Royal United Hospital Bath NHS
NHS Trust

Royal United Hospital Bath NHS Trust
Annual Report 2009/10

United in Excellence

Contents

Financial Review 2009/10

Context
The Royal United Hospital Bath NHS Trust (RUH) met its objective of working within available financial resources for 2009/10. The year was the fourth consecutive one in which we have generated surpluses of income over expenditure. The surpluses have been used to repay the RUH's long term loan from the Department of Health.

A summary of the RUH financial performance over the past four years is set out below. Historic information for 2006/07 and 2007/08 is based on UK Generally Accepted Accounting Principles (UK GAAP). Information for 2008/09 and 2009/10 is based on International Financial Reporting Standards (IFRS). This is in response to the Department of Health's requirement that the NHS is compliant with the requirements of IFRS as applicable to the NHS. Consequently, balances may not be directly comparable between financial years.

Our financial performance is a huge achievement for the RUH and credit must be paid to all our staff for the part they have played in this.

	UK GAAP basis		IFRS basis	
Historical financial information	**2006/07 £000**	**2007/08 £000**	**2008/09 £000**	**2009/10 £000**
Revenue	177,820	194,221	210,149	223,356
Pay expenditure	(114,494)	(119,376)	(127,435)	(137,640)
Non pay expenditure	(67,650)	(68,401)	(72,040)	(78,145)
Operating surplus	**4,324**	**6,444**	**10,674**	**7,571**
Net finance costs and dividends	(4,180)	(4,544)	(4,884)	(6,173)
Net surplus	**144**	**1,900**	**5,790**	**1,398**
Adjustments to arrive at the Trust's Statutory Breakeven Duty				
Impact of transfer to IFRS	0	0	(190)	0
Reversal of impairments	0	0	1,805	4,402
Position against Breakeven duty	**144**	**1,900**	**7,405**	**5,800**

Figure 1: The Trust's financial performance 2006-2010

The change in the RUH surplus from 2008/09 to 2009/10 is explained by the chart below:

For 2010/11, the RUH is aiming to make a surplus of £6.0m in order to make its planned loan repayment to the Department of Health. The RUH must implement and deliver its planned savings in 2010/11 in order to achieve this.

Details of our financial plans are closely monitored by the Trust Board every month, and have been regularly reviewed by the Strategic Health Authority, NHS South West.

Copies of our Trust Board papers are available on our web site, along with details of times and venues for the Public meetings.

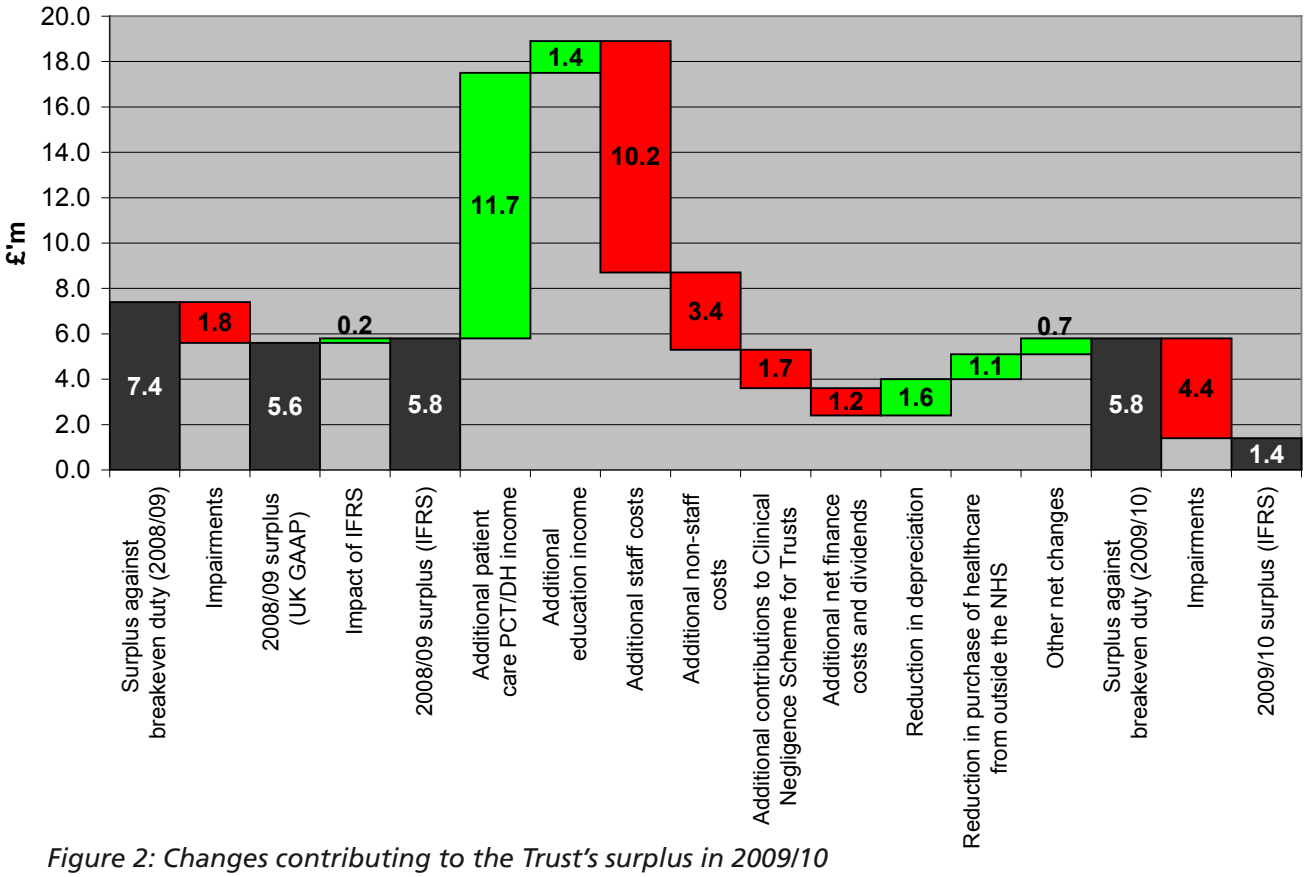


Figure 2: Changes contributing to the Trust's surplus in 2009/10

A bridge chart is a graphical method used to explain movements from one position to another. In this chart, the black bars represent a position for the Trust at a point in time, with green bars explaining positive movements (either as increased income or reduced expenditure) in the Trust's financial position, and red bars explaining negative movements (either as reduced income or increased expenditure).

Financial duties and measures in 2009/10

The RUH met its statutory financial duties in 2009/10 as follows:

Meeting the planned surplus

We achieved our target of a planned revenue surplus of £5.8m (in 2008/09 the Trust achieved its planned surplus of £5.6m on a UK GAAP basis, which translated into £5.8m on an IFRS basis).

