Royal United Hospital Bath NHS
NHS Trust

Annual Report

2006/2007

Contents

1. Chairman's Statement

As chairman, my role is to oversee the governance of the Royal United Hospital's strategic development alongside its operational performance. I joined the trust in November 2006, taking over from Mike Roy who was the hospital's chairman for four years.

I am very pleased to report that during 2006/07 we made many advances in clinical care. I am also delighted to be able to report that as the accounts show, we achieved in year financial balance without additional financial support for the first time since the trust was set up fourteen years ago. To continue to deliver very high standards of patient care whilst addressing financial pressures demonstrates a true team effort by everyone at the RUH. I wish to pay credit to the executive directors led by Mark Davies and to my predecessor Mike Roy as well as all the hospital staff and volunteers. This work has prepared the ground for the RUH 2010 Change Programme, which during the year ahead, will support the trust in providing a more financially stable footing and more efficient services for our patients in the future.

During Mike's term as chairman, the trust turned around from being an organisation that was struggling to meet waiting lists and performance targets, and severely financially challenged, to one that is achieving right across the board. These improvements have been dramatic. As a result the RUH has received well-earned praise for its clinical and financial management and been highly rated in national guides such as Dr Foster and the CHKS Top 40 Hospital assessment.

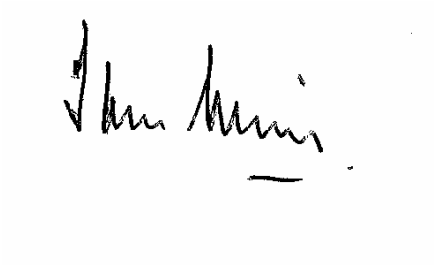
As with any organisation, there have been a number of changes to the trust board membership during the year. Professor Peter Tomkins joined the trust board as a non-executive director and Francesca Thompson became director of nursing. Following Mark Davies' departure at the end of the financial year the board is delighted that James Scott, currently chief executive at Yeovil District Hospital, will be taking over as chief executive in June. Finance director John Williams who is acting chief executive until James arrives will be leaving in June to join Wiltshire Primary Care Trust.

The hospital has come a long way since the Bath United Hospital was created in 1826. At that time it depended on donations from the citizens of Bath and, even the Bath Cycling Club, as well as from fines levied by magistrates for crimes such as poaching and picking flowers in Victoria Park.

Now we are fortunate that a great many individuals and organisations give their time and money for the benefit of the hospital and patient care. I shall continue the keen interest that Mike Roy took in the many charities that work on our behalf including the tireless work carried out by the Bath Cancer Unit Support Group and the hospital Friends who celebrate their 50th anniversary this year.

I would also like to pay tribute to the work of the hospital's Forever Friends Appeal team and thank everyone who contributed to the successful CT scanner appeal.

I am proud and privileged to be chairman and my aim is simply to progress the good work of recent years by helping the staff and volunteers to continue moving the Royal United Hospital forward.



James Carine
Chairman

2. Foreword from Chief Executive (to 31.03.07)

This annual report describes the progress the trust has made, and publishes the summary accounts, for the year 2006/07.

The year has been a momentous one for the trust as, for the first time in its 14 year history, we have broken even. This means we have provided all care within the money made available to us and have not overspent. The NHS South West Strategic Health Authority has commended us for this and for the fact that we continued to provide quality care alongside this achievement.

Our key achievements in 2006/2007

As well as achieving financial balance, the trust continued to make progress across the range of key targets agreed at the beginning of the year. The highlights included:

- Meeting all the key cancer targets
- Reducing maximum waiting times for most patients waiting for inpatient treatment to 20 weeks and for their first outpatient appointment to eleven weeks
- Reducing MRSA and other healthcare associated infections
- Reducing cancelled operations
- Delivering 100% rapid access chest pain clinic waits within two weeks
- Making the hospital site completely smoke free (including outside areas)

Other key achievements

The 2006 Dr Foster Hospital Guide, rates the RUH amongst the best performing hospitals in the UK for safety and quality of care, with expected mortality between 2003-2006 reported as low. These findings are consistent with other national assessments of the RUH's care, including the CHKS Top 40 Hospitals award received in 2005 and 2006, and a top ten rating again in the intensive care national audit. Our breast unit also performed extremely well in the Dr Foster Breast Cancer Guide 2006. This national recognition is thanks to the hard work of our dedicated staff who are consistently providing high quality care to our patients.

The implementation of a state-of-the-art Picture Archiving and Digital Communication System (PACS) has been a great achievement for the trust. Staff installed the system on time, within budget and it is already making a real contribution to improving and modernising patient care and to the way clinicians and staff work both in the RUH and in the community.

Areas of pressures

The knock on effect of the delayed transfer of care of a large number of Wiltshire patients put additional pressure on our emergency department. The trust did not meet the national target that 98% of our patients should not wait more than four hours in A&E from arrival to admission, transfer or discharge. Hospital staff are already working more closely with healthcare and social services partners to address the issues.

Looking forward

The main themes of the trust's objectives for 2007/08 are:

- Putting the patient first
- Getting it right first time
- Better communication and involvement
- Valuing staff
- Making the most of our money
- Supporting our community.

Priorities for 2007/08

Next year's priorities in line with the national NHS priorities will focus on:

- Remaining in financial balance
- Achieving the 18 week referral to treatment time target
- Reducing MRSA and other healthcare associated infections
- Reducing waiting times in A&E

Our local priorities will also reflect what aspects of care really matter to patients:

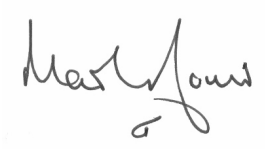
- Clean hospital
- Further reducing cancelled operations
- Further reducing delayed transfers of care
- Improving the patient experience.

During the coming year, a team of change consultants will work with staff to look at how patient services can be provided more efficiently. The aim is to improve patient care, reduce pressure on staff and make financial savings. This work will form part of the RUH 2010 change programme.

The trust consulted widely on a strategy to improve the patient experience in 2006/07. The RUH patient experience group will give final approval of the strategy the aims of which include improvements to the hospital environment, support services and customer care.

Remaining in budget and in control of our finances has been a testimony to the efforts staff have made to find savings and to work within the financial constraints that have been expected of us. Next year's budgets have now been set and we have the reassurance of knowing that we can live within our means.

2006/07 has been my last year as chief executive of the RUH. James Scott began his appointment as chief executive of the trust in June. James was chief executive of Yeovil District Hospital when it became one of the first trusts to achieve Foundation Trust status. I am confident that staff throughout the hospital will do all they can to support James to ensure that the trust continues to build on the good work it has achieved this year.



Mark Davies
Chief Executive
To 31.03.07

3. Statement from Chief Executive (from 01.06.07)

On 1 June 2007, I took up my post as the new chief executive of the Royal United Hospital Bath NHS Trust (RUH). I took over from Mark Davies who led the trust for three and a half years before leaving at the end of March this year.

The RUH has worked hard towards addressing its financial difficulties and breaking even at the end of the last financial year. My arrival is at a time when staff now have the opportunity to step back and consider what changes can be made so that we can provide more effective and efficient patient care, whilst remaining in a financially stable position.

I strongly support the ambition of RUH staff to maintain the already high standards of clinical care, to improve the patient experience and to reduce waiting – whether that is in A&E or for surgery. The change consultants appointed in April 2007, will help us to realise these ambitions but the major effort will be from staff getting involved and contributing their ideas for improvement. There will be a lot of work to do over the coming year; we will look at every aspect of our work with the aim of making efficiencies that will improve patient care and ensure that we continue to remain in financial balance.

James Scott
Chief Executive

4. The Royal United Hospital: Hospital of Choice

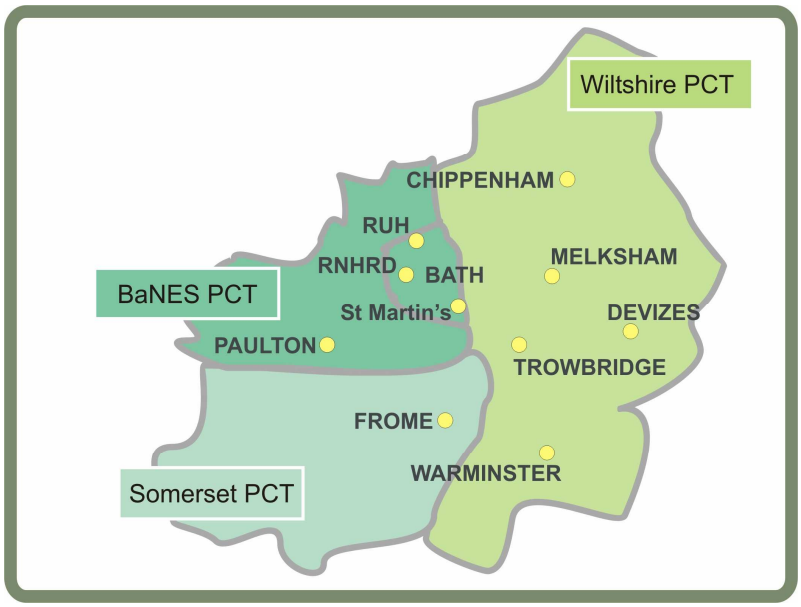
Trust profile

The Royal United Hospital Bath NHS Trust (RUH) is based on one site on the north-western edge of the city of Bath. It has traditionally served the City of Bath, the whole of Bath and North East Somerset (BANES), the majority of the western half of Wiltshire and the Mendip area of Somerset - a total population of some 450,000.

This area is covered by three Primary Care Trusts (BANES, Wiltshire and Somerset), all of which are within the new South West Strategic Health Authority. The trust also provides services for much smaller numbers of patients from the former Avon area, the Cotswolds, Swindon and other parts of Somerset.

The trust provides some 660 beds and a comprehensive range of acute services including emergency and intensive care, elderly care, medical and surgical services, children's services, and diagnostic and support services for its local population. In addition, it provides a substantial volume of cancer related services, including chemotherapy and radiotherapy, and some specialist orthopaedic surgery. Although the trust provides newborn intensive care services, maternity services are provided by Wiltshire Primary Care Trust. Both services are located on the hospital site in accommodation owned by the trust and with direct access to the main hospital buildings.

