibilities of Directors and Auditors

The Foundation Trust is responsible for preparing the Annual Report and the financial statements in accordance with directions issued by the Independent Regulator of Foundation Trusts ("Monitor") under the Health and Social Care (Community Health and Standards) Act 2003. Our responsibility is to audit the financial statements in accordance with relevant statute, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (UK and Ireland).

This report, including the opinion, is made solely to the Council of Members of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 1 of the Health and Social Care (Community Health and Standards) Act 2003 (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 are properly prepared in accordance with the directions issued by Monitor under the Health and Social Care (Community Health and Standards) Act 2003.

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 Chair's Statement, the Chief Executive's Statement and Management Commentary, the Income and Expenditure Report and the Remuneration Report. 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.

The maintenance and integrity of the Foundation Trust's web-site is the responsibility of the Directors: the work carried out by the auditors does not involve consideration of these matters and accordingly the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web-site. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Basis of audit opinion

We conducted our audit in accordance with section 28 and Schedule 5 of the Health and Social Care (Community Health and Standards) Act 2003 and 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. It also includes an assessment of the significant estimates and judgements made by the Foundation Trust in the preparation of the financial statements, and of whether the accounting policies are appropriate to the 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 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.

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 2007 and of its income and expenditure for the year then ended;
- the financial statements have been properly prepared in accordance with the Health and Social Care Act 2003 and the directions made thereunder by Monitor.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of the Health and Social Care (Community Health and Standards) Act 2003 and the Audit Code for NHS Foundation Trusts issued by Monitor.

11th June 2007

PricewaterhouseCoopers LLP
Great George Street
Bristol BS1 5QD

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2007 have been prepared by the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust under schedule 1 para 24 and 25 of the Health and Social Care (Community Health and Standards) Act 2003 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 1, paragraph 25(4) of the Health and Social (Community Health and Standards) Act 2003.

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

Signed……..…….

Nicola Carmichael - Chief Executive

Date: 8th June 2007

INCOME AND EXPENDITURE ACCOUNT

for the year ended 31st March 2007

	NOTE	2006/07 £000	2005/06 £000
Income from activities	3-4	12,013	10,383
Other operating income	5	3,848	3,735
Operating expenses	6-7	(15,629)	(14,035)
OPERATING SURPLUS		232	83
Net financing income	8	7	22
SURPLUS FOR THE FINANCIAL YEAR		239	105
Public Dividend Capital dividends payable	9	(284)	(315)
RECORDED (DEFICIT) FOR THE YEAR		**(45)**	**(210)**

The notes on pages 47 to 72 form part of the accounts.

All activities are classed as continuing.

BALANCE SHEET
as at
31st March 2007

	NOTE	31st March 2007 £000	31st March 2006 £000
FIXED ASSETS			
Intangible assets	13	32	36
Tangible assets	14	8,550	8,322
		8,582	**8,358**
CURRENT ASSETS			
Stocks and work in progress	15	6	6
Debtors	16	1,805	1,416
Cash at bank and in hand		653	505
		2,464	**1,927**
CREDITORS: Amounts falling due within one year	17	**(2,589)**	**(2,074)**
NET CURRENT LIABILITIES		**(125)**	**(147)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**8,457**	**8,211**
PROVISIONS FOR LIABILITIES AND CHARGES	18	0	0
TOTAL ASSETS EMPLOYED		**8,457**	**8,211**
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital		6,015	5,672
Revaluation reserve	20	894	894
Donated asset reserve	20	399	451
Income and expenditure reserve	20	1,149	1,194
TOTAL TAXPAYERS' EQUITY		**8,457**	**8,211**

These accounts have been approved by the Board of Directors on 4th June 2007 and signed on its behalf by:

Nicola Carmichael - Chief Executive

Date: 8th June 2007

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES
for the year ended
31st March 2007

	2006/07 £000	2005/06 £000
Surplus for the financial year before dividend payments	239	105
Unrealised surplus on fixed asset revaluations/indexation	0	10
Increases in the donated asset reserve and government grant reserve due to receipt of donated and government grant financed assets	0	0
Reductions in the donated asset reserve due to the depreciation, impairment and disposal of donated assets	(52)	(54)
Reductions in the government grant reserve due to the depreciation, impairment and disposal of government grant financed assets	0	0
Total recognised gains for the financial year	**187**	**61**