The RUH final reported surplus was £1.4m because its expenditure included impairments totalling £4.4m; this expenditure is not included in the calculation of our planned surplus or its break-even duty.

By meeting this target, we achieved our statutory breakeven duty and ensured that our in-year expenditure did not exceed our income.

External financing limit (EFL)

The EFL sets out how the RUH manages its cash flow and borrowing requirements. During 2009/10 we were able to manage within our cash requirements, and met this target (2008/09: target met).

Capital resource limit (CRL)

The CRL is the maximum amount that the Trust can invest in fixed assets during the year. In 2009/10 we did not exceed our CRL (2008/09: CRL not exceeded).

In addition, the RUH is measured against the following targets:

Capital cost absorption rate

The RUH is required to make a return on the assets it employs of 3.5%. In previous years, the calculation was based on forecast assets and dividend payments for the financial year. During 2009/10, this methodology was amended, and it is now based on actual assets held through the year; the RUH then pays 3.5% of this value as its dividend payment. The RUH achieved its required return of 3.5% (2008/09: 2.5%).

Management costs

The RUH 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.

	2009/10 £000	2008/09 £000
Management Costs	8,738	8,734
Income	223,170	210,150
Cost as a percentage of income	3.9%	4.2%

Management costs and related income figures are as defined by the Department for Health.

Better payment practice code - Measure of compliance

	2009/10 Number	2008/09 Number
Total Non-NHS trade invoices paid in the year	65,513	68,775
Total Non NHS trade invoices paid within target	62,257	61,286
Percentage of Non-NHS trade invoices paid within target	95%	89%
Total NHS trade invoices paid in the year	2,452	2,407
Total NHS trade invoices paid within target	2,250	2,140
Percentage of NHS trade invoices paid within target	92%	89%

The Better Payment Practice Code requires the RUH 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. The Trust places great importance on ensuring that valid invoices are paid quickly, and is a signatory to the Prompt Payment Code www.promptpaymentcode.org.uk. The Prompt payment code requires that at least 95% of valid invoices are paid within 30 days of receipt.

Our monthly performance in achieving the target in 2009/10 has been as follows:

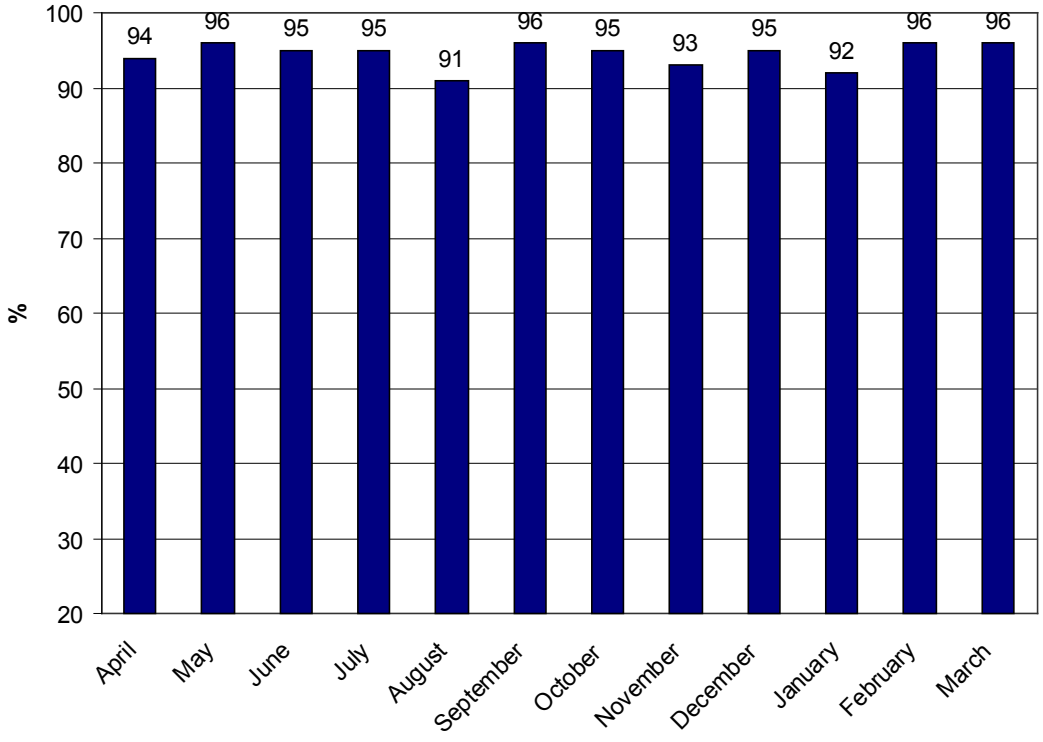


Figure 3 2009/10 performance under the Better Payment Practice Code

Historic Deficit, Breakeven Duty and Legacy Debt

The Trust has demonstrated financial stability since 2006/07, but it has a substantial historic accumulated deficit within Retained Earnings (formerly, the Income and Expenditure Reserve), standing at £44.4m at 31 March 2010.

Legislation requires the Trust to breakeven 'taking one year with another'. In 1997, guidelines were issued by the Department of Health on how this should be measured in practice. Adjustments are required to remove certain transactions from the in-year financial surplus or deficit to compare against the Trust's breakeven duty.

Consequently, there are differences between the historic accumulated deficit and the breakeven duty deficit, as detailed below. The position stated for years up to, and including, 2008/09 are on a UK GAAP basis. The position for 2009/10 is on an IFRS basis.

	In Year (Deficits)/ Surpluses £000	Breakeven 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
2008/09	5,600	7,405
2009/10	1,398	5,800
Changes in accounting policies	(10,285)	-
Accumulated Deficit	**(44,425)**	**-**
Breakeven duty	**-**	**(16,874)**

Figure 4 The Trust's cumulative breakeven duty as at 31st March 2010

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.

At the end of 2006/07, the Trust entered into a loan agreement with the Department of Health and NHS South West for £38m repayable over 20 years. In March 2008, the strategic health authority negotiated a revised repayment structure for both the loan and breakeven duty. These negotiations with the Department of Health and local commissioners were concluded in March 2008. The loan is based on an interest rate which has been fixed by agreement with HM Treasury at an annual rate of 5.05%.

The Trust will repay its legacy debt and recover its remaining deficit over the next three years, ending in 2013. The Trust will make surpluses in each of these years to achieve this.

Future financial plans

The Trust's financial forecasts are shown below. This is based on the terms of the loan agreement, along with income, expenditure and capital projections.