The trust employs around 4,500 staff (approximately 3,000 whole time equivalent). During 2006/07 some of these staff provided outpatient, diagnostic and same day case surgery services at community hospitals in Chippenham, Devizes, Frome, Shepton Mallet, Melksham, Paulton, Trowbridge and Warminster. This fulfils part of the trust's aim to provide high quality care to people in their local communities.



Population characteristics

The population profiles demonstrate a higher than average proportion of the population in the 65+ age bracket (17.5% - 17.9% compared with 16% nationally) with more very elderly citizens (proportion in the 85+ age bracket 2.2 – 2.4% compared with 1.9% nationally). It is projected that this will continue as a consequence of higher than average life expectancy and some movement of older people into the area for retirement.

The levels of health are fairly high with good healthy life-style choices being made although there are some pockets of greater deprivation with associated general health issues. The population is predominantly "white – UK" and is fairly stable in terms of movement in and out of the area. The population is fairly well educated.

The main areas of secondary healthcare need relate to an increasingly elderly population living with one or more chronic conditions. The trust's unplanned admissions show a bias towards cardiac and respiratory admissions. There are also high levels of trauma and the volume of cancer care is also increasing.

National factors

Patient Choice

It is predicted that the local population, whilst having a sense of loyalty to existing healthcare providers, including RUH Bath, will be open to considering alternative providers if these offer a better experience. Relatively high education levels, high levels of car ownership and a semi-rural population mean that patients are already exposed to travelling some distance for care and may feel comfortable being more 'consumerist' in their approach to health care. The trust cannot assume retention of its current patient base for low risk day case and inpatient care and will need to meet patient expectations if it is going to retain market share.

Payment by Results (PbR)

The trust is currently demonstrating a reference cost index of 91, i.e. 9 percent points below the average, and therefore should see an income gain from the full operation of Payment by Results. Because the tariff is the same for inpatients and day cases, if treatment centres take on a greater proportion of day case and low risk work this could make it more difficult for the trust to cover its costs, as it would be dealing with the more complex, and therefore more costly, cases. This could also cause the trust's reference costs to increase.

Practice Based Commissioning (PBC)

In the local health economy there is a strong history of GP and total fundholding and a significant appetite for the development of practice-based commissioning and primary care provision. This could lead to further reductions in the trust's more straightforward workload, particularly outpatients.

Creating a Patient Led NHS

Creating a Patient-Led NHS outlined a vision of work shifting from acute hospitals to more local settings, such as community hospitals and GP practices. Local PCT strategies support this shift from the acute hospital setting. This could lead to new

opportunities for the trust to run services in the community, but will also require cost reduction on the main site.

Local factors

Reconfiguration

During 2006/07, the reconfiguration of health services in England resulted in the trust working with only one strategic health authority (SHA) for the South West. The trust remains a significant provider for three different primary care trusts (PCTs), each of which has a real choice of alternative providers. This continues the difficulties of pathway development and organisational links that have existed in the past. The trust will need to work hard to maintain its market share and to ensure that the population it serves does not lose local services to more providers such as Bristol or Swindon.

Pathways for Change

Following public consultation, the Wiltshire PCT has reduced its number of small community hospitals with an aim to move healthcare provision from acute hospitals closer to home. The trust needs to take the opportunity to explore the vertical integration of services whereby it would take responsibility for running community hospitals/services.

Shaping the Future

The NHS South West SHA has developed a strategy for the development of health services for its population called *Shaping the Future*. The strategy focuses on the need to achieve financial balance within health communities and supports a strategic direction that moves health services out of acute hospital settings. The strategy calls for the RUH to work more closely with Swindon and Marlborough NHS Trust and Salisbury Healthcare NHS Trust. This work is already underway with Swindon and Marlborough. Potential links with Salisbury are less obvious given the distance between organisations, but will be considered.

Social services

Working relationships between social service departments and PCTs are variable. Particular difficulties are being encountered in Wiltshire where both the Social Services department and PCT are in significant financial difficulties. It is not therefore possible currently to see patient care responsibilities being jointly owned and the delayed transfer of care of patients within both community hospitals and acute hospitals remains a significant concern.

Competitive position

Bristol NHS Trusts

A proportion of the BaNES population sees United Bristol Hospitals NHS Trust (UBHT) as its natural district general hospital provider with well established patient flows. For the most part, however, UBHT and North Bristol NHS Trust (NBT) are used by patients for their more specialist services. The area of greatest competition with the RUH is specialist surgery related to cancer care – urology and gynaecology – where the service provided by the RUH achieves good clinical outcomes, but where there is pressure from Improving Outcomes Guidance (IOGs) to centralise.

The trust believes that there is scope to work in joint teams and therefore meet the spirit of the guidelines without a physical centralisation of surgical activity.

Swindon and Marlborough NHS Trust (SMHT)

Traditionally, RUH and SMHT had discrete catchment populations; however, the development of an NHS Treatment Centre on the SMHT site, in conjunction with its PFI partner, has introduced explicit competition between the trusts, particularly in the area of orthopaedics. The RUH is working hard to maintain its market share in this service. Opportunities exist to explore specialty links in some of the more minor surgical specialties and thereby address some workforce issues. Meetings are underway to discuss vascular surgery as a test case for future links. Discussions are led by the chief executives of the two hospital trusts.

Shepton Mallet Treatment Centre (SMTC)

This independent sector treatment centre (ISTC) was procured within wave one of the Department of Health's ISTC programme. It provides a variety of lower risk planned surgical procedures on a day case and inpatient basis. Somerset PCT expects that all patients meeting appropriate clinical criteria should be encouraged to choose SMTC for their care. The basis of the 'take or pay' contract with SMTC means that the PCT has a very explicit incentive to manage activity to the centre and avoid paying twice for the same work. SMTC is used by a small number of BaNES patients, mainly to address waiting time pressures. However, it is possible that it will attract more patients (on the basis of waiting time and experience).It was predicted that RUH would lose £1.074m in income following the opening of SMTC. 2006/07 commissioning intentions demonstrate an actual predicted shift of £0.854m over the 2004/05 baseline.

Bath Clinic (BMI)

The main private provider locally is the Bath Clinic, part of BMI. The majority of medical staff operating at the clinic are employees of the trust undertaking private practice. Currently the Bath Clinic is not a direct NHS competitor on anything other than a 'spot purchase' basis, but it is recognised that this may change as the local market develops.

Future development of independent sector

The Avon, Gloucestershire and Wiltshire area has been identified as an area requiring further development of independent sector provider activity and as such the Department of Health has procured a second-wave of independent treatment centres. Case mix and volumes remain commercial–in-confidence, but crude modelling suggests that approximately £5million of day case and outpatient activity currently provided by the RUH may transfer to this centre under 'free choice'. Until the details are known it is difficult to do any more sensitivity assessment of likely levels of risk. It has recently been suggested that this programme may be delayed. Current activity modelling shows a notional case mix being managed away from RUH Bath in 2008.

RUH 2010

The trust has worked closely with staff and members of the public and other local community organisations to develop a strategic direction for the trust from 2004 to 2010. The strategy, known as RUH 2010, builds upon the trust's vision, values and

strategic objectives. The RUH 2010 Change Programme detailed on page 24 of this report forms part of RUH 2010.

Stakeholders and public involvement

To be sure that the trust is delivering the services that meet the needs of its local population and to encourage patients to choose the RUH as their provider of care, it is essential that the hospital is tuned into those needs. During the year of this report, stakeholders including patients and the public were involved in the planning and development of many aspects of patient care, including children's services and the development of the cancer and patient experience strategies.

The trust also put a lot of effort into improving relations with GPs during 2006/07. Two evening meetings have already taken place which have provided an opportunity for consultants and GPs to discuss issues of concern and understand one another's priorities and future direction.

Changes to the Patient and Public Involvement Forum

Discussions are taking place concerning the future of the RUH Patient and Public Involvement Forum (PPI forum). Hospital PPI forums across the country may be replaced by local involvement networks which link to each primary care trust however a final decision has yet to be made.

Overview and Scrutiny Committee

The trust invested a lot of time during the year in developing its relationship with the local overview and scrutiny committee. A series of meetings has been established through which the trust can keep members of the committee briefed on issues, a practice that is proving a useful addition to the formal consultation process.

Trust vision

The best staff working together to give excellent care

The RUH is committed to doing its best and working to ensure the safety of all who use or work in its services. It is an organisation that can be trusted to do what it says it will do. These behaviours should be recognisable in the way in which each member of staff undertakes his or her job.

Trust values

The RUH is an organisation that wishes to be recognised as valuing the individual and acting in ways that demonstrate respect and dignity for patients, their carers and staff. Together, our staff agreed how we could do this and agreed values which included: treating each other with respect, putting patient care at the heart of what we do, challenging ourselves and others, telling the truth, being willing to have our actions and decisions scrutinised by others and applauding loyalty, improvement and innovation.

Commitment to the NHS Plan

The trust's objectives for 2007/08 will enable us to deliver the Government's NHS Improvement Plan: Putting People at the Heart of Public Services. This plan will significantly reduce waiting times to a maximum waiting time of 18 weeks from GP referral to treatment by 2008. Whilst reducing waiting times, our staff will continue to provide excellent clinical care for patients and find ways to improve our services and achieve financial balance.

5. How the RUH is managed

Management of the hospital is the responsibility of the trust board which comprises eight executive directors (five of whom are voting members) who are professional managers and clinical staff, a chairman, and five voting non-executive directors appointed from within the RUH catchment area.

The trust's board is responsible for the following:

- Understanding and managing risk in the trust's activities
- Setting organisational values and standards of conduct
- Providing leadership to the trust within a framework of effective controls
- Ensuring compliance and statutory responsibility to break-even
- Setting strategic aims and policies
- Ensuring quality and safety of services
- Ensuring progress is made against planned objectives
- Taking major decisions, e.g. approving the provision of an angioplasty service in cardiology, and the purchase of a new CT scanner
- Satisfying itself regarding performance of this through all its activities

It must take account of government policy changes such as the current right of patients to choose the hospital in which they will be treated.

