Royal United Hospital Bath NHS Trust

Royal United Hospital Bath NHS Trust Annual Report & Summary Financial Statements 2007/08

the best staff, working together to give excellent care

contents

Statement from the Chairman

My role as Chairman is to lead a cohesive board overseeing the trust's governance and strategic development.

During its first 14 years, the trust was unable to achieve financial balance without external support. However, in 2006/07 following a tremendous team effort at all levels throughout the hospital, the trust was 'in the black'. This year, again, I am delighted to report that the trust has achieved financial balance.

At the same time, the hospital has continued to make real progress on several clinical fronts and has changed and improved medical working practices and installed new equipment, including, for example, digital breast scanning. Together this has led to a marked reduction in waiting times and welcome improvements for our patients. Grateful thanks go to our fund-raisers and charitable support organisations for their successes in making possible some of these developments.

The hospital has experienced a number of challenges during the year; like many hospitals, some of our day-to-day operations were affected by Norovirus infections - widespread throughout the local community and therefore brought into the hospital environment. Much credit for containing these outbreaks goes to the hard work and efforts of the hospital's infection control team, all ward staff, the internal and external awareness campaigns and the unsung heroes in our cleaning department. There have been several important changes in Board membership. Mark Davies left the trust at the end of March 2007 and there was an inter-regnum during which John Williams, the then Finance Director, took on the extra role of Acting Chief Executive. James Scott, previously Chief Executive of Yeovil District Hospital NHS Foundation Trust, joined in June 2007. John Williams then moved to the Wiltshire Primary Care Trust and Jennifer Howells stood in as Acting Finance Director for some months until Catherine Phillips took up her post as Finance Director. Maura Poole, the non-executive director who chaired our Audit Committee for five years, retired at the end of 2007 and was replaced by Moira Brennan on 1 February 2008.

I have already referred to charitable donations; we are fortunate to have wonderful support from the community. The League of Friends runs our shop and conservatory cafeteria and provides volunteers, acting as guides and helping on the wards. The Friends also tirelessly fund-raise - recently paying for the relocation of the Patient Advice and Liaison Service office in the Atrium. The volunteer Hospital Radio service is extending its services to patients and developing a wider range of programmes. The RUH's Forever Friends Appeal raised funds for a new CT scanner and has embarked on an ambitious £4.5m campaign to provide us with an environmentally friendly and vastly improved neo-natal intensive care unit. The Bath Cancer Unit Support Group has promised major financial aid in the future to help the trust update patient facilities in RUH North.

My aim for the coming year is to help maintain the trust's current financial stability and use that as a platform to enable it to continue its clinical improvements for the benefit of the one third of a million patients treated by this hospital each and every year.

James Carine, Chairman

Statement from the Chief Executive

During 2007/08 the broad focus was on four key priorities: healthcare associated infections, improving waiting times - the four-hour target for emergency access and delivering the 18 week referral to treatment time, delivering value for money in terms of achieving the financial plan and progressing the RUH 2010 Change Programme.

These are recurrent themes throughout this report and you will be able to read how work within different departments of the organisation has contributed to the overall successes in these key priority areas.

To take each of these priorities in turn and briefly detail the successes in each;

In relation to healthcare associated infections (HCAIs), real progress has been made in reducing methicillin resistant *Staphylococcus aureus* (MRSA) bacteraemias, from 42 in 2006/07 to 35 in 2007/08. The plan for 2008/09 is to reduce this number again – down to less than 26. Our assessment is that a similar rate of reduction has been achieved for Clostridium Difficile (C. diff).

The trust had a number of supportive visits and inspections during the year from the Department of Health and the Healthcare Commission (HCC), including an unannounced visit in February from the HCC to look at our compliance with the Hygiene Code. We were one of 120 trusts that HCC assessors visited. The result of that visit was that the trust had 'no material breaches' of the code – this is extremely helpful to us in moving forward.

The trust made significant improvements in waiting times for planned care; 85.3% of patients who needed to be admitted to hospital were treated within 18 weeks of being referred by their GP and 96.2% of outpatients were treated within that same timescale. This is a massive improvement in waiting times and is a tribute to the very hard work of our staff. We have also continued to deliver excellent oncology care to our patients and sustained our performance across all cancer waiting time categories. Following investment by the primary care trusts (PCTs), access to genito-urinary medicine clinics increased to the point of 100% of patients being offered an appointment within 48 hours.

However, there are two areas where we need to improve – in emergency access and in booking of appointments. Whilst delivery of the emergency access standard of four hours is partially determined by the number of patients who remain in a hospital bed after their medical care has been completed because of delays to their discharge or transfer to a nursing or care home, there is also much to do within the hospital. Some progress has been made towards the end of the financial year and the process improvements we have put in place this year will be enhanced and strengthened in 2008/09. Within the area of bookings, we are working to improve the time it takes to get through to us on the phone as we recognise how frustrating it is for our patients to be waiting. We have increased our staffing levels in an attempt to improve this area and it will remain a focus for our attention.

Our assessment is that, as a consequence of our failure to deliver some of the national operational targets, our Healthcare Commission Annual Health Check rating for 'Quality of Services' for 2007/08 will be 'fair'. This is an improvement on our 2006/07 rating of 'weak', but there is more to be done to achieve our ambition of a 'good' rating for 2008/09. Our 'Use of Resources' for 2006/07 also received a 'weak' rating; the main reason for this was

our historic debt. Given our performance in 2007/08 we would predict that this rating will change to 'fair.' During 2007/08 we agreed a loan with the Department of Health that allows us to repay our historic debt over time. In 2007/08 we made our first repayment in full and, with support from our PCTs, we will be debt free by 2013.

A major thrust of work during the last year has been the RUH 2010 Change Programme which focused on improving core patient care processes within the hospital by reducing waste and delivering a better experience for our patients and our staff. Projects included reviewing and revising the ways in which patients are cared for following admission – either for planned operations or from A&E – with a view to allowing patients to go home as soon as they are ready to do so.

Reducing delays also reduces our bed occupancy which means that we are more able to make sure that every patient admitted is cared for within the appropriate specialist area. The Trust also introduced a pilot 'productive ward' scheme – designed to release valuable nursing time for nurses on our wards to spend even more time directly caring for patients.

In 2008/09 we will continue this work to reduce our bed occupancy to 93% and, in addition, we have the funds and the plans in place to recruit to full establishment across all staff groups.

We believe these developmental opportunities to be the key interventions that will enable us to make real progress in improving the patient experience. They sit on a bedrock of exceptional clinical performance right across the specialties. To give just one example – our externally measured Hospital Standard Mortality Rate for 2007/08 is 88.8, more than 11 percentage points better than the English hospitals average.

