RUH

Royal United Hospital Bath NHS
NHS Trust

Royal United Hospital Bath NHS Trust

Annual Report 2010/11

Healthcare you can Trust

Contents

FINANCIAL REVIEW 2010/11

The Royal United Hospital Bath NHS Trust (RUH) met its objective of working within available financial resources for 2010/11. The year was the fifth consecutive one in which we have generated surpluses of income over expenditure. The surpluses have been used to repay the Trust's long term loan from the Department of Health.

A summary of our financial performance over the past four years is set out below. Historic information for 2007/08 is based on UK Generally Accepted Accounting Principles (UK GAAP). Information since 2008/09 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.

	UK GAAP basis	IFRS basis		
Historical financial information	**2007/08 £m**	**2008/09 £m**	**2009/10 £m**	**2010/11 £m**
Revenue[1]	193.4	209.2	222.3	215.6
Pay expenditure	(119.4)	(127.4)	(137.6)	(136.3)
Non pay expenditure	(56.1)	(59.4)	(64.4)	(61.8)
Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA)	**17.9**	**22.4**	**20.3**	**17.5**
Depreciation, amortisation and impairments	(11.5)	(11.7)	(12.7)	(8.0)
Net finance costs and dividends	(4.5)	(4.9)	(6.2)	(5.4)
Net surplus	**1.9**	**5.8**	**1.4**	**4.1**
Adjustments to arrive at the Trust's Statutory Breakeven Duty				
Impact of transfer to IFRS	0	(0.2)	0	0
Reversal of impairments	0	1.8	4.4	0.1
Position against Breakeven duty	**1.9**	**7.4**	**5.8**	**4.2**

[1] Revenue excludes transfers from the Donated Asset reserve relating to depreciation charged on donated assets. This has been offset directly against depreciation.

Figure 1: The Trust's financial performance 2007-2011

Our financial performance is a huge achievement for us and credit must be paid to all our staff for the part they have played in this. The change in the RUH surplus from 2009/10 to 2010/11 is explained by Figure 2 below. The surplus of £4.2m is in line with the position agreed with NHS South West for the financial year.