The forecast for the next three years is part of the Trust's medium term financial plan, and is shown below:

	2010/11 £000	2011/12 £000	2012/13 £000
Trust forecast surplus	4,800	4,800	4,800
Change in finance costs and other net changes	1,200	1,400	1,700
Revised surplus	6,000	6,200	6,500
Loan outstanding at beginning of year	(20,700)	(13,700)	(6,500)
Repayment funded by revised surplus	6,000	6,200	6,500
Planned additional cash repayment	1,000	1,000	-
Loan outstanding at end of year	(13,700)	(6,500)	-
Historic breakeven duty at beginning of year	(16,874)	(10,874)	(4,674)
Historic breakeven duty at end of year	(10,874)	(4,674)	1,826

Figure 5: Rescheduled loan repayments and recovery of breakeven duty

The Trust's future financial plans do require the Trust to ensure that key financial risks are addressed. The main financial risks which are anticipated to affect the Trust in 2010/11 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 efficiency savings to meet the targets;
- The level of income the Trust may earn from commissioned activity, as a result of other providers that have entered the local health economy;
- That capital expenditure addresses the requirements of an affordable long-term Estates strategy.

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

- The Trust is working in partnership with its commissioning primary care trusts to agree a satisfactory contract and to minimise uncertainties around its income position;
- The Trust will spend less if it delivers less activity; savings in variable costs will help offset changes in income;

- The Trust has in place plans for the delivery of efficiency savings, and the requirements of the Department of Health's new work programme, Quality, Innovation, Productivity and Prevention,(QuIPP). The plans are monitored through the Trust's performance framework and by the Trust's Efficiency Board; and
- Business plans for the 2010/11 financial year were reviewed by the Trust Board with representation from each Division to ensure clarity around the requirements from each Division.

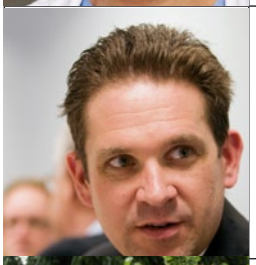
Capital investment

The Trust's capital investment programme is reviewed on a rolling three year basis. Capital expenditure is set by the Trust's Capital Prioritisation Group, which is chaired by the Director of Planning and Strategic Development. The Group has representation from across the Trust, and its decisions are presented and ratified by the Trust Board.

The Trust already has legacy debt due to its working capital loan. As this affects the Trust's ability to borrow in the short to medium term to fund capital investment, future funding options for major capital schemes are constrained. The Trust's Estates Strategy is currently being developed within the anticipated constraints of future NHS funding.

Trust Board Membership

	Name	Position	Tenure	Voting	Board sub-committees	Attendance at Board
	James Carine	Chairman 1.11.06 – 31.3.10	4 years	Yes	Remuneration Committee ex-officio all other Trust Board committees	12/12
	James Scott	Chief Executive	substantive	Yes	Management Board ex-officio all other Trust Board committees	11/12
	Michael Earp	Non-Executive Director and Vice Chairman	4 years	Yes	Audit Committee Remuneration Committee Clinical Governance Committee Charities Committee	12/12
	Rev Jonathan Lloyd	Non-Executive Director 1.04.02 - 30.06.09	4 years	Yes	Remuneration Committee Non-Clinical Governance Committee Whistle blowing contact	2/12
	Moira Brennan	Non-Executive Director	4 years	Yes	Audit Committee Charities Committee Remuneration Committee	11/12
	Prof. Peter Tomkins	Non-Executive Director 1.1.07 – 31.3.10	4 years	Yes	Remuneration Committee Clinical Governance Committee	11/12
	Stephen Wheeler	Non-Executive Director	4 years	Yes	Charities Committee Audit Committee Remuneration Committee Non-Clinical Governance Committee Whistle blowing contact	11/12

	Name	Position	Tenure	Voting	Board sub-committees	Attendance at Board
	John Waldron	Medical Director	Substantive (consultant ENT surgeon)	Yes	Management Board Clinical Governance Committee	10/12
	James Rimmer	Director of Operations (from 15.6.09)	Substantive	Yes	Management Board Non-Clinical Governance Committee	8/12
	Francesca Thompson	Director of Nursing	Substantive	Yes	Management Board Charities Committee Clinical Governance Committee	11/12
	Catherine Phillips	Director of Finance	Substantive	Yes	Charities Committee Management Board Audit Committee	12/12
	Brigid Musselwhite	Deputy Chief Executive & Director of Planning and Strategic Development	Substantive	No	Management Board Non-Clinical Governance Committee	12/12
	Lynn Vaughan	Director of Human Resources	Substantive	No	Management Board Non-Clinical Governance Committee	12/12
	Howard Jones	Director of Facilities	Substantive	No	Management Board Non-Clinical Governance Committee	12/12

Remuneration Report

Membership of the Remuneration committee
All, and only, Non Executive Directors are members of the committee. The committee is quorate with 4 members.

During 2009/10 the following individuals were Non Executive Directors:

James Carine (until 31st March 2010)
Stephen Wheeler
Jonathan Lloyd (until 30th June 2009)
Michael Earp
Peter Tomkins (until 31st March 2010)
Moira Brennan

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;

A discretionary performance related payment system for Executive Directors exists. The bonus arrangement provides for directors to receive an annual inflation uplift providing performance is judged to be satisfactory. Additionally, a non-consolidated bonus of up to 5% may be paid to individuals whose performance exceeds expectation. For individuals judged to have outstanding performance a non-consolidated bonus of up to 10% may be paid. No payments will be made with respect to the 2009/10 financial 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 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.

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 earned but untaken would be due to be paid on termination.

Details of service contracts

Name	Post Title	Date of Contract	Unexpired Term	Notice Period	Provision for Compensation for Early Termination	Other Termination Liability
James Scott	Chief Executive	01/06/2007	Substantive	6 months	None	See text above
Howard Jones	Director of Facilities	03/11/2008	Substantive	6 months	None	As above
Brigid Musselwhite	Director of Planning & Strategic Development Deputy Chief Executive	01/03/2004 01/09/2007	Substantive	6 months	None	As above
Catherine Phillips	Director of Finance	03/09/2007	Substantive	6 months	None	As above
James Rimmer	Director of Operations	15/06/2009	Substantive	6 months	None	As above
Francesca Thompson	Director of Nursing	25/09/2006	Substantive	6 months	None	As above
Lynn Vaughan	Director of Human Resources	01/07/2004	Substantive	6 months	None	As above
John Waldron	Medical Director [1]	01/09/2002			None	As above with respect to Medical Director responsibilities

1 John Waldron's substantive appointment is as a Consultant ENT Surgeon, to which Consultant Contract termination liabilities apply.