James Scott, Chief Executive

The Royal United Hospital: Some Facts and Figures

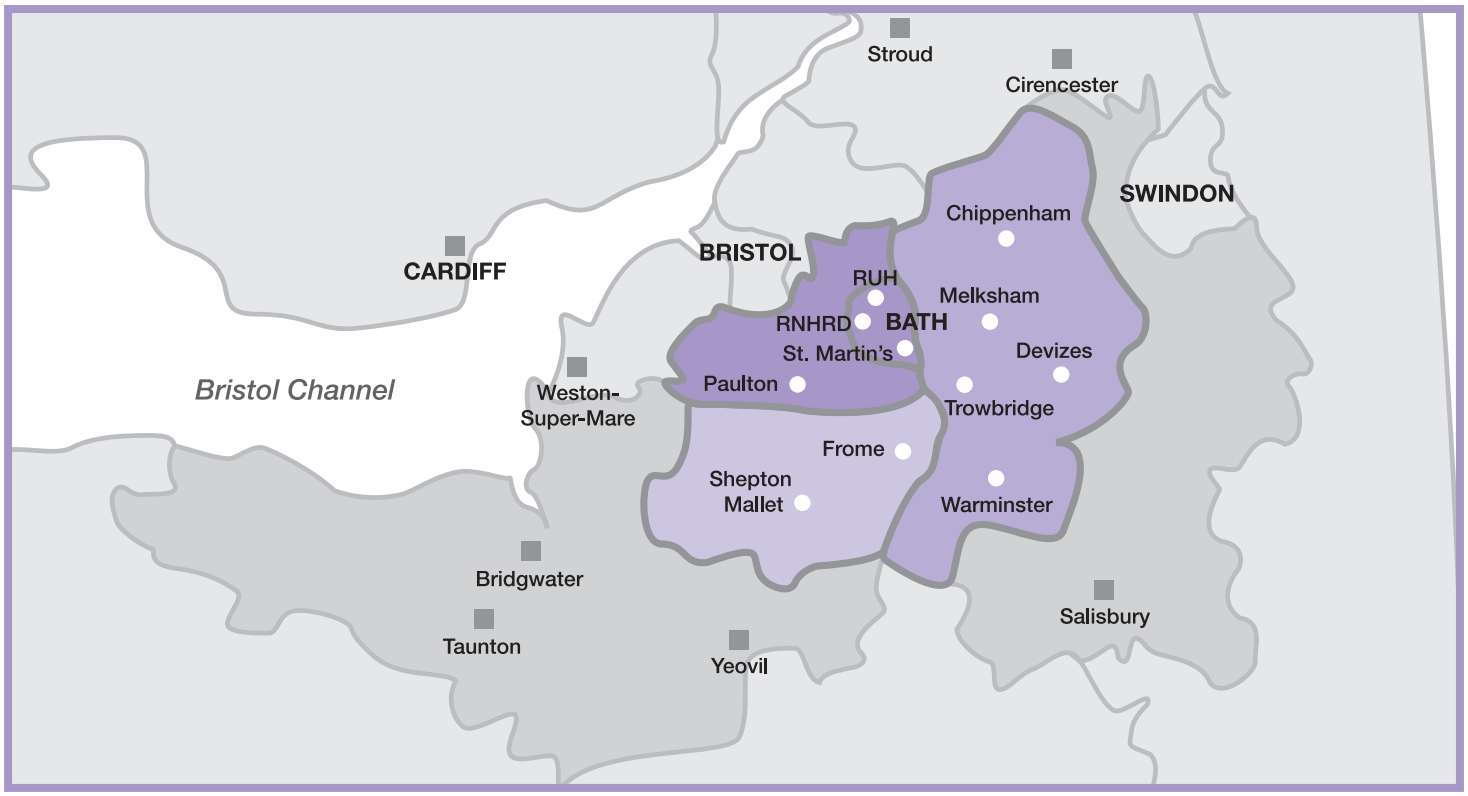
Trust profile

The Royal United Hospital Bath NHS Trust 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 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 has around 660 beds and provides a comprehensive range of acute services including emergency and intensive care, elderly care, medical and surgical services, paediatric services, and diagnostic and support services for its local population. In addition, it provides a substantial volume of oncology (cancer) related services, including chemotherapy and radiotherapy, and some specialist orthopaedic surgery. Although the trust provides neonatal 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 c.4,800 staff who primarily work shifts. During 2007/08 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.



The population profiles demonstrate a higher than average proportion of people who are aged 65 or over. The national average is 16% but the percentage of people aged 65 or over who live in the trust's catchment area is between 17.5% and 17.9%. These figures vary as the population of the different PCTs served by the trust have slightly different age profiles. Similarly, with our more elderly citizens, the proportion in the 85+ age bracket is between 2.2% and 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 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 (oncology) care is also increasing. 18% of emergency patients are female and in the 75+ age bracket. Around 1.8% of elective patients define themselves as being from black or minority ethnic groups, whilst the figure for emergency patients is around 1%. There are a number of patients who do not feel happy to complete ethnicity questions. Levels of black and minority ethnic groups in the local population are around 3%.

The trust takes seriously its statutory responsibility to promote equality and not to discriminate in the provision of patient services or staffing arrangements. During this year the trust has implemented a Gender Equality Scheme and is now working to implement a Single Equality Scheme.

The levels of health are fairly high with good healthy lifestyle choices being made although there are some pockets of greater deprivation with associated general health issues. For example, within the city of Bath there are variations in life expectancy of around five years between different areas. Health inequality is therefore an issue for the local primary care trust.

Some facts and figures about our patients
The following figures indicate the levels and types of care provided by the trust during 2007/08:

- 66,927 patients attended our accident and emergency department and there were 31,189 non-elective admissions. In 2006/07 68,474 patients attended the accident and emergency department and there were 31,291 non-elective admissions.
- 7,392 patients were treated for planned inpatient procedures. This is 535 more than in the previous year, which is a rise of 7.8%.
- 24,370 patients were treated for planned day case procedures. This is 2,069 more day cases than in the previous year, which is a rise of 9.3%
- 255,905 patients were seen in our outpatient departments. This is 6,307 more than in the previous year, a rise of 2.5%.

Hospital of Choice

Trust vision

The best staff, working together, to give excellent care.

The trust is committed to ensuring 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 trust 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.

During 2007/08 the trust substantially reduced its waiting times for planned care. This has been of significant benefit in terms of improving the trust's competitive position with other local providers. Its greatest challenges in attracting patients within the context of patient choice remain around the perception of cleanliness and infection rates in the hospital and the efficiency of its patient administration systems – answering telephones, arranging appointments and last minute cancellations. These issues are being addressed and progress is good. Patients can have confidence that at the trust they will receive very high standards of clinical care in comparison with other hospitals.

The competitive market for acute services remains as last year. The trust's main competition for simple to intermediate surgery comes from Shepton Mallet Treatment Centre (UKSH) which has been used by local commissioners to drive down waiting times. In addition the trust has seen some patients, who live on the edges of its catchment borders with Swindon and Marlborough Hospital and Salisbury Foundation Trust, being referred to these alternative hospitals by GPs. The huge improvements in waiting times at the trust and its competitive advantage in terms of overall clinical safety as measured by Standardised Hospital Mortality Rate mean that RUH Bath is now a very strong option for patients to choose for their care.

In the medium term (1–2 years) competition in planned surgery will increase, with the opening of two further independent sector hospitals within the trust's catchment area. A day surgery facility is planned for Devizes and a day surgery and inpatient surgery hospital is being built at Peasedown St. John. Unlike the trust, neither facility will have emergency, high dependency or intensive care facilities on-site as back-up if required.

There is also a more competitive market developing for primary care services, including outpatient and simple diagnostic services. The trust is establishing relationships with such providers with the objective of ensuring good clinical and patient linkages are maintained. The trust will make choices on service development on a case by case basis.

Services for which commissioners are planning to tender, and that have to date been provided by the trust, include dermatology, deep vein thrombosis diagnosis and care, chronic obstructive pulmonary

disease and community-based outpatients departments.

The trust is developing its relationships with primary care trusts with a view to establishing whether there is a role for the hospital in providing a more integrated service across a number of locations. This may then improve overall patient care and reduce the number of organisations caring for an individual for a single condition or procedure. The trust also continues to express an interest in being the future provider of maternity care for a significant part of Wiltshire, BaNES and parts of Somerset following the decision by Wiltshire PCT to stop providing this service.