CASH FLOW STATEMENT
for the year ended
31st March 2007

	NOTE	2006/07 £000	2005/06 £000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	21.1	775	1,376
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		7	22
Interest paid		0	0
Net cash inflow from returns on investments and servicing of finance		**7**	**22**
CAPITAL EXPENDITURE AND FINANCIAL INVESTMENT			
Payments to acquire tangible fixed assets		(693)	(603)
Receipts from sale of tangible fixed assets		0	0
Payments to acquire intangible assets		0	0
Net cash outflow from capital expenditure		**(693)**	**(603)**
DIVIDENDS PAID		(284)	(315)
Net cash inflow before financing		**(195)**	**480**
FINANCING			
Public dividend capital received		343	0
Other capital receipts		0	0
Net cash inflow from financing		**343**	**0**
Increase in cash		**148**	**480**

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 Manual for Accounts which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2006/07 NHS Foundation Trusts Manual for Accounts issued by Monitor. The accounting policies contained in the manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Resource 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 Acquisitions and discontinued operations

Activities are considered to be 'discontinued' where they meet all of the following conditions:

a) the sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved.

b) if a termination, the former activities have ceased permanently.

c) the sale or termination has a material effect on the nature and focus of the reporting NHS foundation trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the NHS foundation trust's continuing operations; and

(d) the assets, liabilities, results of operations and activities are clearly distinguishable, physicially, operationally and for financial reporting purposes.

Operations not satisfying all of these conditions are classified as continuing.

Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector.

1.3 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.

1.4 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.

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

1.5 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 2004 as at the prospective valuation date of 1 April 2005.

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.

1.5 Tangible fixed assets (continued)

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.

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	5

1.6 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.

1.7 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.

1.8 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.

1.9 Provisions

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

Clinical negligence costs

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.

1.10 Pension Costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. As a consequence it is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore the scheme is accounted for as defined contribution scheme under FRS17 and employers pension cost contributions are charged to operating expenses as and when the become due.

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

1.11 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.

1.12 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.

1.13 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 the Resource Accounting Manual, see note 29.

1.14 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.

1.15 Public dividend capital

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 forecast 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.

1.16 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.

1.17 Expenditure

Expenditure is accounted for applying the accruals convention.

2. Segmental analysis

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

3. Income from activities	**2006/07**	**2005/06**
	£000	£000
Elective income	4,731	3,822
Non-elective income	4,550	4,201
Outpatient income	2,709	2,606
Other types of activity income	111	103
PBR clawback	(235)	(474)
Private patient income	147	125
	12,013	**10,383**
Income from mandatory services	11,866	10,258
Income from non-mandatory services	147	125
	12,013	**10,383**

4. Private patient income

	2006/07	**2005/06**	**2002/03**
	£000	£000	£000
Private patient income	147	125	128
Total patient related income	12,013	10,383	9,748
Proportion (as a percentage)	**1.22%**	**1.20%**	**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%

5. Other operating income	**2006/07**	**2005/06**
	£000	£000
Research and development	697	890
Education and training	449	959
Transfers from donated asset reserve	52	54
Charitable and other contributions to expenditure	54	115
Drugs income	2,077	1,584
Other income	519	133
	3,848	**3,735**

6. Operating expenses

6.1 Operating expenses comprise:	2006/07	2005/06
	£000	£000
Services from other NHS bodies	175	85
Executive directors costs	474	445
Non-executive directors' costs	40	44
Staff costs	9,807	9,101
Drug costs	2,144	1,715
Supplies and services - clinical (excluding drug costs)	836	618
Supplies and services - general	209	199
Establishment	225	256
Transport	150	84
Premises	614	589
Bad debts	(16)	99
Depreciation and amortisation	422	377
Audit fees	55	35
Other auditor's remuneration	0	1
Clinical negligence	0	25
Other	494	362
	15,629	**14,035**

6.2 Operating leases

The Trust has no operating leases.