Salary and Pension entitlements of Senior Managers

Salaries and allowances: Information in this table has been audited	2009/10			2008/09		Date of starting (S) or leaving (L)
Name and title	**Salary (bands of £5,000) £'000**	**Performance related payment 2008/09* (bands of £5,000) £000**	**Other Remuneration (bands of £5,000) £000**	**Salary (bands of £5,000) £000**	**Other Remuneration (bands of £5,000) £000**	
James Scott - Chief Executive	155-160	10-15	0	150-155	0	
Diane Fuller - Director of Patient Care Delivery	0	0	0	65-70	0	31 January 2009 (L)
Beverley Goddard - Director of Finance (acting) 1	0	0	0	0-5	5-10	1 August 2008 (S) 31 August 2008 (L)
Peter Hollinshead - Director of Finance (interim) 2	0	0	0	130-135	0	1 September 2008 (S) 27 February 2009 (L)
Howard Jones - Director of Facilities 3	95-100	0-5	0	40-45	0	
Brigid Musselwhite - Director of Planning and Strategic Development/Deputy Chief Executive	95-100	5-10	0	90-95	0	
Catherine Phillips - Director of Finance	110-115	0-5	0	75-80	0	
James Rimmer - Director of Operations	75-80		0	0	0	16 June 2009 (S)
Francesca Thompson - Director of Nursing	90-95	5-10	0	85-90	0	
Lynn Vaughan - Director of Human Resources 4	85-90	5-10	0	70-75	0	
John Waldron - Medical Director 5	35-40	0	130-135	30-35	140-145	
James Carine - Chairman	20-25	0	0	20-25	0	31 March 2010 (L)
Moira Brennan - Non Executive director	5-10	0	0	5-10	0	
Michael Earp - Non Executive Director	5-10	0	0	5-10	0	
Rev. Jonathon Lloyd - Non Executive Director	0-5	0	0	5-10	0	30 June 2009 (L)
Prof. Peter Tomkins - Non Executive Director	5-10	0	0	5-10	0	31 March 2010 (L)
Stephen Wheeler - Non Executive Director	5-10	0	0	5-10	0	

* A performance related payment was paid in 2009/10 which related to performance in 2008/09. No payment will be made in relation to 2009/10.
No Directors received any benefits in kind (2008/09: none).

1 Beverley Goddard's substantive appointment is as Deputy Director of Finance of the Trust. Her remuneration is therefore split during 2008/09, during the period within which she was acting Director of Finance between that earned for performing the role of Director (Salary) and that earned for her substantive role (Other remuneration).
2 The figures quoted for Peter Hollinshead are based on invoices which included amounts for travel and away from home expenses, pension contributions and the overheads of his business. These costs are therefore not directly comparable to the salaries of other directors.
3 Howard Jones commenced his employment with the Trust in November 2008, and his salary for 2008/09 reflects this.
4 Lynn Vaughan's contract of employment was amended to move from a part-time role in 2008/09 to a full-time role in 2009/10. Her remuneration has consequently increased to reflect this change.
5 John Waldron's substantive appointment is as a Consultant ENT Surgeon. His remuneration is therefore split between his responsibilities as Medical Director (Salary) and that earned in his substantive appointment (Other remuneration).

Pension Benefits: Information in this table has been audited

Name and title	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 2010 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2009	Real increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
James Scott - Chief Executive	2.5-5	7.5-10	50-55	150-155	961	865	96
Howard Jones - Director of Facilities	2.5-5	7.5-10	40-45	125-130	1,049	934	115
Brigid Musselwhite - Director of Planning and Strategic Development	0-2.5	2.5-5	25-30	80-85	471	424	47
Catherine Phillips - Director of Finance	2.5-3	7.5-10	25-30	75-80	367	314	53
James Rimmer - Director of Operations	22.5-25	70-72.5	20-25	70-75	371	0	371
Francesca Thompson - Director of Nursing	0-2.5	2.5-5	20-25	60-65	437	390	47
Lynn Vaughan - Director of Human Resources	0-2.5	2.5-5	15-20	55-60	433	397	36
John Waldron - Medical Director	5-7.5	15-17.5	60-65	190-195	1,445	1,286	159

Non-Executive directors do not receive pensionable remuneration (08/09: nil). The Trust did not contribute to any Director's stakeholder pension scheme (08/09: nil). Pension details have only been disclosed for those Directors in post during 09/10. Balances for those in post during 08/09 can be obtained from the 08/09 Annual Report.

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 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 scheme or arrangement) and uses common market valuation factors for the start and end of the period.

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James Scott, Chief Executive, 7th June 2010

Annual Accounts 2009/10

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 the Director of Finance.

The following statements are attached at Appendix 1:

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

The summary financial statements do not include the results for Royal United Hospital Bath Charitable Fund. The Charitable Fund is registered with the Charity Commission for England and Wales under registration number 1058323. Its principal office is at the Royal United Hospital NHS Trust, Combe Park, Bath BA1 3NG. Details of the charitable fund can be found on the website: www.ruh.nhs.uk. The main fundraising appeal of the fund, the Forever Friends Appeal, can be found at www.foreverfriendsappeal.co.uk.

Administrative details

Trust contact: Director of Finance
Royal United Hospital Bath NHS Trust
Finance Department
Malvern House
Combe Park
Bath
BA1 3NG

Solicitors: Bevan Brittan Solicitors
35 Colston Avenue
Bristol
BS1 4TT

Bankers: Government Banking Service
Sutherland House
Russell Way
Crawley
West Sussex
RH10 1UH

HSBC Bank Plc
45 Milsom Street
Bath
BA1 1DU

Auditors: Grant Thornton LLP
Hartwell House
55-61 Victoria Street
Bristol
BS1 6FT

Audit

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

The Trust, and its auditors, have processes in place to ensure that conflicts of interest are minimised and that the auditor's independence is not compromised. This includes providing the auditor with direct access to the Chair of the Audit Committee, and its other Non-Executive Members. The Audit Committee seek confirmation on an annual basis that the audit function is independent from management. During the year, the external auditor was paid £179,000 for their work (2008/09: £203,000). All of this work related to their statutory activities under the Audit Commission's 'Code of Audit Practice'.

In respect of the preparation of the accounts for 2009/10, 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.

Going concern

The directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future, and for a period exceeding 12 months from the date of signing the accounts. For this reason, the accounts have been prepared on the going concern basis.

Counter Fraud

The Trust has taken all reasonable steps to comply with the requirements set out in the Code of Conduct for NHS managers, and has a named individual nominated to provide the lead local counter fraud specialist function: an accredited counter fraud specialist. If you suspect that fraud may have occurred, affecting either the Trust or any other NHS organisation, please contact the counter fraud helpline on 0800 028 4060.

Openness and accountability

The Trust is committed to ensuring that it operates within an open and transparent environment, where this does not conflict with its legal responsibilities. The Trust is compliant with the requirements of the Freedom of Information Act. The Annual Report and Accounts provides the public with a comprehensive review of the Trust's annual performance and has been subject to audit scrutiny.