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 trust as their provider of care, it is essential that it is tuned into those needs. During the year of this report, stakeholders, including patients and the public, have been involved in the planning and development of many aspects of patient care, including children's services and the development of the cancer strategy. 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. During 2008/09 this will be reviewed and revised.

Overview and Scrutiny Committee

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

How the Hospital 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 hospital 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 the trust 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 trust, from financial management to the quality and effectiveness of the clinical services provided, is properly governed and controlled and that there is effective communication with staff, patients and public.

The trust has a comprehensive information governance policy framework that covers the overlapping areas of data protection compliance (including Caldicott), information security, data quality, confidentiality (with regard to 'common law'), records management, IT system security and freedom of information compliance. This framework includes procedures for the reporting and management of information risks and incidents.

Risks are managed via incident reporting processes which record incidents that are related to breaches of patient confidentiality and IT security.

The table below provides a summary of minor incidents related to the handling of personal information during 2007/08:

Summary of personal data related incidents

Category	Nature of incident	Total
i	Loss of inadequately protected electronic equipment, devices, or paper documents from secured NHS premises	0
ii	Loss of inadequately protected electronic equipment, devices, or paper documents from outside secured NHS premises	0
iii	Insecure disposal of inadequately protected electronic equipment, devises or paper documents	3
iv	Unauthorised disclosure	0
v	Other	3

Trust performance, in relation to information management, is measured using an information governance toolkit assessment produced jointly by the Department of Health and NHS Connecting for Health.

In addition to the above measures, during 2007/08 the trust carried out an assessment of its major IT systems and those departments that are likely to be involved in the transfer of person-identifiable data to ensure that any risk is mitigated.

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 hospital's 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 every month, except August.

Trust Board Membership (as at 1 March 2008) and continued over...

	Name and position	Tenure	Voting	Board Committees	Trust Board Attendance
	James Carine, Chairman, 01.11.06	4 years	yes	1. Remuneration Committee *(ex-officio all Trust Board committees)*	7/7
	James Scott, Chief Executive, 01.06.07	substantive	yes	1. Charities Committee 2. Management Board 3. Audit Committee *(ex-officio all other Trust Board committees)*	5/5
	Michael Earp, Non-Executive Director, 01.12.04	4 years	yes	1. Audit Committee 2. Remuneration Committee 3. Clinical Governance Committee 4. Charities Committee	7/7
	Jonathan LLoyd, Non-Executive Director, 01.04.02	4 years	yes	1. Remuneration Committee 2. Non Clinical Risk Committee *whistle blowing contact*	6/7
	Moira Brennan, Non-Executive Director, 01.02.08	4 years	4 years	1. Audit Committee 2. Charities Committee 3. Remuneration Committee	1/1
	Maura Poole, Non-Executive Director, 01.01.03-31.12.07	4 years	yes	1. Charities Committee 2. Audit Committee 3. Remuneration Committee	4/5
	Prof. Peter Tomkins, Non-Executive Director, 01.01.07	4 years	yes	1. Remuneration Committee 2. Clinical Governance Committee	7/7

	Name and position	Tenure	Voting	Board Committees	Trust Board Attendance
	Steve Wheeler, Non-Executive Director, 01.12.05	4 years	yes	1. Charities Committee 2. Audit Committee 3. Remuneration Committee 4. Non Clinical Risk Committee *whistle blowing contact*	7/7
	Diane Fuller, Director of Patient Care Delivery	substantive	yes	1. Management Board 2. Clinical Governance Committee	7/7
	Francesca Thompson, Director of Nursing	substantive	yes	1. Management Board 2. Clinical Governance Committee	7/7
	John Waldron, Medical Director	substantive as a Consultant ENT Surgeon	yes	1. Management Board 2. Clinical Governance Committee	7/7
	Catherine Phillips, Director of Finance	substantive	yes	1. Charities Committee 2. Management Board 3. Audit Committee	4/4
	Brigid Musselwhite, Deputy Chief Executive & Director of Planning	substantive	no	1. Management Board 2. Non Clinical Risk Committee	6/7
	Lynn Vaughan, Director of Human Resources	substantive	no	1. Management Board 2. Non Clinical Risk Committee	6/7

Committees of the Trust Board from 01.03.08

Remuneration Committee

CHAIR: James Carine

The Remuneration Committee is responsible for the determination of the pay and other terms and conditions of service for executive directors.

Executive attendees are not present when their personal remuneration is considered.

Charities Committee

CHAIR: Michael Earp

The Charities Committee is responsible for the investment of charitable funds. It ensures that all funds are spent on the purpose for which they were donated. The committee reviews the activities of the charitable funds and ensures that expenditure is in accordance with the requirements of the Charity Commission.

Management Board

CHAIR: James Scott

The Management Board is the lead Executive Committee of the trust managing the delivery of operational and strategic performance within the trust. Management Board develops strategic thinking in partnership with the Trust Board.

Non Clinical Risk Committee

CHAIR: Steve Wheeler

The Non Clinical Risk Committee is responsible for risk assurance around the areas of health and safety, environment, facilities and medical equipment as well as information governance and workforce matters.

Audit Committee

CHAIR: Maura Poole until 31.12.07, Moira Brennan from 1.02.08

The Audit Committee is responsible for financial scrutiny of internal financial controls, such as the safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information. Its role has broadened over recent years to conclude on the adequacy and effectiveness of the trust's overall internal control system.

Clinical Governance Committee

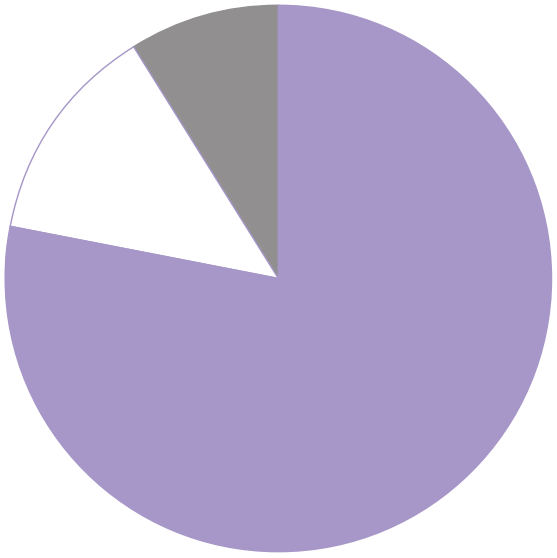
Chair: Michael Earp

The Clinical Governance Committee sets the overall direction for patient safety and experience and its governance within the trust and agrees the programme of work with the Trust Board.

2007/08: The Trust's Objectives, Improvements and Achievements

The trust sets objectives each year. They aim to achieve national targets and the trust's own local aspirations. 2007/08 saw the trust meet its finance target to break-even.

The following pie chart shows the trust's overall performance* against all national targets:



National target indicators

lilac: achieved - 18

white: underachieved - 3

grey: significantly underachieved - 2

* 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 2008. Therefore, comments on performance refer to the likely outcomes but may be subject to change.

In terms of our performance against the more significant non-financial national targets, and performance against the trust's own objectives, there were areas of great achievement. Below is a summary of the areas where those achievements have been most significant.

Improving the control of healthcare associated infections

Figures published in January 2008 by the Health Protection Agency (HPA) show that the trust is making real improvements in tackling healthcare associated infections. Trust checks and audits also support the picture of significant improvements being made in tackling infections such as methicillin resistant *Staphylococcus aureus* (MRSA) and Clostridium difficile (C.diff). In 2006/07 there were 42 recorded cases of MRSA bacteraemias within the hospital. In 2007/08, that figure was 35. This was a significant improvement (around 20%), but it was not sufficient to meet the target of less than 21. Our performance against targets of cases of Clostridium difficile in patients over 65 years is also a success story. Against a target of less than 432 for the year, the trust recorded 301 cases.