It is responsible for ensuring that everything that happens at the RUH, from financial management to the quality and effectiveness of the clinical services we provide, is properly governed and controlled and that there is effective communication with staff, patients and public.

The board oversees the relationships with our partners in the health community and agrees the annual Local Delivery Plan (LDP); this is negotiated with our commissioners, the local primary care trusts, BANES, Somerset, Wiltshire and Gloucestershire and sets out the services we will provide, the funding that will be available and how we intend to meet key national requirements.

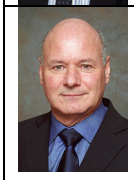
Just as important are the trust's relationships with local authorities, social services, universities, professional organisations, the Patient and Public Involvement Forum and the South West Strategic Health Authority which monitors the trust's performance on behalf of the Department of Health. The trust must also aim to achieve national Government targets some of which are monitored by the Healthcare Commission and contribute towards the Annual Health check.

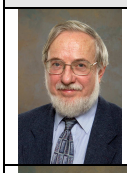
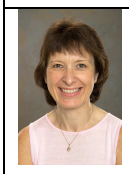
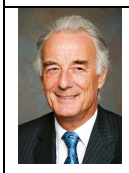
The trust board members are also trustees of the RUH charities currently valued at £3m.

Non-executives are appointed by an independent body; the Appointments Commission and are drawn from the local community to ensure that the interests of the patients and the community remain at the heart of the board's decisions. Their role is to concentrate on strategy, good governance, risk and financial management.

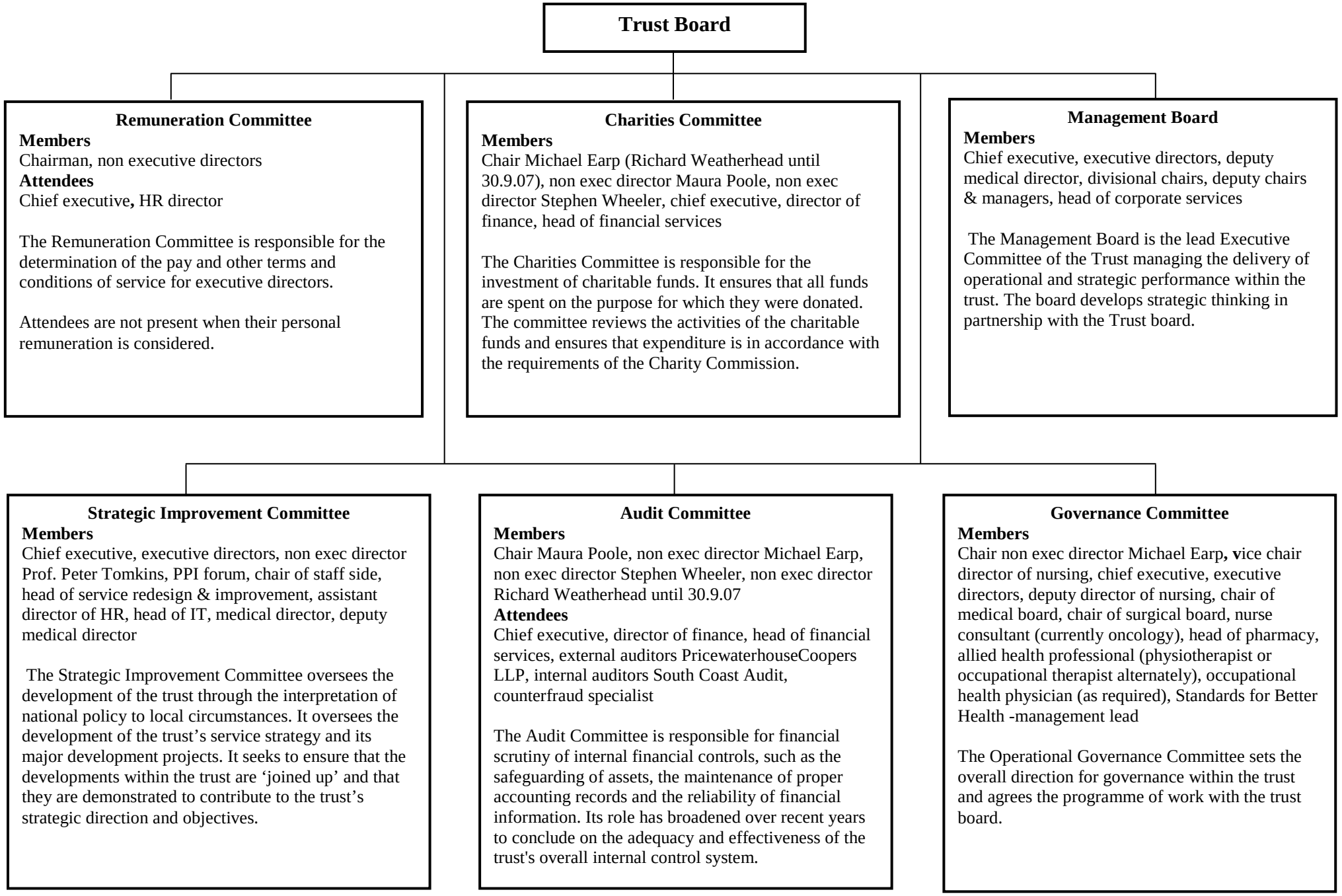
The trust board meets in public on a bimonthly basis. A private formal meeting follows the public session to oversee issues of commercial or personally confidential nature. The trust board also meets on alternate months in a developmental capacity.

Trust board membership

	Name	Position	Tenure	Voting	Board sub-committees	Attendance at trust board
	Mike Roy	Chairman 1.11.02 to 31.10.06	4 years	Yes	Remuneration Committee	3/4
	James Carine	Chairman 1.11.06	4 years	Yes	Remuneration Committee	2/2
	Michael Earp	Non-Executive Director 1.12.04	4 years	Yes	Audit Committee Remuneration Committee Governance Committee Charities Committee	6/6
	Jonathan LLoyd	Non-Executive Director 1.04.02	4 years	Yes	Remuneration Committee Research and Development Committee Arts Committee	6/6
	Maura Poole	Non-Executive Director 1.1.03	4 years	Yes	Charities Committee Audit Committee Remuneration Committee	5/6
	Prof. Peter Tomkins	Non-Executive Director 1.1.07	4 years	Yes	Remuneration Committee Strategic Improvement Committee	1/1
	Richard Weatherhead	Non-Executive Director 1.05.03 to 30.09.06	4 years	Yes	Remuneration Committee Audit Committee Charities Committee	4/4

	Name	Position	Tenure	Voting	Board sub-committees	Attendance at trust board
	Stephen Wheeler	Non-Executive Director 1.11.05	4 years	Yes	Charities Committee Audit Committee Remuneration Committee	6/6
	Mark Davies	Chief Executive 03.11.03 – 31.03.07	Sub-stantive	Yes	Charities Committee Management Board Governance Committee Strategic Improvement Committee	6/6
	Diane Fuller	Director of Patient Care Delivery	Sub-stantive	Yes	Management Board Governance Committee Strategic Improvement Committee	5/6
	Francesca Thompson	Director of Nursing	Sub-stantive	Yes	Management Board Governance Committee Strategic Improvement Committee	2/2
	John Waldron	Medical Director	Sub-stantive as a consultant ENT surgeon	Yes	Management Board Governance Committee Strategic Improvement Committee	6/6
	John Williams	Director of Finance	Sub-stantive	Yes	Charities Committee Management Board Governance Committee Strategic Improvement Committee	6/6
	Stephen Holt	Director of Facilities	Sub-stantive	No	Management Board Governance Committee Strategic Improvement Committee	6/6
	Brigid Musselwhite	Director of planning & strategic developme nt	Sub-stantive	No	Management Board Governance Committee Strategic Improvement Committee	6/6
	Lynn Vaughan	Director of Human Resources	Sub-stantive	No	Management Board Governance Committee Strategic Improvement Committee	6/6

Sub committees of trust board



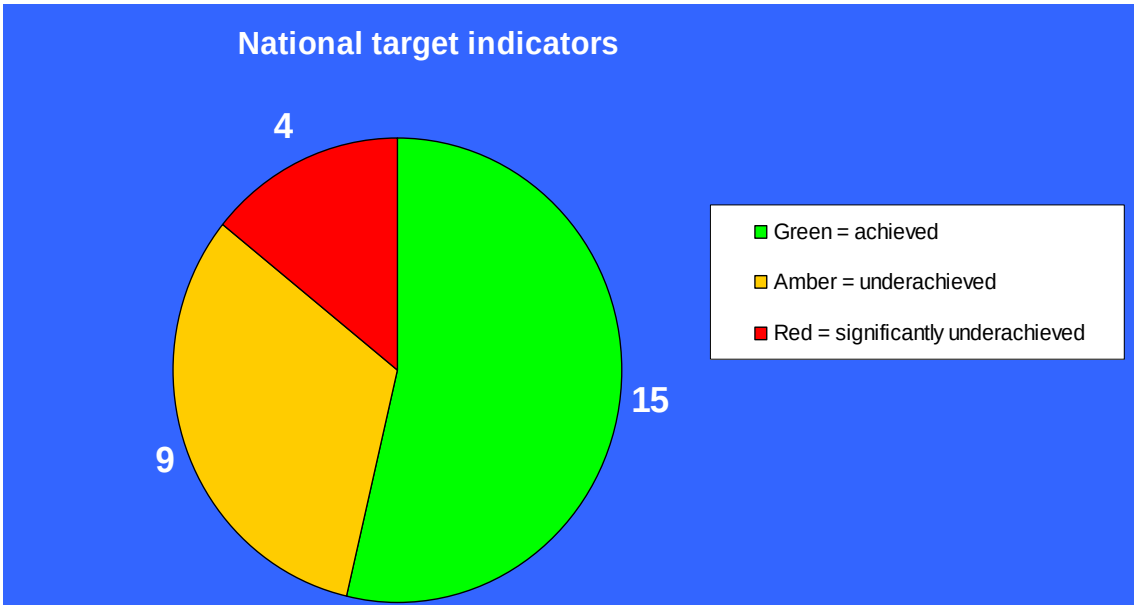
6. Review of Trust Performance 2006/07

The following figures indicate the route our patients took to receive their treatment during 2006/07:

- 68,474 patients (68,958 in 2005/06) attended our emergency department and there were 31,291 non-elective admissions (31,793 in 2005/06)
- 6,857 patients were admitted for elective inpatient procedures (461 less inpatients than in the previous year - a fall of 6.3%)
- 22,301 patients were treated for elective day case procedures (1,022 less day cases than in the previous year – a fall of 4.4%)
- 249,598 patients were seen in our outpatient departments (441 more outpatients than in the previous year)

The trust's performance against key national targets

2006/07 saw the trust meet its finance target to break-even. The following pie chart shows our overall performance* against all national targets:



Our performance against the more significant non financial national targets is summarised below:

Improving the care for cancer patients

The trust has made real progress against cancer targets which were achieved in all areas:
Green: 99.7% of our patients waited for a maximum of two weeks for urgent GP referral to first outpatient appointment for all suspected cancer referrals. This was against a 98% threshold.
Green: 99.9% of our patients waited for a maximum of one month from diagnosis to treatment for all cancers by December 2006, against a threshold of 97%.