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)
2006/07	£000	£000	£000	£
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
2005/06				
Nicola Carmichael, Chief Executive	75-80	0	0	0
Dr Anthony K Clarke, Medical Director	85-90	55-60	0	0
Steven Haynes, Finance Director	60-65	0	0	0
Karen Kerley, Director of Human Resouces & Membership	45-50	0	0	0
Sue Gray, Director of Clinical Services	45-50	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
Gill Prior - Non Exec (until August 2005)	0-5	0	0	0
Angela Newing - Non Exec (until September 2005)	0-5	0	0	0
Richard Darch - Non Exec	0-5	0	0	0
Peter Metcalfe - Non Exec	0-5	0	0	0
Vincent Harral - Non Exec	0-5	0	0	0
Michael Bowden - Non Exec	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 2007 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2007	Cash Equivalent Transfer Value at 31 March 2006	Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000
Nicola Carmichael, Chief Executive	7.5-10.0	105-110	401	350	30
Dr Anthony K Clarke, Medical Director	12.5-15.0	290-295	0	0	0
Steven Haynes, Finance Director (until May 2006)	0-2.5	70-75	269	260	0
Paul Dodd, Finance Director (from September 2006)	0-2.5	30-35	119	107	4
Karen Kerley, Director of Human Resouces & Membership	2.5-5.0	10-15	37	27	7
Sue Gray, Director of Clinical Services (until October 2006)	0-2.5	35-40	135	122	4
Chris Fokke, Director of Clinical Practice/Nursing Professional Advisor	0-2.5	35-40	118	106	7
Hayley Sewell, Director of Governance & Performance	0-2.5	25-30	82	71	6

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

	2006/07	2005/06
	£000	£000
Salaries and wages	**8,559**	**7,897**
Social Security costs	**570**	**578**
Employer contributions to NHSPA	**915**	**863**
Agency and contract staff	**237**	**208**
	10,281	**9,546**

7.2 Average number of persons employed

	2006/07 Total Number	Permanently Employed	Other	2005/06 Total Number
Medical and dental	**18**	17	1	**16**
Administration and estates	**91**	91	0	**95**
Healthcare assistants & other support staff	**44**	44	0	**48**
Nursing, midwifery & health visiting staff	**115**	115	0	**104**
Scientific, therapeutic and technical staff	**14**	14	0	**23**
Bank and agency staff	**41**	0	41	**7**
Total	**323**	**281**	**42**	**293**

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 2006/07.

7.5 Pension costs

The NHS Pension Scheme is subject to a full valuation every four years by the Government Actuary. The last valuation relates to the period 1 April 1994 to 31 March 1999. The valuation as at 31 March 2003 has not yet been published**.** Between valuations, the Government Actuary provides an update of the Scheme liabilities. 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 Agency website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

The notional surplus of the Scheme is £1.1 billion as per the last Scheme valuation by the Government Actuary for the period 1 April 1994 to 31 March 1999. The conclusion of the valuation was that the Scheme continues to operate on a sound financial basis.

Employers' pension contributions are charged to operating expenses as and when they become due. Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. At the last valuation on which contribution rates were rebased (31 March 1999) employer contribution rates from 2003-04 were set at 14% of pensionable pay. Employees pay contributions of 6% (manual staff 5%) of their pensionable pay.

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last three 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 pensionable pay for death in service, and up to five times their annual pension for death after retirement, is payable.

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 employees can make contributions to enhance their pension benefits. The benefits payable relate directly to the value of the investments made.

8. Net financing income	2006/07	2005/06
	£000	£000
Interest receivable	7	22
	7	**22**

9. Public Dividend Capital dividend		
	£000	£000
Actual public dividend capital dividend incurred during the year	**284**	**315**
	%	**%**
The actual dividend rate is	3.41%	3.77%
The forecast dividend rate was	3.50%	3.50%
Difference between actual and forecast rate	**-0.09%**	**0.27%**

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

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

10. Public Sector Payment Policy

Better Payment Practice Code - measure of compliance

	2006/07		2005/06	
	Number	£000	**Number**	£000
Total bills paid in the year	6,708	5,565	5,079	5,055
Total bills paid within target	1,210	1,232	2,560	2,220
Percentage of bills paid within target	18.04%	22.14%	50.40%	43.92%