Pensions

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Staff sickness absence

The Manual for Accounts requires that the Trust disclose, for the first time in 2009/10, details of staff sickness absences. This disclosure is included below:

	2009/10 Number
Days lost (long term)	22,753
Days lost (short term)	18,550
Total days lost	**41,303**
Total staff years	**3,406**
Average working days lost	12.13
Total staff employed in period (headcount)	4,638
Total staff employed in period with no absence (headcount)	1,614
Percentage staff with no sick leave	**34.8%**

NHS Trust Manual for Accounts

The operating and financial review has been prepared in accordance with the NHS Trust Manual for Accounts for 2009/10, as directed by the Secretary of State.

Directors' Interests

Executive Directors

Director of Planning and Strategic Development – Brigid Musselwhite
Vice-President of Bath Chamber of Commerce (since July 2009)

Director of Human Resources – Lynn Vaughan
External Examiner in Human Resources Management at the University of the West of England (Bristol Business School)

Medical Director – John Waldron
Partner, Circle Healthcare Bath

Non Executive Directors

Chairman - James Carine
Welfare Representative BLESMA (British Limbless Ex-Servicemen Association)
Member Copyright Tribunal

Moira Brennan
Trustee of the Royal Mail Senior Executive Pension Scheme

Michael Earp
Director of Softmedia Productions Ltd (expired 10th April 2009)

Peter Tomkins
Vice Chairman/Trustee of Chartered Institute of Marketing (and Director of Related Boards)
CEO of D M Management Consultants Ltd
Member of the Advisory Board of CASS Business School, City University
Vice President of UK Youth
Visiting Academic at CASS Business School, Cranfield Business School and St Gallen University

Stephen Wheeler
Chair of Trustees of the Evaluation Trust

Appendix 1 Summary Financial Statements (Audited)

STATEMENT OF COMPREHENSIVE INCOME

	2009/10	2008/09
	£000	£000
Revenue		
Revenue from patient care activities	**202,129**	190,685
Other operating revenue	**21,227**	19,464
Operating expenses	**(215,785)**	(199,475)
Operating surplus	**7,571**	10,674
Finance costs:		
Investment revenue	**48**	747
Other gains and (losses)	**(22)**	(117)
Finance costs	**(1,433)**	(1,692)
Surplus for the financial year	**6,164**	9,612
Public dividend capital dividends payable	**(4,766)**	(3,822)
Retained surplus for the year	**1,398**	**5,790**
Other comprehensive income		
Impairments charged to the Revaluation and Donated asset reserves	(32,394)	(7,801)
Receipt of donated and government granted assets	475	569
Reclassification adjustments:		
Transfers from donated and government grant reserves	(1,144)	(955)
Total comprehensive income for the year	**(31,665)**	**(2,397)**

The Trust's performance against its statutory breakeven duty is not the same as its retained surplus for the year. Performance against the breakeven duty requires the reversal of impairments charged to earnings. The impact in 2009/10 was a reversal of impairments of £4,402,000 to arrive at a surplus of £5,800,000 (2008/09: reversal of £1,805,000 to arrive at a surplus of £7,405,000).

Comparative balances for 2008/09 have been amended following the adoption of International Financial Reporting Standards, as required by the Department of Health. They are therefore not directly comparable with the published financial statements for 2008/09. An explanatory note is appended to these Summary Financial Statements.

STATEMENT OF FINANCIAL POSITION

	31 March 2010	31 March 2009	1 April 2008
	£000	£000	£000
Non-current assets			
Property, plant and equipment	**145,836**	180,519	191,463
Intangible assets	**760**	255	234
Other financial assets	**121**	165	0
Trade and other receivables	**1,762**	1,476	1,320
Total non-current assets	**148,479**	182,415	193,017
Current assets			
Inventories	**3,139**	3,309	3,237
Trade and other receivables	**11,026**	13,926	13,827
Other financial assets	**61**	55	0
Cash and cash equivalents	**690**	1,470	2,465
Total current assets	**14,916**	18,760	19,529
Total assets	**163,395**	201,175	212,546
Current liabilities			
Trade and other payables	**(10,858)**	(13,813)	(12,682)
Other liabilities	**(24)**	(24)	(24)
Department of Health Working capital loan	**(7,000)**	(6,800)	(8,600)
Borrowings	**(233)**	(246)	(170)
Provisions	**(1,844)**	(1,175)	(1,563)
Net current liabilities	**(5,043)**	(3,298)	(3,510)
Total assets less current liabilities	**143,436**	179,117	189,507
Non-current liabilities			
Borrowings	**(497)**	(649)	(893)
Department of Health Working capital loan	**(13,700)**	(20,700)	(27,500)
Provisions	**(903)**	(743)	(568)
Other liabilities	**0**	(24)	(48)
Total assets employed	**128,336**	157,001	160,498
Financed by taxpayers' equity:			
Public dividend capital	**130,445**	127,445	128,545
Retained earnings	**(44,425)**	(45,860)	(51,650)
Revaluation reserve	**37,356**	69,302	77,055
Donated asset reserve	**5,060**	6,114	6,548
Government grant reserve	**0**	0	0
Total Taxpayers' Equity	**128,336**	157,001	160,498

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Govenment grant reserve	Total
	£000	£000	£000	£000	£000	£000
Balance at 31 March 2008						
As previously stated	128,545	(41,138)	66,752	6,548	0	160,707
Prior Period Adjustment relating to adoption of International Financial Reporting Standards	0	(10,512)	10,303	0	0	(209)
Restated balance	128,545	(51,650)	77,055	6,548	0	160,498
Changes in taxpayers' equity for 2008/09						
Total Comprehensive Income for the year:						
Retained surplus for the year	0	5,790	0	0	0	5,790
Impairments and reversals	0	0	(7,753)	(48)	0	(7,801)
Receipt of donated/government granted assets	0	0	0	545	24	569
Reclassification adjustments:						
- transfers from donated asset/government grant reserve	0	0	0	(931)	(24)	(955)
Public Dividend Capital repaid in year	(1,100)	0	0	0	0	(1,100)
Balance at 31 March 2009	127,445	(45,860)	69,302	6,114	0	157,001
Changes in taxpayers' equity for 2009/10						
Balance at 1 April 2009	127,445	(45,860)	69,302	6,114	0	157,001
Total Comprehensive Income for the year						
Retained surplus for the year	0	1,398	0	0	0	1,398
Transfers between reserves	0	37	(37)	0	0	0
Impairments and reversals	0	0	(32,009)	(385)	0	(32,394)
Receipt of donated/government granted assets	0	0	0	458	17	475
Reclassification adjustments:						
- transfers from donated asset/government grant reserve	0	0	0	(1,127)	(17)	(1,144)
New Public Dividend Capital received	3,000	0	0	0	0	3,000
Balance at 31 March 2010	130,445	(44,425)	37,256	5,060	0	128,336