Green: 97.2% of our patients waited a maximum of two months from urgent referral to treatment for all cancers by December 2006, against a threshold of 94%.

Reducing waiting times

Green: The trust achieved a maximum wait of 13 weeks for an outpatient appointment with only 0.014% of our patients not being seen within this time against a threshold of 0.03%
Amber: The trust underachieved on the target for the maximum wait of 11 weeks for an outpatient appointment (95% versus 97% threshold) and 13 weeks for a diagnostic test; however, substantial improvements to waiting times for scans and for endoscopy were achieved.

Improving the control of hospital associated infections

Amber: Figures published in January by the Health Protection Agency (HPA) show that the RUH is making real improvements in tackling healthcare acquired infections. The trust implemented an effective MRSA improvement programme during the year that was shared with acute trusts nationally at the request of the Department of Health. Since September, the trust has performed well; however, the number of cases earlier in the year has meant that the trust missed the overall annual target.

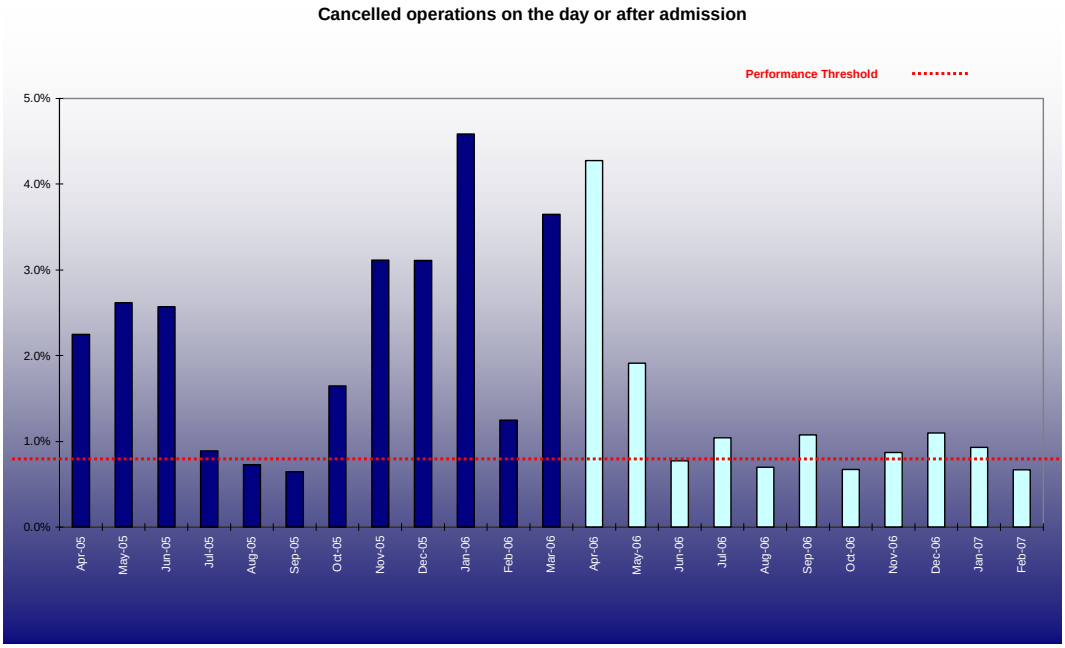
Improving the care for patients waiting or needing an operation

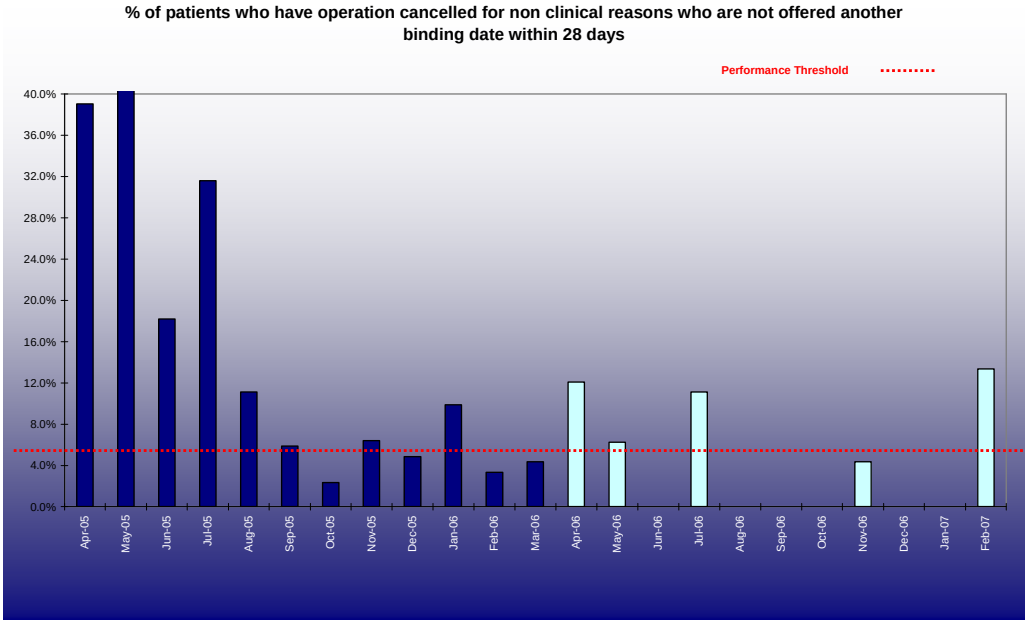
Amber: During the year the trust reduced waiting times below 20 weeks for those PCTs that had commissioned reduced waiting times. For other PCTs the trust maintained a 26 week wait. Our forecast underachievement for the percentage of patients waiting less than 20 weeks for an elective admission for 2006/07 is due in very large part to the levels of activity commissioned by our local PCTs (88% versus a 97% threshold).
Red: Whilst we successfully reduced waits for our Somerset and Wiltshire inpatients and managed patients to a maximum 26 week wait, administration errors – which have now been addressed – led to a number of breaches which meant we failed to meet the 26 week target for maximum wait for inpatients in 2006/07.

Reducing cancelled operations

Amber: Significant improvements (up 13% from last year) were made towards the target for patients who have operations cancelled for non clinical reasons to be offered another date within 28 days. 6.4% of cancellations in the 2006/07 year were not re-booked within 28 days against a threshold of 5%. Performance has substantially improved through the year as is shown by the graphs below.

* The Healthcare Commission assesses a trust's performance against the national targets by defining performance thresholds. These thresholds are subject to confirmation by the commission prior to the announcement of Annual Health Check results in autumn 2007. Therefore, comments on performance refer to the likely outcomes but may be subject to change.





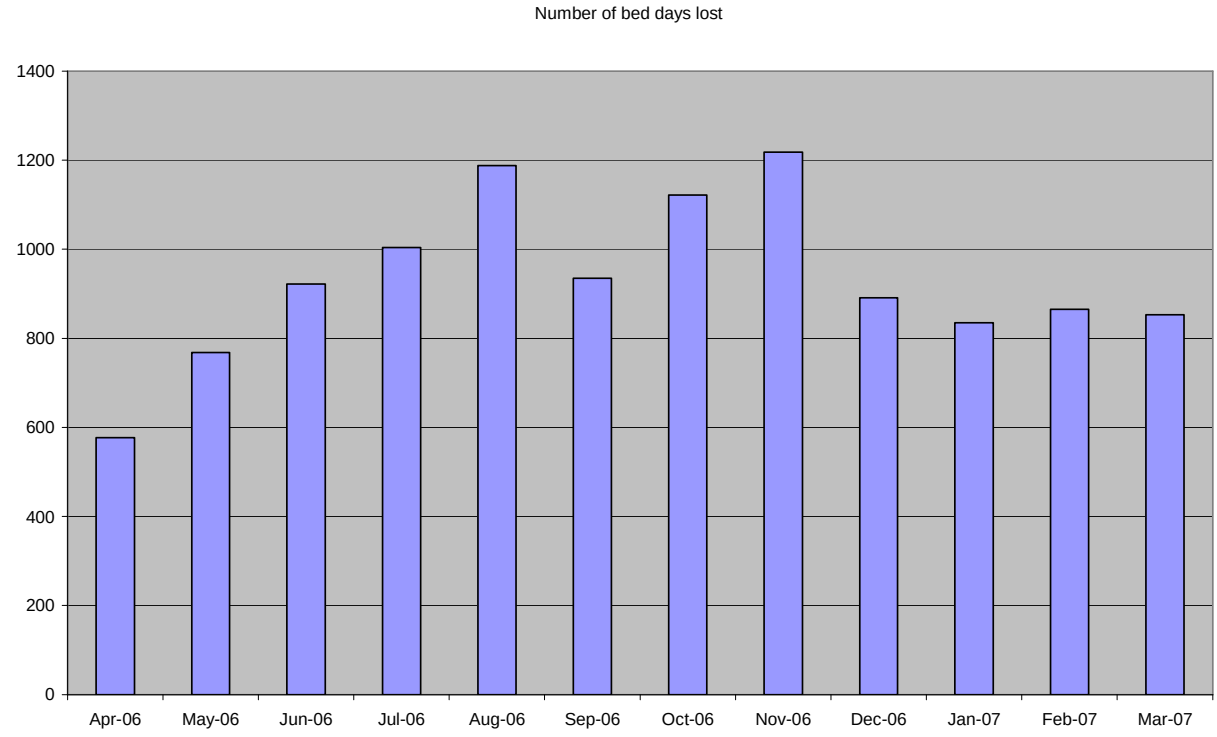
Areas requiring further work

Delayed transfers of care for patients who no longer need to be in an acute hospital setting continued to be the major operational issue for the trust in 2006/07. Failure to facilitate patients leaving hospital as soon as they were ready meant that hospital beds were not always available for sick patients waiting to be admitted from A&E. An increasing number of patients also attended the A&E department for minor reasons that should more appropriately be managed elsewhere. The trust aims to improve its relationships with local primary care trusts, the ambulance trust and social services to encourage unplanned patients (those requiring emergency treatment) to use the hospital appropriately, ensure patients with chest pain are treated quickly and to ensure that patients are able to go home as soon as they are well enough. It is anticipated that this work will improve the following performance:

Amber: 60 minute call to needle thrombolysis target for patients suffering heart attacks. Although the trust has achieved its part of the target by treating patients within half an hour of arrival, it is forecast to underachieve the thrombolysis– 60 minute call to needle time target (return on data still awaited). Thrombolysis is a treatment that may help patients who have had heart attacks but it needs to be given shortly after the onset of chest pain.