A high profile campaign, *'Hands up, sleeves up, thumbs up',* was aimed at staff, patients and visitors. This is part of the trust's ongoing initiative aimed at further reducing hospital associated infections and making the hospital a safer place. From September new, more restricted visiting arrangements were introduced on wards to help make the hospital cleaner and safer for patients, their relatives and staff and to give patients more rest time. February and March 2008 saw an external and internal awareness campaign aimed at reducing the opportunities

for infections to be brought into the hospital and for them to spread once they were here.

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. For the period October 2007 to March 2008, the trust performed well, with only six cases found to have been acquired once the patient had been admitted. That is to say, the infection was acquired in the hospital, rather than the patient coming in with it.

Improving waiting times for care

The NHS has committed to ensuring that, by December 2008, no-one will wait more than 18 weeks from a GP referral to receiving hospital treatment. As part of this, 'milestones' were set for March 2008, to deliver 85% of admitted patients and 90% of non-admitted patients being treated within 18 weeks. Over the year the trust delivered very significant reductions in waiting times so that these milestones were not only met, but exceeded.

By the end of March 2008:

- 85.3% of admitted patients and 96.2% of non-admitted patients received treatment at the hospital within 18 weeks of being referred by their GP.
- The wait for all diagnostic tests had reduced to a maximum of six weeks, with an average wait of three-four weeks.
- The wait for elective surgery had reduced to a maximum of eight weeks, except for orthopaedics which was ten weeks.
- Outpatients had a greater range of access times with most specialties at four weeks or below, and with no speciality above eleven weeks.

Improving the care for cancer patients

The trust continued to make good progress against cancer waiting time targets:

- 99.8% of our patients waited less than two weeks from urgent GP referral to first outpatient appointment for all suspected cancer referrals, against a 100% threshold.
- 99.6% of our patients waited less than one month from diagnosis to treatment for all cancers, against a threshold of 98%.
- 97.2% of our patients waited less than two months from urgent referral to treatment for all cancers, against a threshold of 95%.

Chemotherapy
A groundbreaking oral chemotherapy clinic was launched, bringing significant benefits to patients. The oncology and haematology pharmacist has set up, and runs, the special clinic twice a week. She gives advice to patients on how to take oral chemotherapy preparations and how to manage the side effects. As an independent pharmacist prescriber, this pharmacist can now also prescribe medication for patients in the clinic, instead of them having to be seen by a doctor. This additional service is freeing up valuable clinic time, which in turn enables doctors to see more patients or patients who require more complex care.

Prostate cancer
Men with prostate cancer are now being offered keyhole surgery as part of their treatment. The innovative technique - laparoscopic radical prostatectomy (LRP) - is offered in only a handful of UK hospitals. Its availability at this trust means that it is now one of the few hospitals in the UK to offer all treatments for prostate cancer on one site. Laparoscopic radical prostatectomy is a new treatment for prostate cancer, which offers better functional outcomes for patients than conventional surgery. Patients have a shorter length of stay in hospital for their surgery and a quicker recovery time, are less likely to need a blood transfusion during the operation, and experience lower incontinence and impotence rates post-operatively. Our surgeons have been mentored in laparoscopic radical prostatectomy by a visiting world expert from Bordeaux. The urology department will treat around 60 patients per year using this technique.

Breast screening
The trust is one of the first hospitals in the West to offer an all-digital mammography in its breast screening service for patients who have symptoms of cancer or a family history of breast cancer. The breast unit has installed two new mammogram units and two new ultrasound machines. These scanners will allow clearer, more accurate

images - helping to detect cancers at an even earlier stage and giving more information in order to guide treatment. In December 2007 the Department of Health highlighted the importance of digital mammography services in its Cancer Reform Strategy. It recommended that all women under 50 should have access to being screened digitally by 2010.

Improving care for patients with heart problems

Angioplasty
During 2007/08 the trust has been able to offer angioplasty three days a week and is working towards five day provision in 2008/09, including the introduction of primary angioplasty. Angioplasty is a treatment which improves the blood supply to the heart muscle when narrowing of the arteries has been identified.

Waiting times
In order to speed the provision of cardiac surgery and to offer patients a choice, the trust has widened its providers of this service to include a service from Barts and the London NHS Trust. Waiting times for diagnostic cardiology, for example echocardiography, have been driven down from in excess of six months to four weeks.

Thrombolysis
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. It involves the administering of drugs to dissolve clots within the blood stream, particularly in the heart. Significant improvements were made over the year towards the target of a 60 minute 'call to needle time' to thrombolyse patients suffering heart attacks. This means that no more than an hour should pass between the initial 999 call being made and the thrombolytic drug being given. In 2007/08 the trust delivered an overall performance of 45% against a 48% target for call to needle time. Whilst the trust did deliver 85% for door to needle time – the time span between a patient being brought into the hospital and thrombolytic drugs being given - this was not sufficient to deliver the overall call to needle time target for the year.

Improving access to Genito-Urinary Medicine

Access to Genito-Urinary Medicine has improved significantly over the year with the development of open access clinics throughout the week to allow 100% of patients to be offered a GU Medicine outpatient appointment within 48 hours by March 2008.

Reducing cancelled operations

Significant improvements were made in reducing last minute cancellations in the first half of 2007. Performance deteriorated over the winter months due to high incidences of Norovirus and further improvement is still required. Good progress was made towards the target for patients who have operations cancelled for non clinical reasons to be offered another date within 28 days, with 6.2% of cancellations in the 2007/08 year not re-booked within 28 days against a threshold of 5%.

Reducing delays for patients leaving hospital
Delays in transferring patients who no longer needed care within an acute hospital continued to be a major operational issue for the trust in 2007/08. Failure to facilitate discharge as soon as patients were clinically ready meant that hospital beds were not always available on a timely basis for patients waiting to be admitted from Accident and Emergency (A&E).

The target is that the number of patients whose discharge is delayed due to the unavailability of further community health or social care provision is minimised. Due to difficulties across the health community, in particular within Wiltshire, the Trust did not achieve the target for delayed transfers of care. The trust had a high level of delays across the year with 6.0% delayed transfers of care versus a threshold of 3.5%. Work is ongoing across the health community to deliver the challenge of minimising delayed transfers of care in the hospital and to achieve a minimal level of 1% delayed transfers of care.

Delays for emergency patients
The standard is that patients have a 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 2007/08; 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, 94.9% of patients in A&E waited four hours or less from arrival to admission, transfer or discharge versus a threshold of 98%.

The trust, along with partner organisations including PCTs, ambulance trusts and Social Services departments, produced a joint action plan to drive up performance against the four-hour standard. Improved performance began to be seen in December 2007 but was hindered by outbreaks of Norovirus across the health community which reduced overall bed capacity. Significant elements of the action plan include: the development of seven-day consultant working in some medical specialties, an hospital-based Discharge Assessment Team and the reduction of delayed transfers of care. The trust is now building upon these initiatives with partner organisations to develop a plan for 2008/09 to ensure that the A&E four-hour standard is delivered early in 2008 and maintained on an ongoing basis.

The trust is continuing to work with local primary care trusts, ambulance trusts and Social Services to encourage unplanned patients (those requiring emergency treatment) to use appropriate services in the community and to ensure that patients are able to go home as soon as they are clinically ready for discharge.

Delivering financial balance

Our financial performance is a huge achievement for the trust and a tremendous success shared by all our staff.

The trust met its corporate objective of 'Making the most of our money', which was linked to the target of achieving financial balance in 2007/08. The trust met that objective by:

- meeting its responsibilities to break-even in year;
- meeting its responsibility to make the first repayment on its loan covering its historic debt;
- achieving its internal savings and efficiency plans.