STATEMENT OF CASH FLOWS

	2009/10	2008/09
	£000	£000
Cash flows from operating activities		
Operating surplus	**7,571**	10,674
Depreciation and amortisation	**9,299**	10,757
Impairments and reversals	**4,402**	1,805
Transfer from donated asset reserve	**(1,127)**	(931)
Transfer from government grant reserve	**(17)**	(24)
Interest paid	**(1,419)**	(1,680)
Dividends paid	**(4,723)**	(3,822)
Decrease/(increase) in inventories	**170**	(72)
Decrease/(increase) in trade and other receivables	**2,614**	(255)
(Decrease)/increase in trade and other payables	**(3,487)**	1,073
(Decrease)/increase in other current liabilities	**(24)**	0
Increase/(decrease) in provisions	**818**	(162)
Net cash inflow from operating activities	**14,077**	**17,363**
Cash flows from investing activities		
Interest received	**48**	747
Payments for property, plant and equipment	**(10,373)**	(8,714)
Proceeds from disposal of plant, property and equipment	**28**	5
Payments for intangible assets	**(595)**	(90)
Payments for other investments	**0**	(359)
Net cash outflow from investing activities	**(10,892)**	(8,411)
Net cash inflow before financing	**3,185**	**8,952**
Cash flows from financing activities		
Public dividend capital received	**3,000**	0
Public dividend capital repaid	**0**	(1,100)
Loans repaid to the DH	**(6,800)**	(8,600)
Capital element of finance leases	**(165)**	(247)
Net cash outflow from financing	**(3,965)**	**(9,947)**
Net decrease in cash and cash equivalents	**(780)**	(995)
Cash and cash equivalents at the beginning of the financial year	**1,470**	**2,465**
Cash and cash equivalents at the end of the financial year	**690**	**1,470**

TRANSITION TO INTERNATIONAL FINANCIAL REPORTING STANDARDS

		Retained earnings	Revaluation reserve	Donated asset reserve	Government grant reserve
		£000	£000	£000	£000
Taxpayers' equity at 31 March 2008 under UK GAAP:		**(41,138)**	**66,752**	**6,548**	**0**
Adjustments for IFRS changes:	Leases (a)	(9)	0	0	0
Holiday pay accrual (b)		(200)	0	0	0
Revaluation reserve adjustment (c)		(10,303)	10,303	0	0
Taxpayers' equity at 1 April 2008 under IFRS:		**(51,650)**	**77,055**	**6,548**	**0**
Taxpayers' equity at 31 March 2009 under UK GAAP:		**(45,841)**	**69,302**	**6,114**	**0**
Adjustments for IFRS changes:	Leases (a)	(19)	0	0	0
Taxpayers' equity at 1 April 2009 under IFRS:		**(45,860)**	**69,302**	**6,114**	**0**
Surplus for 2008/09 under UK GAAP		**5,600**			
Adjustments for IFRS changes:	Leases (a)	(10)			
Holiday pay accrual (b)		200			
Surplus for 2008/09 under IFRS		**5,790**			

The adjustment for leases represents the effect of recognising leases which were classified as operating leases under UK GAAP as finance leases under IFRS. This had an effect on the balance sheet at 1 April 2008 for historic arrangements, and a subsequent impact on the expenditure for 2008/09.

IFRS requires that the costs of untaken annual leave are accrued within the financial year. The balance sheet at 1 April 2009 has therefore been restated to include this effect. During 2008/09, the impact of annual leave was accounted for within the UK GAAP accounts. The adjustment posted on the 2008/09 UK GAAP accounts has therefore been reversed.
IFRS does not allow negative balances to be carried for individual assets within the Revaluation reserve, which was previously permitted under certain circumstances. The transfer between the Revaluation reserve and Retained earnings represents the historic effect of this change in policy.

Statement on Internal Control

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

The NHS South West Strategic Health Authority (SHA), commissioning Primary Care Trusts (PCTs) and the Trust have worked closely in 2009/10 and the Trust's performance is reviewed by the SHA and PCTs on a regular basis.

The Bath & Wiltshire Health Community, which consists of the Trust, NHS Bath and North East Somerset (BaNES) and NHS Wiltshire have continued to worked hard in 2009/10 to improve relationships across the organisations and the Chief Executives meet regularly. The PCTs, Overview and Scrutiny Panel, Public and Local Involvement Networks (LINKs) and other partner organisations have worked closely with the Trust and have agreed the areas of work where focus is required. They have been involved in several aspects of the Trust's activities particularly related to patient experiences.

A representative, nominated by the Trust's LINKs, attends the Trust Board and provides a voice for public and patient views.

2. The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives; and evaluate the likelihood of those risks being realised and the impact should they be realised; and to manage them efficiently, effectively and economically.

The system of internal control has been in place at the Trust for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

I have overall responsibility for all risks. A nominated lead Director, the Director of Nursing, has been designated as the Director responsible for clinical governance and risk management. I am responsible for corporate governance issues.

The Trust Board is ultimately responsible for managing and directing the Trust's business. However, there are three Assurance sub-committees which provide the Board with assurance. These are the Clinical Governance Committee; Non-Clinical Risk Committee; and the Audit Committee.

The Trust Board has approved the risk management processes and defined significant risks for the Trust. The Trust has a risk register; all new significant risks are reviewed by the Trust Board at each Trust Board meeting. Existing significant risks are reviewed by the Assurance sub-committees on a quarterly basis and by the Trust Board on a half-yearly basis.

Assurance Committees have been established as sub-committees of the Trust Board, with membership from Executive and Non Executive Directors, clinical representatives from the Divisions and other senior clinical and managerial representatives. The Strategic

Framework for Risk Management includes a reporting structure which details the groups and committees that report to the Assurance Committees and Trust Board.

Each clinical specialty has a forum for discussing risk management and clinical governance issues with a nominated risk management lead. Guidance for the specialty lead and group is included in the Strategic Framework for Risk Management. The Clinical Governance Performance Framework includes standards on risk management and the pillars of clinical governance. Key Performance Indicators (KPIs) have been developed for clinical governance and these are monitored through the Trust's performance measures and included in a corporate scorecard on a monthly basis. The evidence used to monitor against the KPIs has been used in a number of areas to provide evidence for the achievement of the Healthcare Commission's Standards for Better Health and the Care Quality Commission's Essential Standards of Quality and Safety.

Lessons learned from risk and incident investigations are communicated to the relevant Assurance Committee and result in the development of Trust-wide practice change where appropriate. Incidents are dealt with following the Risk and Incident Management Policy or the Serious Untoward Incident Policy. Lessons learned from complaint investigations are communicated throughout the Trust. The Risk Management team holds a training matrix that details which training is mandatory, best practice, and available for each group of staff.

The Risk and Control Framework

4.1 Context

The Strategic Framework for Risk Management identifies the key risk areas for the Trust as clinical risk, non clinical risk, financial risk, human resource risk and information risk.