Red: Maximum four hour stay in an A&E department before transfer, admission or discharge. The trust did not achieve the four hour maximum wait target for A&E in 2006/07; this is in part due to the high levels of patients whose transfer of care has been delayed resulting in a lack of beds into which patients can be admitted. During the year, 95.8% of patients waited four hours or less in A&E from arrival to admission, transfer or discharge versus threshold of 98% (despite a reduction in emergency bed days). To address this issue a six month programme of work with primary care trust partners will begin early in 2007/08.

Red: Reduction in patients fit for discharge for whom discharge is delayed due to the unavailability of further community health or social care provision. Due to difficulties that Wiltshire Social Services has in providing appropriate care for its patients in the community, the trust did not achieve the target for delayed transfers of care. The trust achieved 6.3% delayed transfers of care versus threshold of 3.5%. The graph below shows the number of bed days lost during the year as a result of patients experiencing delayed transfer of care:



Performance against other national targets

In addition to the key targets above, the trust is also forecast to achieve the following national targets: elective outpatient booking, waiting time for rapid access chest pain services and reduction in emergency bed days.

Other achievements

Good clinical outcomes

The 2006 Dr Foster Hospital Guide, rates the RUH amongst the best performing hospitals in the UK for safety and quality of care, with expected mortality between 2003-2006 reported as low. These findings are consistent with other national assessments of the RUH's care, including the CHKS Top 40 Hospitals award received in 2005 and 2006, and a top ten rating again in the intensive care national audit. Our breast unit also performed extremely well in the Dr Foster Breast Cancer Guide 2006. This national recognition is thanks to the hard work of our dedicated staff who are consistently providing high quality care to our patients.

Highly recommended for work around patient safety alerts

The trust has had excellent feedback following an assessment of the effectiveness of our internal processes for the receipt, dissemination, validation and instigation of changes required from Safety Alert Broadcasts from the National Patient Safety Agency. Several innovative practices at the RUH were adopted for national learning.

Annual Health Check

The trust received a rating of 'fair' by the Healthcare Commission in the 2006 Annual Health Check. Staff continued to make huge efforts through the year to improve performance at a time when they were also under a lot of pressure to make real financial savings. As mentioned previously, substantial improvements were made to waiting times for diagnostic tests and waiting times for planned surgery.

Hospital cleanliness

92% of patients responding to a recent ward survey rated the cleanliness of their ward as being good or excellent. Hospital cleanliness remains a key issue for the public and is constantly heightened by concerns around hospital acquired infections. The trust was rated as 'satisfactory' in the 2006 Patient and Environment Action Team (PEAT) assessment for hospital cleanliness. Additional investment, including a further deep cleaning team have helped the trust to make progress in this area. The successful introduction of a smoking ban making the hospital site completely smoke free (including outside areas) has also contributed towards the RUH becoming a cleaner hospital.

Patient survey results

In May 2007, the Healthcare Commission published the results of the national inpatient survey which related to patients discharged from the RUH in June, July and August 2006. Nine out of ten inpatients who responded to the survey rated their care here as 'good or better', the majority had trust and confidence in our doctors and nurses treating them and believed that we care for our patients with dignity and respect. For the second year running patients also highly rated how quickly and effectively staff controlled their pain at the RUH.

As a result of the survey, our priorities for action include: reducing the length of time patients sometimes have to wait to get to a bed on a ward, providing more privacy

when discussing a patient's condition or treatment and improving the way information is given to patients about their care. Staff are also working hard to improve the way that we manage patients leaving hospital as more patients than we would have liked experienced delays around discharge, were waiting for medicines or wanted better information about their medication.

Patient experience

Encouragingly, during 2006/07, the trust also performed well in a number of other important aspects of patients' experience at the RUH. This includes gaining a 'good' score for hospital food and receiving a food hygiene award. The trust received many letters of praise and thanks from grateful patients and many thank you letters were published in local newspapers as evidence of the high level of patient care provided.

As part of our aim to put patients at the heart of everything we do, the trust is launching a new strategy to improve patient experience – the strategy's main focus is to listen and to respond to patient views.

A new patient experience group - with representation from former and current patients, social services and voluntary groups, the RUH Patient and Public Involvement Forum, non executive director, director of nursing and senior managers and clinicians – was launched in May. As well as helping to develop the patient experience strategy, initial areas that the group will focus on include patient information, customer care, and a mobile phone policy. Response to the new group has been very positive and it is anticipated that members will make a significant contribution towards improving patient experience.

Privacy and dignity

Last year we also established a privacy and dignity group, chaired by one of the modern matrons, to review and monitor this aspect of patient care and make recommendations for improvements. The group has been auditing privacy and dignity in outpatient areas and will be revisiting inpatient wards later in the year.

The trust has identified a number of priorities to improve privacy and dignity for our patients. They include providing signs on doors and bed curtains to remind staff and visitors to ask permission before entering the bedside area and providing more privacy when discussing a patient's condition or treatment.

Standards for Better Health

The trust's performance against the core standards will form part of the 2006/07 rating as part of the Annual Health Check. From the March board paper 'Final self assessment report for Standards for Better Health Declaration' the trust is fully compliant with 21 out of 24 core standards. Further work is in progress in the areas of both medicine management and records management, and the trust was compliant in the implementation of NICE Technology appraisals at the end of the financial year.

7. Trust's Objectives 2006/07: The Highlights

The trust sets objectives for each year in line with national objectives. The objectives aim to meet these and the strategic development and performance objectives of the trust. The personal objectives of staff should aim to meet the trust objectives.

Below are examples of some of the achievements made towards meeting the objectives for 2006/07.

Putting the patient first

The Intensive Care National Audit and Research Centre (ICNARC) again reported in 2006/07 that the intensive care unit at the RUH continues to be one of the safest in the country. When compared to 35 units of similar size, the unit has the second best survival rate and is rated in the top ten nationally. Treatments in the unit include a radical new cooling treatment for heart patients used to help prevent brain damage in patients whose heart has been restarted after a cardiac arrest. Around 80 patients have undergone this therapeutic hypothermia which uses either an 'inflatable tent' or an intravenous method to cool the patient's core temperature from the normal 37ºC to 33ºC.

The RUH has also expanded cardiac services including installation of a second specialist catheter laboratory and the appointment of two further cardiologists. This has enabled the RUH to offer a new coronary angioplasty service to local patients who would previously have had to travel to Bristol for their treatment.

Getting it right first time

In February, the trust introduced a state-of-the-art Picture Archiving and Digital Communication System (PACS) - the most significant change in medical imaging since the discovery of x-rays. PACS enables images such as x-rays and scans to be stored electronically and viewed on standard computer screens.

The implementation of PACS has been a great achievement for the trust. The system was installed on time, on budget and it is already making a real contribution to improving and modernising patient care and to the way clinicians and staff work. x-rays and scan images can now be viewed and stored digitally without the need for x-ray films which are less accessible.

Better communication and involvement

A great deal of effort has been made during the year to address this objective with a particular focus on staff who were working under a great deal of pressure. A staff involvement policy was agreed, its aim being to improve two-way communication within the trust and to help staff feel more involved and more positive about the organisation.

The policy supports a formal team briefing system which was implemented at the end of the year and a new staff newsletter that is being issued to all staff via their payslip at the end of each month.

As part of an annual staff honours system a new award for ‘personal achievement’ was established and is now being presented to individuals deserving recognition for their outstanding contribution in their area of work. Staff who have worked at the RUH for 25 or more years also receive a loyalty award which recognises their long service at the hospital.

Learning together

The 2006 Staff Survey reported a significant increase in the percentage of staff receiving appraisals (from 12% to 61%) and in staff reporting that they have personal development plans (from 38% to 52%). The education and training team worked hard during the year to support managers and staff in implementing the new knowledge and skills framework (KSF) that underpins appraisals. The trust was described as being at the forefront of this work within the former Avon, Gloucestershire and Wiltshire Strategic Health Authority.

The survey also reported the trust was well above the average of acute trusts in providing job-relevant training, learning or development with 74% staff reporting that they had received training in the previous 12 months.

Making the most of our money

Staff put forward over 100 suggestions to the trust consultation and negotiation committee, to save money or increase efficiency. Savings ideas included making better use of a range of products and drugs, reducing sickness absence, recycling and energy efficiencies, reducing use of pre-printed stationery and reducing food wastage. Each idea was carefully considered to see which of them could offer potential savings and efficiency in the immediate, short and longer term.

Examples include savings identified by the pathology department that resulted in a one-off saving of £434,659 at the end of December. Around £600,000 was saved by the end of the financial year. Another suggestion to abolish automatic use of first class post has achieved an annual saving of £15,000.