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

	2006/07 Software Licences £000	2005/06 Software Licences £000
Gross cost at 1 April and 31 March	**181**	**181**
Accumulated amortisation at 1 April	145	140
Provided during the year	4	5
Accumulated amortisation at 31March	**149**	**145**
Net book value		
- Purchased at 1 April	36	41
- Purchased at 31st March	32	36

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 2006	2,165	6,210	1,357	48	496	55	10,331
Additions - purchased	0	506	33	0	100	7	646
At 31 March 2007	**2,165**	**6,716**	**1,390**	**48**	**596**	**62**	**10,977**
Accumulated depreciation at 1 April 2006	0	525	955	19	460	50	2,009
Provided during the year	0	284	81	5	46	2	418
Accumulated depreciation at 31 March 2007	**0**	**809**	**1,036**	**24**	**506**	**52**	**2,427**
Net book value							
- Purchased at 1 April 2006	2,165	5,329	307	29	36	5	7,871
- Donated at 1 April 2006	0	356	95	0	0	0	451
Total at 1 April 2006	**2,165**	**5,685**	**402**	**29**	**36**	**5**	**8,322**
- Purchased at 31 March 2007	2,165	5,567	295	24	90	10	8,151
- Donated at 31 March 2007	0	340	59	0	0	0	399
Total at 31 March 2007	**2,165**	**5,907**	**354**	**24**	**90**	**10**	**8,550**

14.2 Analysis of tangible fixed assets

Net book value							
Mandatory assets at 31 March 2007	2,165	5,907	0	0	0	0	8,072
Non-mandatory assets at 31 March 2007	0	0	354	24	90	10	478
	2,165	**5,907**	**354**	**24**	**90**	**10**	**8,550**

14.3 Tangible fixed assets (contd)

Of the totals at 31 March 2007, 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 2007 £000	31 March 2006 £000
Raw materials and consumables	**6**	**6**

16. Debtors

	31 March 2007 £000	31 March 2006 £000
Amounts falling due within one year:		
NHS trade debtors	**1,387**	**795**
Provision for irrecoverable debts	**(58)**	**(99)**
Other prepayments and accrued income	**227**	**232**
Other debtors	**249**	**488**
	1,805	**1,416**

17. Creditors

Creditors at the balance sheet date are made up of:

	31 March 2007	31 March 2006
	£000	£000
Amounts falling due within one year:		
NHS trade creditors	**1,226**	**1,047**
Non - NHS trade creditors - revenue	**933**	**429**
Non - NHS trade creditors - capital	**58**	**105**
Tax and social security costs	**191**	**196**
Accruals and deferred income	**181**	**297**
	2,589	**2,074**

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

2. NHS creditors include:

£112k outstanding pensions contributions as at 31 March 2007.

18. Provisions for liabilities and charges

There were £7k included in the provisions of the NHSLA at 31st March 2007, in respect of Clinical Negligence Provisions for the Trust. (31st March 2006 was £0)

19. Prudential Borrowing Limit

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

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

	2006/07		2005/06	
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	2.3x	3.3x	2.1x	3.2x
Minimum Interest Cover	-	-	-	-
Minimum Debt Service Cover	-	-	-	-
Maximum Debt Service to Revenue	0%	0%	0%	0%

20. Movements on reserves

Movements on reserves in the year comprised the following:

	Revaluation reserve £000	Donated Asset reserve £000	Income and Expenditure reserve £000	**Total** **£000**
At 1 April 2006	894	451	1,194	**2,539**
Transfer from the Income and Expenditure account	0	0	(45)	**(45)**
Transfer to the I & E Account for Depreciation, impairment, and disposal of donated assets	0	(52)	0	**(52)**
At 31 March 2007	**894**	**399**	**1,149**	**2,442**

21. Notes to the cash flow statement

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

	2006/07	2005/06
	£000	£000
Total operating surplus	232	83
Depreciation and amortisation charge	422	377
Transfer from donated assets reserve	(52)	(54)
Decrease/(Increase) in debtors	(389)	337
Increase in creditors	562	663
Decrease in provisions	0	(33)
Decrease in stocks	0	3
Net cash inflow from operating activities	**775**	**1,376**

21.2 Reconciliation of net cash flow to movement in net debt

	2006/07	2005/06
	£000	£000
Increase in cash in the period	148	480
Change in net funds resulting from cashflows	**148**	**480**
Net funds at 1 April	505	25
Net funds at 31 March	**653**	**505**

21.3 Analysis of changes in net debt

	At 31 March 2007	Cash flows	At 1 April 2006
	£000	£000	£000
OPG cash at bank	**402**	158	244
Commercial cash at bank and in hand	**251**	(10)	261
	653	**148**	**505**

22. Capital commitments

There were no commitments under capital expenditure contracts at the balance sheet date.