The policy for Risk and Incident Management includes a clear risk management process. If a risk cannot be resolved at a local level the risk can be referred to a sub-group of one of the Assurance Committees, or the Committees themselves. The risk is also added to the risk register with a plan detailing ways to minimise the risk, and each risk is assessed for its severity and likelihood of occurrence, and are allocated a risk 'traffic light'. The pathway for putting risks onto the Trust risk register includes discussion at Divisional level and the Risk and Clinical Effectiveness Panel (RACE).

Strategic risks outside the remit of the Trust's local governance groups are entered onto the risk register and are reviewed by the Trust Board and the appropriate Assurance Committee. The Trust Board reviews each new significant risk and either explores the solutions or accepts the risk. Existing significant risks are reviewed half-yearly by the Trust Board. Training in risk management is included as part of the induction programme for new members of staff.

The public and stakeholders are involved in managing risk through representation from the LINKs and the local council-led Overview and Scrutiny Committees. In addition, the Trust holds stakeholder events to discuss the issues that should be fed into the Trust strategy. A patient experience strategy has been approved and its progress monitored during 2009/10 by both the Trust Board and the Patient Experience Group (PEG).

4.2 Assurance Framework

The Assurance Framework is a process by which the Trust gains assurance that it has a well-balanced set of objectives for the year and that there are controls in place to manage the key risks associated with achieving the objectives.

The Assurance Framework was developed using the Trust's corporate objectives for 2009/10. The framework focused on patient and public safety, effectiveness, efficiency, and hospital development. The objectives were assessed, and risks in achieving the objectives identified including any gaps in assurance or control. The Assurance Framework was reviewed by the Trust Board regularly throughout the year and included in the public Trust Board papers. Internal Audit reviewed the Assurance Framework in March 2010 and an assessment of significant assurance was provided.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Equality impact assessments are considered and completed for all policies as they are developed or updated.

The Trust has undertaken risk assessments, and Carbon Reduction Delivery Plans are in place. These plans have been based on the UK Climate Impacts Programme 2009 weather projects. They have been developed to ensure that they do not conflict with emergency preparedness and civil contingency requirements and ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Assurance Framework has highlighted a number of gaps in control and assurance as at 31 March 2010. These, and the related actions are overleaf:

	Gap in assurance	Actions to address
1	Consistently meeting the 4 hour emergency care target.	The Trust is in the process of implementing the recommendations of the National Urgent Care intensive support team.
2	Achievement of the 18 week wait from referral to treatment time.	Capacity plans to deliver the target are being reviewed. Demand management progress has been limited due to increased referrals from GPs and limited transfers to the independent sector.
3	Delivery of the NHS National Stroke Strategy.	A 'Stroke Taskforce' has been established which meets on a weekly basis.
4	Reducing the length of stay of patients for elective care.	A 'Length of Stay Taskforce' has been established, and plans are in place to reduce the length of stay of patients.
5	Improvements in theatre utilisation.	The Trust is in the process of reviewing the performance of theatres as part of a 'Productive Theatres' review. Progress around demand management has been limited as for 2, above.
6	The replacement of a Patient Administration System, which is planned for 2010/11.	Contractual discussions are ongoing.
7	The implementation of the Recruit, Respect and Respond campaign.	Risk assessments are being carried out to ensure that recruitment needs are addressed.

As a consequence of the gaps highlighted above, notably 1 and 2, the Trust has decided to defer its application to become an NHS Foundation Trust which was originally an objective for 2010.

The Trust received limited assurance arising from certain internal audits commissioned during the year. The main issues highlighted related to Health and Safety concerns surrounding the Trust's records management; and the processes in place to manage consultants' contracts. A work plan is in place to address these issues.

4.3 Quality and Safety

During the year, the Trust has put in place a Quality Board, chaired by the Deputy Medical Director, with the Director of Nursing as Lead Executive Director. The Quality Board is responsible for setting the strategic direction for quality improvements across the Trust and reports directly to the Trust's Management Board. This includes responsibilities for overseeing the Care Quality Commission's requirements and those from the National Institute of Clinical Excellence (NICE), ensuring that these aspects are addressed within a clinical audit strategy.

The regulatory regime in the NHS changed during 2009/10. During the year, and as in previous years, the Trust was required to make a self assessment on its performance against the core standards as set out by the Department of Health in its Standards for Better Health. The Trust has declared full-compliance with the core standards.

The transition of NHS regulation from the Healthcare Commission to the Care Quality Commission (CQC) requires the Trust to assess its performance against the Essential Standards of Quality and Safety. This exercise was a pre-requisite to obtaining CQC registration. Registration was confirmed in March 2010 with no conditions.

The Trust recognises that the Health Act 2006 introduced a statutory duty on NHS organisations to observe the provisions of the Code of Practice on Healthcare Associated Infections. The Trust Board is aware of its responsibilities in assuring that it has suitable systems and arrangements in place to ensure that the Code is being observed.

The CQC made an unannounced visit to the Trust in November 2009. During the visit, they inspected the duties outlined in the Hygiene Code. There were no concerns arising from their visit.

The Trust confirmed that it met the CQC's requirements on Safeguarding Children and Young People in full by 31 March 2010. The Trust was unable to confirm full compliance with the same-sex accommodation requirements. This relates to the Medical Assessment Unit. It is expected that full compliance with the requirements will be achieved by 31 May 2010 through the delivery of a robust action plan.

4.4 Information Governance

Information Governance within the RUH is managed and controlled through the implementation of the Trust Information Governance strategy which is owned by the Trust Board. The strategy is delivered through an Action Plan which looks to improve the way that information is handled and managed within the Trust. The Action Plan is firmly based on the requirements given in the NHS IG Toolkit and national legislation, polices and directives.

In 2008/09 the Trust had an overall compliance score of 68% (Amber). In April 2009 the IG Group set a minimum compliance target of 75% (Green) which has now been reached. The overall compliance score for 2009/10 has improved to 80% (Green), however, the target of all individual initiatives being Green has not been achieved. The two initiatives which remain as Amber are Secondary Use Assurance and Corporate Information Assurance and these will form the focus for next years Action Plan.
25 of the 62 requirements are designated as being "key requirements" by Connecting for Health and have to be a minimum of Level 2. These requirements are also subject to particular monitoring and reporting by the SHA. The RUH has achieved Level 2 or greater in all 25 and is thus compliant.

Areas where key improvements have taken place has been the establishment of Information Asset Owners (IAOs) in 35 key departments and specialties across

the Trust. These IAOs are senior managers in the organisation who play a key role in understanding the Information risks within their areas of responsibility. Emphasis has also been placed on the controls on key Trust IT systems and these have been subject to a programme of audits with measures being put in place to reduce any identified vulnerabilities.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. These include ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that members' Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. During 2009/10 there have been no serious untoward incidents relating to information.