The full financial report can be found towards the back of this report.

Improving efficiency and effectiveness

The trust began a major change programme during the year called 'RUH 2010: Towards Foundation.' The programme aims to improve the whole range of services which the trust provides – outpatients, planned care, emergency care and diagnostics. As well as making services more efficient, so that resources can be freed up to reinvest elsewhere, the main aims of the programme are to provide a better service for patients, and to improve the working lives of staff. When complete the programme will deliver:

- reduced length of stay, which frees up beds and reduces pressure on staff;
- better discharge planning;
- reduction in unnecessary delays to patients' care and treatment;
- a new 'one-stop' pathway for planned patients, which will greatly reduce the number of visits patients are required to make to the hospital, and help further reduce waiting times;
- improved theatre productivity;
- reduced numbers of patients who do not attend their outpatient appointments, which avoids wasting resources;
- reduced waiting times for diagnostic appointments;
- over £1m savings on medical and non-medical supplies.

In addition the programme will help the trust to achieve its financial targets, ensuring a stable position from which the trust can move forward to develop services.

The hospital was one of the first trusts in the South West to introduce a new programme called 'releasing time to care - the productive ward'. This aims to increase the amount of time that nurses spend on direct patient care and looks at individual ward settings and how care is delivered. The programme focuses on six core areas: discharging patients, medicine rounds, toileting of patients, meal times, handover and vital signs observation.

The programme will be rolled out to all ward areas during 2008.

Four new computerised workforce information systems were introduced during the year to improve the efficiency in the way that the trust recruits and pays staff, manages occupational health appointments, trains staff and carries out workforce planning.

A new IT system is helping the trust to manage its beds more effectively by discharging patients promptly in order to release beds for new medical admissions. It allows staff in the medical admissions unit and the bed management office to simultaneously view bed occupancy status via a large LCD screen. The medical assessment unit and the bed management office can very quickly see on screen the number of admissions and discharges that are recorded. This means that patients can be matched to appropriate available beds immediately.

What more have we done?

Valuing and developing staff

During the year the trust extended its loyalty awards scheme to recognise personal achievement, team working and innovation and improvement. Winners received their awards at a ceremony in January 2008 held at Bath Forum. The 'team of the year' was the Gastroenterology team who managed to reduce routine waiting times for endoscopy from 13 weeks to three – a quite amazing improvement!

The introduction of the 'Managed Learning Environment' (MLE), an electronic training facility, increased the level of training provided in a range of required areas such as fire safety and equality and diversity. The MLE gives every member of staff personal access to their own training record so that they can see what education and development they need and can plan their learning to suit themselves. It also provides a platform for managing training records and has enabled the RUH to assure the Healthcare Commission that staff receive the necessary training to provide excellent care.

The trust is committed to supporting staff, particularly the unqualified workforce, to achieve qualifications. The trust has signed the skills pledge with a focus on unqualified workers and also implemented a range of NVQs in subjects such as health awards, customer care, business administration and basic skills.

A wide range of staff have also received support to achieve learning and qualifications associated with their jobs. For example, staff in the HR team receive support to undertake their professional qualifications with the Chartered Institute of Personnel and Development. We have also assisted individuals undertaking their foundation science degree to support the assistant practitioner role by allowing them study leave and mentoring support. Modern apprenticeships will commence in September 2008, which will provide opportunities for aspiring electricians and engineers.

The trust has invested resources this year in developing the skills of leaders to introduce changes identified by the RUH 2010 programme.

As part of a national initiative the trust applied for and received funding of £45,000 to provide further training and development opportunities for staff who do not have professional qualifications. This will be used to provide skills development in such areas as basic skills, IT, appraisal, equality and diversity and customer care.

In addition to these new initiatives staff had the benefit of an appraisal and personal development plan and the results of the staff survey showed a significant improvement in this area since 2006.

The trust continues to be a provider of good quality education and development for medical undergraduates and doctors in training and received an excellent report from the joint Deanery/Strategic Health Authority review.

The trust recognises that staff on the 'front line' are in the best place to ensure that changes to the way they work benefit patients. A number of initiatives have been taken forward to increase staff involvement

in the important decisions and changes that affect them. The trust has formal staff consultative and negotiating arrangements that meet regularly and are active in proposing ideas for improvement. During the year a number of policies were negotiated to support staff to respond to changes to their jobs. The Chair of Staff Side became a full-time role and the elected role holder has been active in presenting the views of staff side in senior management meetings. A team briefing system and additional newsletters were introduced to ensure that staff are aware of the trust's progress and factors in the community and nationally which affect their work. In December 2007 the trust ran a 'listening event' to ask staff how improvements could be made to the systems and processes to benefit patient care.

Patient advice and support

As part of an initiative to make the Patient Advice and Liaison Service (PALS) even more accessible to those patients and relatives who need it, a new PALS office was created in the hospital's atrium. This was formally opened in September by health policy analyst, writer and broadcaster Roy Lilley.

The trust has invested in a new post of Head of Patient Experience to bring together existing patient feedback routes including PALS and complaints and to work with the Patient Experience Group (comprising patients and their carers) to develop a clear picture of patient and carer needs and to ensure that the trust is responding to these.

Listening to GPs

Following feedback from GPs that their preferred communication method is via E-mail, the trust changed the format of its 'RUH Matters' GP newsletter from paper to E-mail. The content is more focused on the clinical issues which are most important to GPs. During 2008/09 this will move to a monthly publication.

A lot of work has also been done on developing a new trust website, with a particular focus on the areas accessed by GPs. It's expected that this will be launched in trial form in April 2008. This will be further developed during 2008 with a view to the whole website being launched mid 2008.

Performance against other national targets

In addition to the key targets above, the trust is also forecast to achieve the following national targets:

- improved access to retinal screening;
- reduced waiting time for rapid access chest pain clinic;
- case-mix specific reduced lengths of stay;
- improved response times to patient complaints.

Priorities for the Year Ahead: 2008/09

The RUH Bath aims to build on recent successes. The objectives for the year ahead have been informed by feedback from staff and patients in 2007/08. Their feedback is at the heart of the of the trust's objectives and there are four overarching themes;

- Patient safety and experience
- Staff experience, incl. education & training
- Business delivery
- Organisational development & improvement

Patient safety

The safety of patients – reducing their risk of harm and promoting a culture of safety – are key targets for the year ahead.

The trust will maintain and improve upon its high standards of infection control – reducing the number of MRSA bacteraemias and the number of cases of Clostridium difficile. Specific targets are to reduce the number of MRSA bacteraemias to less than 26 – down from 35 in 2007/08 and to reduce the number of cases of C.diff to no more than 20 per month for all ages – down from 30 a month in the 65+ age bracket in 2007/08.

The trust has joined the Leading Improvement in Patient Safety (LIPS II) which puts attention to safety at the centre of all its activities and processes. Associated with this programme the trust has set itself two 'break through' targets that demonstrate its intolerance of failure in key areas. These are:

- the trust will, by the end of April 2009, have no MRSA bacteraemias;
- the trust will have no deaths for which the primary cause has been assessed as C. diff infection throughout the year.

In addition, the trust aims to be within the top-performing 10% of acute trusts for the Standard Mortality Rate (SMR) measurement. The hospital's SMR is currently 90, significantly below the expected rate of 100.

Patient experience

Improving the experience of patients using our services, improving customer care and ensuring far more information is available to them than at present are key aims for 2008/09.