The Forever Friends campaign for a second CT scanner is now complete, thanks to the superb generosity of the appeal’s supporters, businesses, patients and the general public. Former CT patients also raised a magnificent £160,000 towards the scanner. Their overwhelming support meant that the campaign target was exceeded by £60,000. The equipment is on order and is due to be installed in summer 2007.

Supporting our community

In November 2006 the trust carried out a survey of GPs within its catchment area. The purpose of the survey was to understand how GPs felt the RUH was performing in key areas, to be clear about GP areas of priority and to highlight any concerns they may have. The trust received responses from 89 local GPs.

The feedback was taken into account when drafting the trust’s objectives and action plans for 2007/08 to ensure the trust improves the way it communicates and works with GPs. The trust is planning to operate the survey on an annual basis to track improvement in these key areas.

From the November survey, 74% of GPs rated the quality of medical care at the RUH as positive or very positive. In addition, GPs rated the RUH in positive terms for the quality of nursing care and treating patients with dignity and respect.

Key areas of priority included general patient administration and communication and improving the timeliness and content of discharge summaries. The trust objectives for 2007/08 include areas to address these concerns, namely, 'designing and implementing a patient experience strategy and action plan' (to include patient information) and 'ensuring accurate and timely discharge summaries for every patient'.

8. The Year Ahead: Trust Objectives 2007/08

Next year's priorities are in line with the national NHS priorities which include financial balance, reducing MRSA, C. diff and other healthcare associated infections, and achieving the 18 week referral to treatment time target. An additional big priority for the trust is to ensure the RUH is perceived by all users as a clean hospital.

The trust's corporate objectives for 2007/08 address the areas of relative weakness and support trust development with the potential to becoming a Foundation Trust. They form the basis of the RUH Business Plan 2007/08, and are incorporated into the Foundation Trust Action Plan and Organisational Development Plan and are set out at the end of this section.

RUH 2010 Change Programme

Breaking-even at the end of 2006/07 was just the first step towards greater financial stability and efficiency. Significant focus during the year ahead will be on the RUH 2010 Change Programme which represents that next step of the organisation's plans to become a more efficient and better performing hospital. To help facilitate this, a team of change consultants were selected at the beginning of 2007/08 to work with staff to identify and make further financial and efficiency savings. The consultants have a track record of success in other healthcare organisations; their expertise will form an essential part of the RUH 2010 Change Programme as well as providing the transfer of essential skills to our staff. They will support the trust in meeting the 18 week GP referral to treatment target which will greatly improve patient care and encourage patients to make the RUH their hospital of choice.

RUH objectives for 2007/2008

Themes	Associated work programmes	Lead committee	Action to be taken in 2007/08
Putting the patient first	**Patient Experience**	Governance	Design and implement a patient experience strategy and action plan (to include customer service)
	Patient Safety - Clinical Quality	Governance	Develop a procedure to capture information on clinical quality in order to inform governance and patient choice

Themes	Associated work programmes	Lead committee	Action to be taken in 2007/08
		Strategic Workforce Forum	Implement Modernising Medical Careers and develop a sustainable model for out of hours care
	- Infection control	Governance	Achieve MRSA and CDiff targets
	- Standards for Better Health	Governance	Achieve compliance with all core standards and developmental standards D1 and D2
	Patient Access	Management Board	Achieve 18 week milestones by 31 March 2008
	- 18 weeks - National targets	Management Board	Achieve other national service targets
		Strategic Workforce Forum	Implement gender equality scheme
Better communication and involvement	Consistent communication and involvement	Strategic Workforce Forum	Implement the staff involvement policy, including trust-wide team briefing, and ensure action plan is monitored
	External communication	Strategic Improvement	Implement trust-wide marketing plan
		Governance	Ensure accurate and timely discharge summaries for every patient
Valuing staff	Appraisal	Strategic Workforce Forum	Ensure that 100% of staff receive an annual appraisal
			Ensure medical and non-medical appraisals link to corporate objectives.
	Leadership	Strategic Workforce Forum	Ensure a coordinated strategy for leadership across the organisation with particular emphasis on clinical and team leadership
	Understanding staff	Strategic Improvement	Have in place a planned programme for the 'back to the floor' initiative
Getting it right first time	RUH 2010 change management programme	Strategic Improvement	Commission external support in order to achieve organisational transformation and associated sustainability plan
		Management Board	Ensure benefits of Millennium and the Electronic Staff Record are achieved
Making the most of our money	Achieving financial balance	Management Board	Achieve divisional saving plan for 07/08
			Define and achieve trust wide efficiencies that fit with the RUH 2010 change management programme
		Strategic Workforce Forum	Ensure compliance with requirements of the Local Auditors' Evaluation
		Strategic Improvement	Ensure a programme of business skills development for Trust board and accountable senior managers

Themes	Associated work programmes	Lead committee	Action to be taken in 2007/08
	Develop efficient and fit for purpose estate	Strategic Improvement	Progress Trust Estate Development Plan
Supporting our community	Achieve integrated service planning	Strategic Improvement	Work in partnership on designing effective community wide patient pathways, specifically around urgent care and diagnostics
	Critical mass and service portfolio	Strategic Improvement	Further refine service strategy based on critical mass requirements and equity of access

9. If you would like to know more

If you would like to know more, or to comment on our plans, please write to the chairman James Carine or the newly appointed chief executive James Scott at:

Royal United Hospital NHS Trust
Combe Park
BATH
BA1 3NG

Telephone: 01225 824033

E-mail: info@ruh-bath.swest.nhs.uk

Website: www.ruh.nhs.uk

10. Financial Review 2006/07

In 2006/07 one of the trust's corporate objectives was 'Making the most of our money' and within this was the targets of 'achieving financial balance' and 'maximising appropriate income'.

In 2006/07 the Trust demonstrated the achievement of these by 1) recording a surplus of **£144k** (2005/06 deficit of £7.3m) and 2) making savings of £14.5m.

2006/07 was the first year that the trust made a surplus on its income and expenditure account without additional financial support since it was formed in 1992. This is a huge achievement, not arrived at without a lot of pain, but a tremendous success to be shared amongst the whole of the trust staff.

The trust has continued in 2006/07 to implement a vigorous financial recovery plan so that it can achieve financial balance in the longer term. In 2006/07 the trust had a target financial recovery plan of £13.2m, all of which was identified and implemented. In addition to the £13.2m, a further £1.3m had to be found to cover the top slicing of centrally held budgets when these were distributed to the Trust.

A summary of the trust's financial performance over the past 4 years is set out below:

Historical financial information	**2003/04 £m**	**2004/05 £m**	**2005/06 £m**	**2006/07 £m**
Income	147	160	166	178
Pay expenditure	-97	-107	-115	-114
Non pay expenditure	-43	-44	-46	-50
SURPLUS/-DEFICIT before INTEREST	**7**	**9**	**5**	**14**
Net interest, depreciation & dividend	-9	-10	-12	-14
NET DEFICIT	**-2**	**-1**	**-7**	**-**
Financial support received	-10	-10	-	-
Other one-off factors (net)	-5	-2	-	-
NORMALISED DEFICIT	**-17**	**-13**	**-7**	**-**
Key financial indicators	**%**	**%**	**%**	**%**
Reference Cost Index (RCI)	93	90	91	-
Cost improvements as % of clinical income	6	9	10	8
Increase in admitted patient care spells	-	3	2	-3

The impact of the cost improvement plans can be seen in the reducing reference cost index, and the increasing proportion of savings achieved (see table above).

Resource Accounting and Budgeting (RAB) was introduced into the NHS in 2003/04. The way RAB works is that for any organisation that overspends in one year, the value of the over spend is taken off their income in the following year. The Trust was required to repay the deficit from 2005/06 (of £7.3m) over a period of 4 years,

starting in 2007/08 at £1.8m per year. In addition to this, an interest charge of 10% on the £7.3m being £734,000 had to be covered from savings within the trust in 2006/07.

A recent announcement has been made on the removal of RAB in the NHS from April 2007. The trust will therefore not be required to repay the £7.3m.

Details of the trust's financial recovery plans are closely monitored by the trust board every month, and have been closely monitored and reviewed by the strategic health authority (SHA). Copies of board papers are available on the trust's web site.

Accumulated deficit, breakeven duty and accumulated cash deficit

Despite the financial stability demonstrated in 2006/07, the trust has a substantial accumulated deficit on the Income and Expenditure Reserve, standing at £43m.

The deficit has been built up over the years as follows:

	In Year Deficits	Breakeven Duty
	£'000	£'000
1992/93	-2,724	-
1993/94	-676	-
1994/95	-2,545	-
1995/96	-586	-
1996/97	-777	-
1997/98	-722	-
1998/99	-478	-
1999/00	-543	-
2000/01	-336	-
2001/02	1,242	-
2002/03	-24,784	-24,784
2003/04	-1,968	-1,968
2004/05	-946	1,022
2005/06	-7,339	-6,393
2006/07	144	144
Accumulated Deficit	-43,038	-31,979

In every year since its formation in 1992 the trust has recorded a deficit, with the exception of 2001/02 when it received £17.9m of support. Legislation requires the trust to break-even 'taking one year with another'. In 1997, guidelines were issued by the Department of Health on how this should be measured in practice. The guidelines specified that Trusts should breakeven over a 3 year period, although in extreme circumstances this would be extended to 5 years. At this point any deficits incurred before 1997 were disregarded for the purposes of monitoring ongoing breakeven.

Due to the size of the deficit incurred by the trust in the 2002/03 financial year, the SHA agreed to extend the trust's breakeven period to 5 years. This means that the deficits incurred in 2002/03 and subsequent years, needed to be recovered by 31st March 2007. It should be noted that the trust's balance sheet deficit (£43.1m)

includes deficits prior to 2002 and consequently is larger than the amount to be recovered by 2007 under the statutory breakeven duty of £32m.

To meet the breakeven duty, the trust was required to make a surplus of £32m by 31 March 2007. This was clearly not achievable. In addition, the trust was reliant on cash brokerage from the SHA each year to ensure it could continue to pay its bills.

In March 2007, the trust entered into a loan agreement with the SHA for £38m repayable over 20 years. The loan repayments are £1.9m per year and must be made from a surplus on the Income and Expenditure Account each year. Achievement of such a surplus each year will effectively reduce the accumulated deficit of the trust.