4.5 Continuous improvement

Where possible improvements have been identified through either self-assessments; external assessments; or incidents, detailed action plans are developed to address these and responsibility assigned to a lead Executive Director. Plans are taken through the annual Board cycle (both the Trust's Management Board and Trust Board) to ensure continuous improvement. The monthly reporting of progress against the Trust's objectives and the Care Quality Commission's Essential Standards of Quality and Safety, in conjunction with the Assurance Framework, help the Trust Board identify and mitigate any risks in meeting the Trust's objectives. The Assurance Committees ensure that action plans to eliminate gaps identified in previous years are being monitored.

5. Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the Internal Audit work. Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- Care Quality Commission registration;
- Internal Audit reports;
- External Audit reports;
- Auditors' Local Evaluation (ALE);
- CQC inspections in respect of compliance with the Hygiene code;
- NHSLA assessments;
- Self Assessments on:
- the Core Standards for Better Health;
- CQC's Essential Standards of Quality and Safety;
- safeguarding children and young people;
- delivering same-sex accommodation;
- Clinical audits;
- Patient and staff surveys;
- Improving Working Lives practice assessment; and
- Benchmarking information.

I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee, Clinical Governance Committee, Non-Clinical Governance Committee, Charities Committee and the Management Board. When issues are identified, plans are put in place to ensure that any learning is embedded in the organisation. This ensures that the system is subject to continuous improvement.

The Trust declared full compliance with the core Standards for Better Health and the Essential Standards of Quality and Safety. Any improvements which have been identified as part of this assessment have been reviewed and an action plan is in place to address these, which will be monitored during 2010/11.

The Trust's major risks this year are the achievement of the 4 hour emergency target on a consistent basis throughout the year, and the achievement of the 18 week wait from referral to treatment. These remain risks which will be monitored throughout 2010/11.

During the year, the Trust overspent compared to its planned budget. A financial recovery plan was implemented and the Trust achieved its planned surplus for the year. Maintaining expenditure controls and delivering savings plans are key requirements for the coming year.

The Trust Board has a vital role in ensuring that the Trust has an effective system of internal control. 2009/10 has seen further improvements in the system on internal control, building on the work of previous years. The Trust Board and its sub-committees have functioned effectively throughout the year.

My review confirms that the Royal United Hospital Bath NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

7th June 2010
James Scott, Chief Executive

Statement of the Chief Executive's responsibility 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 are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities who govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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.

7th June 2010
James Scott, Chief Executive

Statement of Directors' responsibility 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 HM 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, recognised gains and losses and cash flows for the year. 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 HM Treasury;
- make judgements and estimates which are reasonable and prudent; and
- 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

7th June 2010
James Scott, Chief Executive

7th June 2010
Catherine Phillips, Director of Finance

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

We have examined the summary financial statement for the year ended 31 March 2010 the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity and the Statement of Cash Flows.

This report is made solely to the Board of Directors 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 49 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors' as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditor
The directors are responsible for preparing the Annual Report.

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 my report if we become aware of any misstatements or material inconsistencies with the summary financial statement. The other information comprises only the Chief Executive's Statement, the Directors Report, the unaudited part of the Remuneration Report, and the remaining elements of the Financial Review.

We conducted our work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of my opinion on those financial statements.

Opinion
In our opinion the summary financial statement is consistent with the statutory financial statements of the Royal United Hospital Bath NHS Trust for the year ended 31 March 2010.

Grant Thornton UK LLP

7th June 2010

Grant Thornton UK LLP
Hartwell House
55-61 Victoria Street
Bristol
BS1 6FT

Glossary

Term	Definition
Agenda for Change	Current NHS pay system (excluding doctors, dentists and some senior managers) implemented to standardise pay across various staff groups and across NHS organisations.
Amortisation	An amount which is charged to expenditure on a periodic basis to reflect the use of an intangible asset over more than one reporting period.
Asset	A balance which represents the value of finance benefit the Trust will gain in future periods as a result of a past transaction or event.
Borrowings	Amounts which the Trust has borrowed, either as a loan or as a finance lease.
Breakeven Duty	A statutory requirement for the Trust to ensure that it balances income and expenditure over a period of three years (or in certain exceptions, five years).
Cash Equivalents	Assets that can be easily and quickly converted into cash.
Current Asset	An asset used or sold in the Trust's normal activities, such as stocks.
Depreciation	An amount which is charged to expenditure and which recognises the reduction in value of a non-current asset over its life due to wear and tear, technological changes or the general passing of time.
Donated Asset Reserve	An account which is credited with a balance to reflect assets donated to the Trust.
Finance Costs	A balance which represents interest costs, arising from borrowings and unwinding the discounts applied to future liabilities reflecting the time-value of money.
Finance Lease	A contractual agreement arising where an underlying asset is transferred to the lessee, but where legal ownership remains with the lessor.
IFRS	International Financial Reporting Standards, a set of rules that were set up to standardise accounting procedures and reporting processes across international boundaries. These have been applied for the first time in 2009/10.
Impairment	The reduction in value of an asset due to damage or obsolescence.
Independent Sector Treatment Centres	Privately owned treatment centres which perform procedures on behalf of the NHS.
Intangible Asset	An asset which cannot be seen or touched but which value, such as software licences.
Inventories	Stock.
Liabilities	A balance which represents an expected future financial outflow to the Trust arising as a result of a past transaction or event.

Term	Definition
Non-Current Asset	An asset which is held for more than one year and not sold during the normal course of Trust activities, such as medical equipment.
Operating Expenses	Costs incurred through carrying out the day to day activities of the Trust i.e. patient care activities.
Operating Revenue	Income received from the day to day activities of the Trust i.e. patient care activities.
Payables	Balances owed to others.
PDC Dividend	An amount which represents a return on the net assets of the Trust which is paid annually to HM Treasury. The net assets used for this calculation excludes the value of donated assets and cash held in Government Banking Services bank accounts.
Provision	A liability arising as a result of a past event which will be payable in future periods.
Public Dividend Capital (PDC)	Represents Central Government's investment in the Trust. This is similar to the 'Share Capital' in a company.
Receivables	Balances owed by others.
Revaluation Reserve	A reserve which is credited with historic increases in the value of assets as a result of changes in prices. Any reductions in values are also When assets are assessed and found to have increased in value the additional amount is recorded here
Taxpayers' Equity	A balance representing the net assets of the Trust.
UK GAAP	UK Generally Accepted Accounting Practice represents the collective term for the standards, rules and practices which developed in the UK. From 2009/10 onward, these have been replaced by International Financial Reporting Standards in the NHS.

If you would like to know more, or to comment on our plans, please write to the Chairman Brian Stables or Chief Executive James Scott at:

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