The trust will reduce waiting times so that the majority of patients wait no more than ten weeks from referral to treatment – making this the lowest waiting time for any trust in the local area. Length of stay for our patients will also reduce so that only 93% of the trust's beds on average are occupied at any one time. This provides the flexibility to place patients within the right specialties first time and reduces pressure on staff.

100% of complaints will be responded to within 25 days and work will focus on achieving a 2% improvement in the trust's performance in the 2009 national Inpatient Survey.

The trust will be introducing the new Millennium computer system during 2008. This will replace the trust's ageing patient administration system and bring many benefits, including live information on which beds are occupied, and direct booking of appointments by GP practices and patients. It will be a major change for staff which will require the whole trust to work together.

Improving the experience of staff

The trust will work to fill all vacancies in nursing (qualified and unqualified), cleaning and patient administration staff. This will improve both staff morale and satisfaction and improve the service that we offer our patients.

The other areas of focus for 2008/09 are management and leadership skills, good communication, health and safety and celebrating success. The RUH will support local teams to learn skills for business leadership, change and improvement and give them the responsibility to deliver their own targets.

Business delivery

As part of the wider NHS, the trust has responsibilities to deliver national and local performance targets, contractual obligations and a financially balanced position. Work through the year will demonstrate reliable and consistent delivery of care to these standards.

The trust will also be working to build its reputation through other initiatives, including the development of a trust identity in its documentation and information. Effort will also be put into building positive relationships with GPs and the improvement of the timeliness and quality of discharge summaries.

Organisational development and improvement

Attention will be given to the improvement of services for staff and patients. The RUH 2010 programme, launched in May 2007, will continue as the umbrella programme for improvement. The key changes which the programme will see in 2008/09 include:

Process efficiency

- introduction of the new 'one stop' pathway for admitted patients so that they receive their outpatient appointment, diagnostics and pre-operative assessment all on the same day, reducing their waiting time and saving them from making multiple visits to the hospital;
- introduction of a central admissions ward for all inpatients and ensuring that theatres start earlier to improve efficiency;
- introducing a new service in outpatients to remind patients of their appointments through an automated telephone system. This will reduce unused outpatient slots, ensuring the trust's capacity is used as efficiently as possible.

Productive ward
This programme will be extended to cover all wards at the trust through the year.

Leading Improvement in Patient Safety (LIPS II)
Led by the Chief Executive, Director of Nursing and Deputy Medical Director, the LIPS will build the trust culture as a Highly Reliable Organisation, intolerant of failures in safety and building a positive learning approach to risk identification and management.

Service Line Management
Through 2008/09 the trust will work to develop a more 'devolved' system of management that places as much control as possible as close to the patient as possible.

Looking ahead

The emerging five-year vision for RUH Bath contains the following core elements:

- the Royal United Hospital will have achieved foundation status;
- all of the historic debt will have been repaid;
- the RUH will be seen to be an excellent hospital, as evidence by its annual rating by the Healthcare Commission, and by being within the top ten percent of hospitals as rated by Dr Foster;
- the trust will continue to be a major acute hospital, but will also be providing a range of services in the community, perhaps including maternity services, and services within community hospitals. It will have close links with the private sector, working with them to provide a comprehensive range of health services.
- more patients will choose the RUH for their treatment, and GPs will recommend the trust to their patients;
- the trust will be seen as a good place to work, and will attract high-quality staff;
- the trust's estate will have been upgraded and rationalised to ensure it is fit for purpose to provide modern, safe healthcare;
- power and accountability to make decisions will be held as near to the front-line as possible, through the creation of effective business units by clinical staff.

Financial Review: 2007/08

The Royal United Hospital Bath has met its corporate objective of 'Making the most of our money', which was linked to the target of achieving financial balance in 2007/08.

Our financial performance demonstrates how we have met our objective by:

- achieving a surplus of income over expenditure of £1.9m in 2007/08;
- delivering savings and embedding our financial recovery plans through the RUH 2010 Change Programme;
- strengthening our financial position by building on the surplus achieved in 2006/07 of £0.1m. This was the first year in which we achieved a surplus without additional financial support since becoming a trust in 1992.

Our financial performance is a huge achievement for the trust and a tremendous success shared by all our staff.

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

Underlying the trust's financial achievement is its ability to implement and embed savings plans. In 2007/08, the trust was able to meet some of its requirement to make savings through non recurring measures such as additional income earned through activity to meet the 18 week target. This gave the trust headroom to develop longer term financial benefits through the RUH 2010 change programme.

Details of the trust's financial plans are closely monitored by the Board every month, and have been regularly reviewed by the South West Strategic Health Authority (SWSHA). Copies of our trust board papers are available on our website.

Financial targets in 2007/08

The trust met its other financial targets in 2007/08, as detailed in the full accounts:

External financing limit (EFL)
The EFL sets out how the trust must manage its cash flow and borrowing requirements. During 2007/08 the trust was able to manage within its cash requirements, and met this target.

Historical financial information	2004/05 £m	2005/06 £m	2006/07 £m	2007/08 £m
Income	160	166	179	194
Pay expenditure	-107	-115	-114	-119
Non pay expenditure	-44	-46	-50	-58
SURPLUS/-DEFICIT before INTEREST	**9**	**5**	**14**	**17**
Net interest, depreciation & dividend	-10	-12	-14	-15
NET DEFICIT (-)/SURPLUS	**-1**	**-7**	**-**	**2**
Financial support received	-10	-	-	-
Other one-off factors (net)	-2	-	-	-
NORMALISED DEFICIT (-)/SURPLUS	**-13**	**-7**	**-**	**2**

Table 1: The trust's financial performance 2004-2008

Capital resource limit (CRL)
The CRL is the maximum amount that the trust can invest in fixed assets during the year. In 2007/08 the trust did not exceed its CRL.

Other financial measures detailed in the full accounts include:

Capital cost absorption rate
The trust is required to make a return on the assets it employs of 3.5%. In 2007/08 the trust achieved a return of 2.4%.

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.

	2007/08 £000	2006/07 £000
Management Costs	7,264	6,863
Income	186,572	171,747
Cost as a % of income	3.89%	4.00%

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

Historic deficit, break-even duty and cash loan

The Royal United Hospital Bath has demonstrated financial stability in 2006/07 and 2007/08, but it has a substantial accumulated deficit on the Income and Expenditure Reserve, standing at £41m at 31 March 2008.

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 break-even over a three year period, although in extreme circumstances this would be extended to five years. At this point any deficits incurred before 1997 were disregarded for the purposes of monitoring ongoing break-even.

Due to the size of the deficit incurred by the trust in 2002/03, the SHA agreed to extend the trust's break-even period to five years. This meant that the deficits incurred in 2002/03 and subsequent years needed to be recovered by 31 March 2007. It should be noted that the trust's balance sheet deficit (£41.1m) includes deficits prior to 2002 and consequently is larger than the amount to be recovered by 2007 under its statutory break-even duty, as detailed in Table 2 overleaf. To meet this, the trust would have been required to make a surplus of £32m in the year 2006/07. This was clearly not achievable. In addition, the trust had previously been reliant on cash brokerage from the local health community

Better payment practice code - measure of compliance	2007/08 Number	2006/07 Number
Total Non-NHS trade invoices paid in the year	62,358	62,624
Total Non NHS trade invoices paid within target	57,876	57,131
Percentage of Non-NHS trade invoices paid within target	93%	91%
Total NHS trade invoices paid in the year	2,211	2,390
Total NHS trade invoices paid within target	1,877	2,008
Percentage of NHS trade invoices paid within target	85%	84%

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.