23. Post balance sheet events

There were no post balance sheet events having a material effect on the accounts for 2006/7

24. Contingent liabilities

There are no contingent liabilities.

25. Movements in taxpayers' equity

	£000
Surplus for the financial year	**239**
Public dividend capital dividends	**(284)**
New public dividend capital	**343**
Transfers from the donated asset reserve	**(52)**
Net reduction in Taxpayers' equity	**246**
Opening Taxpayers' equity	**8,211**
Closing Taxpayers' equity	**8,457**

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 also 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 £54,312 from Funds Held on Trust in 2006/7. The Trust processed payments totalling £201,298 in 2006/07. Funds Held on Trust owed the Trust £48,093 as at 31st March 2007. The Trust owed Funds Held on Trust £0 as at 31 March 2007.

During the year Dr A.K. Clarke, Medical Director of the Trust and Vincent Harral, Non Executive Director, were also members of the Bath Institute for Rheumatic Diseases (BIRD).

There was a contract between this Trust and the Bath Institute for Rheumatic Diseases for the Trust to purchase from BIRD immunological testings totalling £116,255 for 2006/07 (2005/06 £109,442). The Trust received income of £0 relating to recharges of costs from BIRD in 2006/07. The Trust owed BIRD £1,686 and £58,127 was accrued income as at 31st March 2007. BIRD owed the Trust £9,774 as at 31 March 2007.

During the year P Metcalfe, Non-executive Director of the Trust, was also a councillor at B&NES council. There were transactions between this Trust and B&NES council for Non-Domestic rates totalling £59,757 for 2006/07 (2005/06 £56,736).
No money was owed by the Trust to BANES Council at 31st March 2007.

The Trust also had significant transactions with the following NHS organisations during 2006/07:

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 partnerships.

28. Financial instruments

FRS 13, Derivatives and Other Financial Instruments, 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 main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Due to the way that the commissioners are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 mainly applies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than the currency profile.

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 largely finances its capital expenditure from funds made available from Government. The Trust also has a working capital facility of £1 million available. The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

Interest-rate risk

38% of the Trust's financial assets carry nil or fixed rates of interest. The remaining 62% is subject to changes in the Bank of England base rate.100% of the Trust's financial liabilities carry nil or fixed rates of interest. The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk. The following two tables show the interest rate profiles of the Trust's financial assets and liabilities:

28.1 Financial Assets

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed rate: Weighted average interest rate	Fixed rate: Weighted average period for which fixed	Non-interest bearing: Weighted average term
	£000	£000	£000	£000	%	Years	Years
At 31 March 2007							
Sterling	653	402	0	251	0%	0	0
Other	0	0	0	0	0%	0	0
Gross financial assets	**653**	**402**	**0**	**251**			

28.2 Financial Liabilities

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed rate: Weighted average interest rate	Fixed rate: Weighted average period for which fixed	Non-interest bearing: Weighted average term
	£000	£000	£000	£000	%	Years	Years
At 31 March 2007							
Sterling	6,015	0	0	6,015	0%	0	0
Other	0	0	0	0	0%	0	0
Gross financial liabilities	**6,015**	**0**	**0**	**6,015**			

Note: The public dividend capital is of unlimited term.

Foreign currency risk

The Trust has negligible foreign currency income or expenditure.

28.3 Fair values

Set out below is a comparison, by category, of book values and fair values of the NHS Foundation Trust's financial assets and liabilities as at 31 March 2007.

	Book value	Fair value
	£000	£000
Financial assets		
Cash	653	653
Total	653	653
Financial liabilities		
Provisions under contract	0	0
Public dividend capital	6,015	6,015
Total	6,015	6,015

29. Third party assets

The Trust held £280 cash at bank and in hand at 31 March 2007 which relates to monies held by the NHS Foundation Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts for 2006/07.