The loan has to be repaid with interest and this is being charged at 5.05%. The interest charge of £1.85m is an additional cost to the trust and will have to be covered from further savings.

Together, the loan repayment and interest payment equate to approximately £4m of additional costs to the trust each year.

Financial targets in 2006/07

As well as the breakeven duty, the trust had other financial targets to meet in 2006/07. Brief details of these are set out below; they are also included in the attached full set of accounts.

External financing limit (EFL)
The EFL sets out the amount of cash that the trust is expected to hold at the end of the financial year. To meet the EFL, the trust must manage its cash flow and borrowing requirements. During the 2006/07 financial year the trust was able to manage within its cash requirements, and meet this target.

Capital resource limit (CRL)
The CRL is the maximum amount that the trust can invest in fixed assets during the year. In 2006/07 the Trust met its CRL.

Capital cost absorption rate
The trust is required to make a return on the assets it employs of 3.5%. In 2006/07 the Trust achieved a return of 3% which is within acceptable tolerances on this target.

Management costs
The trust is required to record its management costs according to parameters set by the Department of Health and to state these in relation to relevant income.

	2006/07 £000	2005/06 £000
Management Costs	6,863	6,836
Income	171,747	158,261

Cost as a percentage of income	4.00%	4.32%

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

Better payment practice code - Measure of compliance

	2006/07 Number	2005/06 Number
Total Non-NHS trade invoices paid in the year	62,624	65,295
Total Non NHS trade invoices paid within target	57,131	57,023
Percentage of Non-NHS trade invoices paid within target	91%	87%
Total NHS trade invoices paid in the year	2,390	2,679
Total NHS trade invoices paid within target	2,008	2,059
Percentage of NHS trade invoices paid within target	84%	77%

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

Future financial plans

The trust has completed its financial forecasts based on a set of assumptions. The forecasts for the next 4 years are shown below:

Four year financial forecast

Forecast financial information		**2007/08 £m**	**2008/09 £m**	**2009/10 £m**	**2010/11 £m**
Income		176	171	171	174
Gain from PbR		11	13	13	13
Pay expenditure		-118	-114	-114	-116
Non pay expenditure		-53	-53	-53	-54
Earnings before interest, tax, depreciation, and amortisation		**16**	**17**	**17**	**17**
Depreciation		-9	-9	-9	-9
PDC dividend		-3	-4	-4	-4
Net interest		-2	-2	-2	-2
NET SURPLUS		**2**	**2**	**2**	**2**
Financial support received		0	0	0	0
Other one-off factors (net)		0	0	0	0
NORMALISED EARNINGS		**2**	**2**	**2**	**2**
Key financial indicators		**%**	**%**	**%**	**%**

Cost improvements as % of clinical income		2	2	3	3
Increase in patient spells %		6	-5	-3	0

Future income and payments by results

The trust makes gains from *Payment by Results* (PbR) between 2006 and 2008 from both the difference in local prices and national tariffs, and the volume effect of being paid for all the activity it provides.

In 2007/08, additional activity has been commissioned by the PCTs and represents £5m-£6m of additional non-recurrent income for the trust in 2007/08. This is to pay for work required to meet the 18 week referral to treatment target. Much of the non–recurrent income will be needed to fund non–recurrent capacity to deliver the activity.

In order to release the funds to repay the loan in future years, the trust has engaged a team of external consultants to work with staff to redesign trust processes and release efficiency savings of £6m-£7m per year from 2008/09 onwards.

Future cost improvements and financial recovery plans

The requirement for cost improvements will be driven by three main elements:

- **existing financial recovery plans** including the repayment of the loan and interest. These are built into the budgets that form the basis of the 2007/08 and future years' forecast outturns. Plans are identified for these savings before the start of each financial year and they will be recurrent.
- **savings required to balance cash-releasing efficiency saving reductions inherent in the national tariff**: these are percentages of the Trust's clinical income and are based on SHA guidance on the levels of efficiency to be built into the tariff uplift each year.
- **cost reductions that may be necessary to offset reductions in income from activity**: these are based on a marginal cost of 50% from 2008/09 onwards.

Future risk assessments

The trust has assessed its risks for 2007/08 under the headings clinical, financial and governance risks.

In high level terms, the key risks for the trust relate to the following:

- management of historic debt and loan repayments
- delivery of financial recovery plan
- management of patient flow through the hospital and meeting the national 18 week maximum wait for all patients
- control of infection, in particular MRSA
- delivery of the A&E four hour wait target
- *Connecting for Health* implementation.

The most substantial risk facing the trust is in relation to the management of its historic debt and the effect that this debt burden has on the trust's recurrent financial position now it has been translated to a loan with interest and principal repayment requirements.

Capital expenditure

Under the current financial regime, the trust receives an annual allocation of central funds for capital investment. In 2006/07 the trust's basic capital allocation was £5m, equivalent to 3% of its existing asset base. The trust also received further capital allocations for specific items such as major items of equipment or building works.

The trust's capital investment in 2006/07 is set out below.

Capital investment

	2006/07 £m
Buildings maintenance	2.7
Equipment	2.3
Special projects & allocations	3.8
Total Capital Investment	**8.8**

Future capital expenditure

Funding for future capital expenditure will be available from the following sources:

- internally generated resources (e.g. reinvestment of depreciation);
- capital receipts, which the trust will be at liberty to retain for its own use;
- allocations of public dividend capital previously agreed;
- NHS loans.

Because the trust will already have a substantial loan due to the conversion of cash brokerage into longer term borrowing, it is unlikely that the trust will be able to meet the terms and conditions for new loans for capital investment in future years. This means that the trust would look to partnerships with the private sector, or the restructuring of its site to generate capital receipts, in order to fund future major capital expenditure. It will also be possible to lease significant assets.

The trust has produced an estates strategy which would necessitate such financing, but as this is still under consideration and consultation, its costs and likely funding streams have not been considered in detail.

The trust's projected capital investment for the next four years is set out below.

Projected capital investment

Forecast capital investment		07/08 £m	08/09 £m	09/10 £m	10/11 £m
Buildings maintenance		2	2	2	2
Equipment		4	4	4	4
Other projects		1	1	1	1
Total Capital Investment		7	7	7	7

11. Remuneration Report

Membership of the Remuneration Committee

All, and only, non executive directors are members of the committee. The committee is quorate with four members.

During 2006/7 the following individuals were non executive directors:

Mike Roy - Chairman until 31.10 2006
James Carine - Chairman from 1.11.2006
Maura Poole
Stephen Wheeler
Jonathon Lloyd
Richard Weatherhead until 30.09.2006
Michael Earp
Peter Tomkins from 01.01.2007

Statement on the policy on the remuneration of senior managers for current and future years

Starting salaries for executive directors are determined by the committee by reference to independently obtained NHS salary survey information, internal relativities and equal pay provisions and other labour market factors where relevant, e.g. for cross sector, functional disciplines such as human resources.

Progression is determined by the committee for:

- Annual inflation considerations in line with nationally published indices (RPI/CPI), DH guidance and other nationally determined NHS pay settlements
- Specific review of individual salaries in line with independently obtained NHS salary survey information, other labour market factors where relevant , e.g. for cross sector, functional disciplines, internal relativities and equal pay provisions. Such review is only likely where an individual director's portfolio of work or market factors change substantially
- One or more executive directors may benefit from protected historical pay/ benefits packages from 'closed' schemes.

The policy does not currently include specific reference to performance conditions however the remuneration committee will, in establishing any general review of salaries, take into account the Trust's annual performance review with the strategic health authority.

Other senior managers are paid in accordance with the national NHS Agenda for Change pay system.

Contracts

Contracts are normally substantive (permanent) contracts subject to termination by written notice of 6 months, by either party.

On occasion as required by the needs of the organisation appointments may be of a temporary or 'acting' nature in which case a lesser notice period may be agreed.

James Scott
Chief executive

Date: 19.06.07

Details of service contracts

Name	Post Title	Date of Contract	Unexpired Term	Notice Period	Provision for Compensation for Early Termination	Other Termination Liability
John Williams	Director of Finance	19/4/2004	Substantive – Left 1st June 2007	6 months	None	Statutory entitlements in the event of unfair dismissal. Balance of holidays due to be paid on termination. Entitlements under NHS Whitley Council and NHS Pension scheme
Stephen Holt	Director of Facilities	26/11/2000	Substantive	3 months	None	As above
Diane Fuller	Director of Patient Care Delivery	01/09/2005	Substantive	6 months	None	As above
Lynn Vaughan	Director of Human Resources	01/07/2004	Substantive	6 months	None	As above
Brigid Musselwhite	Director of Planning & Strategic Development	01/03/2004	Substantive	6 months	None	As above
Francesca Thompson	Director of Nursing	25/09/2007	Substantive	6 months	None	As above
Mark Davies	Chief Executive	03/12/2003	Substantive	6 months	None	As above, resigned on 31.03.2007
John Waldron	Medical Director *	01/09/2002	5 months	3 months	None	As above with respect to the Medical Director element, Consultant Contract terms for the ENT Consultant element

* Mr Waldron's substantive appointment is as consultant ENT surgeon.

There have been no significant awards to past senior managers, during 2006/07.The salary and pension entitlements of Senior Management are shown in the following table.