	In Year Deficits £'000	Break-even Duty £'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
2007/08	1,900	1,900
Accumulated Deficit	**-41,138**	**-**
Break-even duty	**-**	**-30,079**

Table 2 : The trust's cumulative break-even duty as at 31 March 2008

each year to ensure that it could continue to pay its bills.

The solution to the trust's situation was sought through long-term financing which would allow the trust to meet its break-even duty over time and also resolve its cash flow issues.

Rescheduling the trust's loan and recovering the historic deficit

At the end of 2006/07, the trust entered into a loan agreement with the Department of Health and SWSHA for £38m repayable over 20 years. Since then, the SWSHA has negotiated a revised repayment structure for both the loan and break-even duty. These negotiations with the Department of Health and local commissioners were concluded in March 2008.

The trust will repay its cash loan and recover its deficit over the next five years ending in 2013. The trust will make surpluses each year and additional income from the trust's commissioning primary care trusts has been agreed for five years to achieve this.

In 2008/09, the trust was planning to make a surplus of £1.9m, but with the additional income and other measures linked to the trust's interest payable, the revised surplus for 2008/09 will be £5.6m.

Future financial plans

The trust has completed its financial forecasts as shown below, based on the revised loan agreement and projections of income and expenditure.

The forecasts for the next five years are shown at the top of the opposite page:

	2008/09 £m	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m
Trust forecast surplus	1.9	1.9	1.9	1.9	1.9
Additional income	2.9	2.9	2.9	2.9	2.9
Change in interest payable/ other changes	0.8	1.0	1.2	1.4	1.7
Revised surplus	**5.6**	**5.8**	**6.0**	**6.2**	**6.5**
Loan outstanding at beginning of year	36.1	27.5	20.7	13.7	6.5
Planned additional cash repayment	3.0	1.0	1.0	1.0	0.0
Loan outstanding at end of year	**27.5**	**20.7**	**13.7**	**6.5**	**0.0**
Historic break-even duty at beginning of year	30.1	24.5	18.7	12.7	6.5
Historic break-even duty at end of year	**24.5**	**18.7**	**12.7**	**6.5**	**0**

Table 3: Rescheduled loan repayments and recovery of break-even duty.

The major financial risks for the trust in 2008/09 and beyond are:

- the delivery of the required surpluses each year to meet the terms of the loan and recovery of the historic deficit;
- the delivery of savings to meet the CRES targets;
- the delivery of financial benefits from the RUH 2010 change programme;
- the management of patient flows through the hospital and the operational demands this brings whilst keeping within financial budgets and plans.

The trust has identified a number of factors which will strengthen its ability to manage its financial risks:

- service level agreements were signed with its commissioning PCT before the start of the financial year and therefore any uncertainties around income and contractual arrangements have been minimised;
- the NHS has completed its transition to full Payments by Results and there will no longer be any transitional reductions in income;
- the trust will spend less if it delivers less activity; savings in variable costs will help offset changes in income;
- learning from the RUH 2010 process is being applied as the trust identifies financial benefits for future years.

Capital investment

The trust's capital investment programme is reviewed on a rolling three year basis. Under the new rules for capital expenditure, all capital investment must be funded from internally generated resources or loans.

Because the trust already has a substantial loan, it is unlikely that it will be able to meet the terms and conditions for new loans for capital investment in the short-term. This means that the trust would look to partnerships with the private sector, or the restructuring of its site, in order to fund future major capital expenditure.

The trust is currently reviewing the use of its internally generated funds for capital investment in the wider context of its estate strategy.

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 2007/8 the following individuals were non-executive directors:

- James Carine
- Maura Poole (until 31.12.2007)
- Steve Wheeler
- Jonathon Lloyd
- Michael Earp
- Peter Tomkins
- Maura Brennan (from 01.02.2008)

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.

Details of service contracts

Name	Post Title	Date of Contract
James Scott	Chief Executive	01/06/2007
John Williams	Director of Finance Acting Chief Executive	19/04/2004 01/04/2007
Jennifer Howells	Acting Director of Finance	01/06/2007
Catherine Phillips	Director of Finance	03/09/2007
Diane Fuller	Director of Patient Care Delivery	01/09/2005
Lynn Vaughan	Director of Human Resources	01/07/2004
Brigid Musselwhite	Director of Planning & Strategic Development Deputy Chief Executive	01/03/2004 01/09/2007
Francesca Thompson	Director of Nursing	25/09/2006
Stephen Holt	Director of Facilities	26/11/2000
John Waldron	Medical Director *	01/09/2002

* Mr Waldron's substantive appointment is as a Consultant ENT Surgeon, to which Consultant

- 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, although 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.

During 2007/08 the Remuneration Committee agreed to introduce a performance related payment system for executive directors relating to performance during the 2008/09 business year.

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 six 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.

Termination liabilities for executive directors

There are no provisions for compensation for early termination for any executive directors, as detailed in the table below.

Other termination liabilities for all executive directors are the entitlements under the NHS Whitley Council and/or Agenda for Change and the NHS Pension Scheme. Statutory entitlements also apply in the event of unfair dismissal. The balance of annual leave would be due to be paid on termination.

Unexpired Term	Notice Period	Provision for Compensation for Early Termination	Other Termination Liability
Substantive	6 months	None	See text above
Substantive: left 31/05/2007	6 months	None	As above
Term expired 31/08/2007	3 months	None	As above
Substantive	6 months	None	
Substantive	6 months	None	As above
Substantive	6 months	None	As above
Substantive	6 months	None	As above
Substantive	6 months	None	As above
Substantive: left 22/11/2007	6 months	None	As above
		None	As above with respect to Medical Director *

Contract termination liabilities apply.

Salary and pension entitlements of senior managers - year ended 31 Ma

Salaries and allowances

	2007/08			
	Salary (bands of £5,000)	Other Remun-eration (bands of £5,000)	Benefits in kind (rounded to nearest £00)	Date of starting (S) or leaving (L)
Name and title	**£000**	**£000**	**£00**	
James Scott - Chief Executive	**130-135**			01.06.07 (S)
John Williams - Director of Finance/Acting Chief Executive	**30-35**			31.05.07 (L)
Jennifer Howells - Acting Director of Finance	**20-25**			01.06.07 (S) 31.08.07 (L)
Catherine Phillips - Director of Finance	**60-65**			03.09.07 (S)
John Waldron - Medical Director	**40-45**	**125-130**		
Francesca Thompson - Director of Nursing	**75-80**			
Brigid Musselwhite - Director of Planning and Strategic Development/Deputy Chief Executive [1]	**85-90**			
Stephen Holt - Director of Facilities	**45-50**	**30-35**		22.11.07 (L)
Lynn Vaughan - Director of Human Resources	**70-75**			
Diane Fuller - Director of Patient Care Delivery	**75-80**			
James Carine - Chairman	**20-25**			
Maura Poole - Non Executive Director	**0-5**			31.12.07 (L)
Steve Wheeler - Non Executive Director	**5-10**			
Jonathon Lloyd - Non Executive Director	**5-10**			
Michael Earp - Non Executive Director	**5-10**			
Professor Peter Tomkins - Non Executive Director	**5-10**			
Moira Brennan - Non Executive Director	**0-5**			01.02.08 (S)

1: from 01.09.2007

Pension benefits

	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2008 (bands of £2,500)
Name and title	**£000**	**£000**	**£000**
James Scott - Chief Executive	5-7.5	15-17.5	40-45
John Williams - Director of Finance	2.5-5	7.5-10	60-65
Jennifer Howells - Acting Director of Finance	2.5-5	10-12.5	0-5
Catherine Phillips - Director of Finance	2.5-5	10-12.5	15-20
John Waldron - Medical Director	5-7.5	20-22.5	45-50
Francesca Thompson - Director of Nursing	0-2.5	2.5-5	15-20
Brigid Musselwhite - Director of Planning and Strategic Development	0-2.5	5-7.5	20-25
Stephen Holt - Director of Facilities	(10)-(12.5)	(20)-(22.5)	15-20
Lynn Vaughan - Director of Human Resources	0-(2.5)	0-(2.5)	10-15
Diane Fuller - Director of Patient Care Delivery	0-2.5	2.5-5	20-25

As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-e

arch 2008

	2006/07		
	Salary (bands of £5,000)	Other Remun-eration (bands of £5,000)	Benefits in kind (rounded to nearest £00)
	£000	£000	£00
	110-115		
	60-65	100-105	
	35-40		
	80-85		
	70-75		
	75-80		
	75-80		
	5-10		
	5-10		
	5-10		
	5-10		
	5-10		
	0-5		

Cash Equivalent Transfer Values
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 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.