Salary and Pension entitlements of senior managers

A) Remuneration

Name and Title	2006-07				2005-06		
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Date of Starting(S) or leaving (L)	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100
Mark Davies - Chief Executive	145-150	-	-		145-150	-	-
John Williams - Director of Finance	110-115	-	-		110-115	-	-
John Waldron - Medical Director	60-65	100-105	-		55-60	95-100	-
Francesca Thompson – Director of Nursing.	35-40	-	-	S 25/09/2006		-	-
Brigid Musselwhite - Director of Planning and Strategic Development	80-85	-	-		80-85	-	-
Stephen Holt - Director of Facilities	70-75	-	-		75-80	-	-
Lynn Vaughan - Director of Human Resources	75-80	-	-		75-80	-	-
Diane Fuller - Director Of Patient Care Delivery	75-80	-	-		40-45	-	-
Carol De Halle - Acting Director of Nursing.	10-15	-	-	L 31.08.2006*	0-5	-	-
Deborah Gray - Acting Director Of Nursing.	10-15	-	-	L 31.08.2006*	0-5	-	-
Mike Roy - Chairman	10-15	-	-	L 31.10.2006	15-20	-	-
James Carine - Chairman	5-10	-	-	S 01.11.2006		-	-
Maura Poole - NED	5-10	-	-		5-10.	-	-
Stephen Wheeler - NED	5-10	-	-		0-5	-	-
Jonathan Lloyd - NED	5-10	-	-		5-10.	-	-
Richard Weatherhead - NED	0-5	-	-	L 30.09.2006	5-10.	-	-
Michael Earp - NED	5-10	-	-		5-10.	-	-
Professor Peter Tomkins - NED	0-5	-	-	S 01.01.2007		-	-

*Relinquished their role as acting director of nursing

Salary and Pension entitlements of senior managers **Subject to audit**

B) Pension Benefits

Name and title	Real increase in pension and related lump sum at age 60 (bands of £2500) £'000	Total accrued pension and related lump sum at age 60 at 31 March 2007 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2007 £000	Cash Equivalent Transfer Value at 31 March 2006 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Mark Davies - Chief Executive	(112.5)-(115)	80-85	298	679	(279)	-
John Williams - Director of Finance	2.5-5	225-230	1,024	964	25	-
John Waldron - Medical Director	17.5-20	165-170	676	565	68	-
Francesca Thompson – Director Of Nursing.	2.5-5	55-60	225	196	17	-
Brigid Musselwhite - Director of Planning and Strategic Development	2.5-5	80-85	261	236	13	-
Stephen Holt - Director of Facilities	2.5-5	110-115	427	395	16	-
Lynn Vaughan - Director of Human Resources	2.5-5	55-60	240	213	14	-
Diane Fuller - Director Of Patient Care Delivery.	10-12.5	75-80	241	201	24	-

As non-executive members do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive members.

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.

Annual accounts 2006/07

The summary financial statements which follow do not contain sufficient information to allow as full an understanding of the results and state of affairs of the trust and its policies and arrangements as provided by the full set of annual accounts.

A full set of the accounts is available on request from:

Director of Finance
Royal United Hospital, Bath, NHS Trust
Combe Park
Bath
BA1 3NG

The following statements are attached:

- Summary Financial Statements
- Statement of Internal Control
- Directors Statements
- Independent Auditors report

Audit

The independent auditor's statement is included within the Summary Financial Statements.

In respect of the preparation of the accounts for 2006/07, as far as the directors are aware there is no relevant audit information of which the trust's auditors are unaware. The trust's directors have taken all steps that they ought to have taken as directors to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

NHS Trust Manual for Accounts

The operating and financial review has been prepared in accordance with the NHS Trust Manual for Accounts for 2006/07, as directed by the Secretary of State.

12. Directors Interests

Chairman Mike Roy (to 31.10.2006)
Governor of Bath Spa University
Member, Bristol Employment Tribunal

Chairman James Carine (from 1.11.2006)
Welfare representative British Limbless Ex- servicemen Association (BLESA)
Member Copyright Tribunal

Non executive directors

Maura Poole
Trustee of the Learning Curve - registered charity
Director of Pooled Perspectives Ltd
Director of Targeteasy Ltd

Richard Weatherhead
Director of 5 Lansdown Place West Management Company Ltd

Michael Earp
Director of Softmedia Productions Ltd

Stephen Wheeler
Chair of trustees of the Evaluation Trust

Peter Tomkins
Vice chairman/trustee: Chartered Institute of Marketing (+ director, Related Boards (2001).
CEO: D M Management Consultants Ltd (1976).
Advisory Board: CASS Business School (City University) (2004).
Vice president UK Youth (1990)
Visiting academic: CASS Business School, Cranfield Business School, St Gallen University (Su) (Various Dates)

Executive directors

Chief executive Mark Davies
Associate Director of Coalescence Consulting as from 1st January 2006

Director of finance John Williams
Director of Hunt Marine. Company trades exclusively in Maritime Consultancy and there should be no conflict of interest. Directorship is for a temporary period only.

Medical director John Waldron
Signed up to an agreement with Centres of Clinical Excellence (CCE) to transfer at least 50% of the time currently devoted to private practice to a CCE facility once established in this area. In return for signing up the medical director has received 10,000 shares in CCE. The medical director does not feel he should represent the trust in any future discussions with CCE because it could be perceived that he has a conflict of interest.

Appendix 1 Summary Financial Statements

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED
31 March 2007

	2006/07	2005/06
	£000	£000
Income from activities	**162,204**	**149,942**
Other operating income	**15,415**	**16,070**
Operating expenses	**(173,295)**	**(167,896)**
OPERATING (DEFICIT) SURPLUS	**4,324**	**(1,884)**
Profit/(loss) on disposal of fixed assets	**-**	**(8)**
SURPLUS/(DEFICIT) INTEREST	**4,324**	**(1,892)**
Interest receivable	**502**	**227**
Interest payable	**(47)**	**-**
Other finance costs - unwinding of discount	**(19)**	**(19)**
Other finance costs - change in discount rate on provisions	**-**	**(11)**
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR	**4,760**	**(1,695)**
Public Dividend Capital dividends payable	**(4,616)**	**(5,644)**
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR	**144**	**(7,339)**

BALANCE SHEET AS AT 31 March 2007

	31 March 2007	31 March 2006
	£000	£000
FIXED ASSETS		
Tangible assets	**184,819**	**171,854**
CURRENT ASSETS		
Stocks and work in progress	**3,428**	**3,395**
Debtors	**11,317**	**9,141**
Cash at bank and in hand	**464**	**464**
	15,209	**13,000**
CREDITORS: Amounts falling due within one year	**(11,988)**	**(12,034)**
NET CURRENT ASSETS	**3,221**	**966**
TOTAL ASSETS LESS CURRENT LIABILITIES	**188,040**	**172,820**
CREDITORS: Amounts falling due after one year	**(36,100)**	**-**
PROVISIONS FOR LIABILITIES AND CHARGES	**(993)**	**(819)**
TOTAL ASSETS EMPLOYED	**150,947**	**172,001**
FINANCED BY:		
TAXPAYERS' EQUITY		
Public dividend capital	**131,217**	**166,610**
Revaluation reserve	**56,594**	**42,459**
Donated asset reserve	**6,174**	**6,114**
Income and expenditure reserve	**(43,038)**	**(43,182)**
TOTAL TAXPAYERS EQUITY	**150,947**	**172,001**

Signed: (Chief Executive) Date: 19.06.07

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 March 2007

	2006/07 £000	2005/06 £000
Deficit /Surplus for the financial year before dividend payments	**4,760**	**(1,695)**
Fixed asset impairment losses	**(760)**	**-**
Unrealised surplus on fixed asset revaluations/indexation	**15,212**	**4,656**
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	**451**	**899**
Total gains and losses recognised in the financial year	**19,663**	**3,860**

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 March 2007

	2006/07 £000	2005/06 £000
OPERATING ACTIVITIES		
Net cash inflow from operating activities	**10,398**	**6,084**
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:		
Interest received	**502**	**227**
Interest paid	**(47)**	**-**
Net cash inflow from returns on investments and servicing of finance	**455**	**227**
CAPITAL EXPENDITURE		
Payments to acquire tangible fixed assets	**(9,295)**	**(9,291)**
Net cash outflow from capital expenditure	**(9,295)**	**(9,291)**
DIVIDENDS PAID	**(4,616)**	**(5,644)**
Net cash outflow before management of liquid resources and financing	**(3,058)**	**(8,624)**
Net cash outflow before financing	**(3,058)**	**(8,624)**
FINANCING		
Public dividend capital received	**-**	**10,742**
Public dividend capital repaid (not previously accrued)	**(35,393)**	**(3,017)**
Other capital receipts	**451**	**899**
Loans received from the DH	**38,000**	**-**
Net cash inflow from financing	**3,058**	**8,624**
Increase in cash	**-**	**-**

Statement on Internal Control 2006/07

Royal United Hospital, Bath, NHS Trust

The board is accountable for Internal Control. The chief executive of the board, as accountable officer has responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. He is also responsible for safe guarding the public funds and the organisations assets for which he is personally responsible as set out in the Accountable Officer Memorandum.

A copy of the statement of internal control is included within the trusts annual accounts and is available by contacting the director of finance office.

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Secretary of State has directed that the chief executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officers' Memorandum issued by the Department of Health.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an accountable officer.

19.06.07 Date  Chief Executive

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure of the trust for that period. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury

- make judgements and estimates which are reasonable and prudent

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are 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.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

19.06.07 Date  Chief Executive

19.06.07 Date  Finance Director

Independent auditors' statement to the Directors of the Board of Royal United Hospital Bath NHS Trust

We have examined the summary financial statements 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. We have also audited the information in the trust's Remuneration Report that is described as having been audited.

This report, including the opinion, has been prepared for and only for the Board of Royal United Hospital Bath NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 36 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission. We do not, in giving this opinion, accept or assume responsibility for any other purpose or to any other person to whom this statement is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Respective responsibilities of directors and auditors

The directors are responsible for preparing the annual report, including the remuneration report. Our responsibility is to audit the part of the remuneration report to be audited and to report to you our opinion on the consistency of the summary financial statements within the annual report with the statutory financial statements. We also read the other information contained in the annual report and consider the implications for our statement if we become aware of any apparent misstatements or material inconsistencies with the summary financial statements.

Basis of opinion

We conducted our work in accordance with Bulletin 1999/6 'The auditors' statement on the summary financial statement' issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our audit opinion on those financial statements and on the information in the remuneration report to be audited.

Opinion

In our opinion:

- the summary financial statements are consistent with the statutory financial statements of the Trust for the year ended 31 March 2007; and
- the part of the remuneration report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England.

[Signature]

PricewaterhouseCoopers LLP
31 Great George Street
Bristol
BS1 5QD Date:

Royal United Hospital Bath NHS
NHS Trust

Royal United Hospital, Combe Park, Bath, BA1 3NG
Tel: 01225 428331
Website: www.ruh-bath.swest.nhs.uk
E-mail: info@ruh-bath.swest.nhs.uk