16 June 2008

Lump sum at age 60 related to accrued pension at 31 March 2008 (bands of £2,500)	Cash Equivalent Transfer Value at 31 March 2008	Cash Equivalent Transfer Value at 31 March 2007	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
£000	£000	£000	£000	£000
120-125	593	483	97	
180-185	1,125	1,024	75	
10-15	44	0	44	
50-55	196	148	44	
145-150	832	676	139	
45-50	255	225	23	
65-70	299	261	31	
65-70	0	428	(438)	
40-45	246	240	1	
60-65	276	242	28	

xecutive members.

Directors' Interests and Appendix 1

Annual accounts 2007/08

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
Finance Department
Malvern House
Combe Park
Bath BA1 3NG

The following statements are attached at Appendix 1:

- Summary Financial Statements
- Statement on 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 2007/08, 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 2007/08, as directed by the Secretary of State.

Directors' interests

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.

Non-Executive Directors
Chairman - James Carine:
Welfare Representative BLESA (British Limbless Ex- servicemen Association);
Member Copyright Tribunal.

Michael Earp:
Director of Softmedia Productions Ltd

Steve 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).

Maura Poole (Until 31 December 2007)**:**
Director of Pooled Perspectives Ltd;
Director of Targeteasy Ltd.

Moira Brennan (from 1 February 2008)**:**
Trustee of Royal Mail Senior Executive Pension Scheme.

Appendix 1: Summary Financial Statements

Income and expenditure account for year ended 31 March 2008	2007/08 £000	2006/07 £000
Income from activities	**177,544**	162,204
Other operating income	**16,677**	15,415
Operating expenses	**(187,777)**	(173,295)
OPERATING SURPLUS	**6,444**	4,324
Profit/(loss) on disposal of fixed assets	**0**	0
SURPLUS BEFORE INTEREST	**6,444**	4,324
Interest receivable	**934**	502
Interest payable	**(1,858)**	(47)
Other finance costs - unwinding of discount	**(5)**	(19)
SURPLUS FOR THE FINANCIAL YEAR	**5,515**	4,760
Public Dividend Capital dividends payable	**(3,615)**	(4,616)
RETAINED SURPLUS FOR THE YEAR	**1,900**	144

Balance sheet as at 31 March 2008	31 March 2008 £000	31 March 2007 £000
FIXED ASSETS		
Tangible assets	**190,643**	184,819
Investments	**0**	0
CURRENT ASSETS	**190,643**	184,819
Stocks and work in progress	**3,237**	3,428
Debtors	**15,147**	11,317
Investments	**0**	0
Cash at bank and in hand	**2,465**	464
	20,756	15,209
CREDITORS: Amounts falling due within one year	**(21,013)**	(11,988)
NET CURRENT (LIABILITIES)/ASSETS	**(257)**	3,221
TOTAL ASSETS LESS CURRENT LIABILITIES	**190,386**	188,040
CREDITORS: Amounts falling due after more than one year	**(27,548)**	(36,100)
PROVISIONS FOR LIABILITIES AND CHARGES	**(2,131)**	(993)
TOTAL ASSETS EMPLOYED	**160,707**	150,947
FINANCED BY:		
TAXPAYERS' EQUITY		
Public dividend capital	**128,545**	131,217
Revaluation reserve	**66,752**	56,594
Donated asset reserve	**6,548**	6,174
Government grant reserve	**0**	0
Income and expenditure reserve	**(41,138)**	(43,038)
TOTAL TAXPAYERS' EQUITY	**160,707**	150,947

The financial statements were approved by the Board on 16 June 2008 and signed on its behalf by:

James Scott,
Chief Executive

Statement of total recognised gains and losses for the year ended 31 March 2008

	2007/08 £000	2006/07 £000
Surplus for the financial year before dividend payments	**5,515**	4,760
Fixed asset impairment losses	**(2,059)**	(760)
Unrealised surplus on fixed asset revaluations/indexation	**12,548**	15,212
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	**851**	451
Total gains and losses recognised in the financial year	**16,855**	19,663

Cash flow statement for the year ended 31 March 2008

	NOTE	31 March 2008 £000	31 March 2007 £000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	16.1	**17,806**	10,398
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**934**	502
Interest paid		**(1,858)**	(47)
Net cash (outflow)/inflow from returns on investments and servicing of finance		**(924)**	455
CAPITAL EXPENDITURE			
Payments to acquire tangible fixed assets		**(6,694)**	(9,295)
Net cash outflow from capital expenditure		**(6,694)**	(9,295)
DIVIDENDS PAID		**(3,615)**	(4,616)
Net cash inflow/(outflow) before management of liquid resources and financing		**6,573**	(3,058)
MANAGEMENT OF LIQUID RESOURCES		**0**	0
Net cash inflow/(outflow) from management of liquid resources		**0**	0
Net cash inflow/(outflow) before financing		**6,573**	(3,058)
FINANCING			
Public dividend capital repaid (not		**(2,672)**	(35,393)
previously accrued)		**0**	38,000
Loans received from DH		**(1,900)**	0
Loans repaid to DH		**0**	451
Other capital receipts			
Net cash (outflow)/inflow from financing		**(4,572)**	3,058
Increase in cash		**2,001**	0

Statement on Internal Control 2007/08

Royal United Hospital, Bath, NHS Trust
The Board is accountable to 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 safeguarding the public funds and the organisation's assets for which he is personally responsible as set out in the Accountable Officer Memorandum.

A copy of the Statement on Internal Control is included within the trust's annual accounts and is available by contacting the Director of Finance Office (see page 30).

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.

16 June 2008
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

16 June 2008
Chief Executive

16 June 2008
Finance Director

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

We have examined the summary financial statement for the year ended 31 March 2008 which comprises the Income and Expenditure Account, the Balance Sheet, the Statement of Total Recognised Gains and Losses, the Cashflow Statement, the related notes and the information in the Trust's Remuneration Report that is described as having been audited.

This statement, 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 and summary financial statement, in accordance with directions issued by the Secretary of State.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement 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 the Remuneration Report.

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements and the Remuneration Report of the trust for the year ended 31 March 2008 complies with the relevant requirements of the directions issued by the Secretary of State.

PricewaterhouseCoopers LLP

16 June 2008

PricewaterhouseCoopers LLP
31 Great George Street
Bristol
BS1 5QD

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 Chief Executive James Scott at:

Royal United Hospital NHS Trust
Combe Park
BATH
BA1 3NG

Telephone: 01225 824033

E-mail: communication@ruh.nhs.uk

Website: www.ruh.nhs.uk

Are we talking your language?

If you need this documents in another format, including large print, please contact the PALS (Patient Advice and Liaison) Service

Tel: 01225 825656

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

the best staff, working together to give excellent care