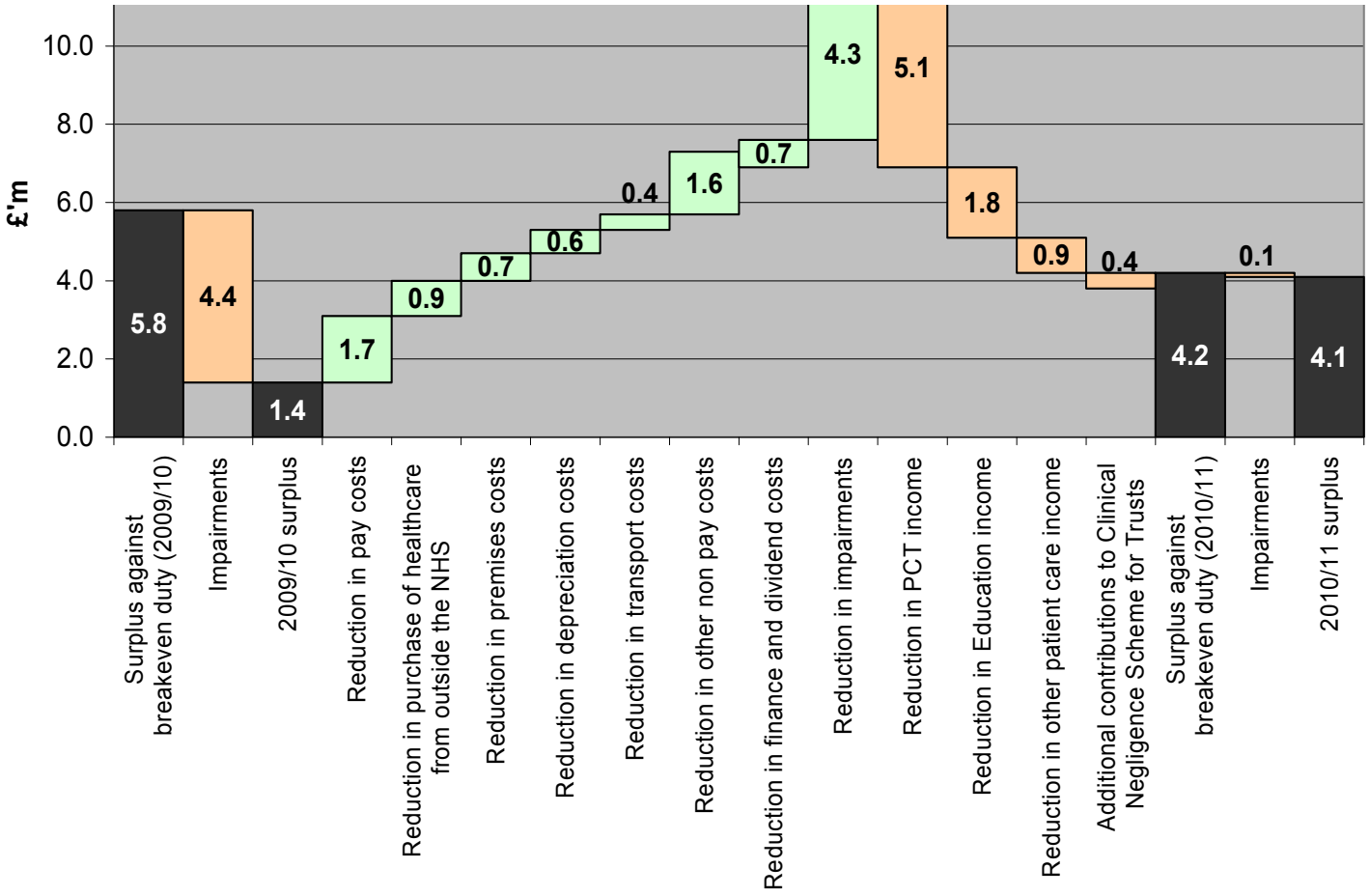

Figure 2: Changes contributing to the Trust's surplus in 2010/11

For 2011/12, we are aiming to make a surplus of £6.2m in order to make our planned loan repayment to the Department of Health. We must implement and deliver our planned savings in 2011/12 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 website and members of the public and our staff are welcome to attend the public section of our monthly Trust Board meetings. Details are on our website and advertised on posters within the hospital a few days before each meeting.

Financial duties and measures in 2010/11

We met our statutory financial duties in 2010/11 as follows:

Meeting the planned surplus

We achieved our target of a planned revenue surplus of £4.2m (in 2009/10 we achieved our planned surplus of £5.8m).

Our final reported surplus is adjusted to remove the effect of impairments before calculating our planned surplus or break-even duty.

By achieving this target, we accomplished 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 we, the RUH, must manage cash flow and borrowing requirements. During 2010/11 we were able to manage within our cash requirements, and met this target (2009/10: target met).

Capital resource limit (CRL)

The CRL is the maximum amount that the RUH can invest in fixed assets during the year. In 2010/11 we did not exceed our CRL (2009/10: CRL not exceeded).

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

Capital cost absorption rate

We are required to make a return on the assets we employ of 3.5% based on actual assets held through the year; we then pay 3.5% of this value as our dividend payment. We achieved this requirement (2009/10: achieved).

Management costs

We are required to record our management costs according to parameters set by the Department of Health and to state these in relation to relevant income.

	2010/11 £000	2009/10 £000
Management Costs	8,876	8,738
Income	215,806	223,170
Cost as a percentage of income	4.1%	3.9%

Management costs and related income figures are as defined by the Department for Health. We are reviewing its management costs to ensure that they remain low. The primary reason for the increase in management costs as a percentage of income is a reduction in NHS Primary Care Trust income of £5,124,000.
Management costs as a percentage of income remain lower than in 2008/09 (4.2%).

Better payment practice code - Measure of compliance

	2010/11 Number	2009/10 Number
Total Non-NHS trade invoices paid in the year	60,926	65,513
Total Non NHS trade invoices paid within target	57,902	62,257
Percentage of Non-NHS trade invoices paid within target	95%	95%
Total NHS trade invoices paid in the year	2,418	2,452
Total NHS trade invoices paid within target	2,189	2,250
Percentage of NHS trade invoices paid within target	91%	92%

The Better Payment Practice Code requires us 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. We place 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 2010/11 has been as follows:

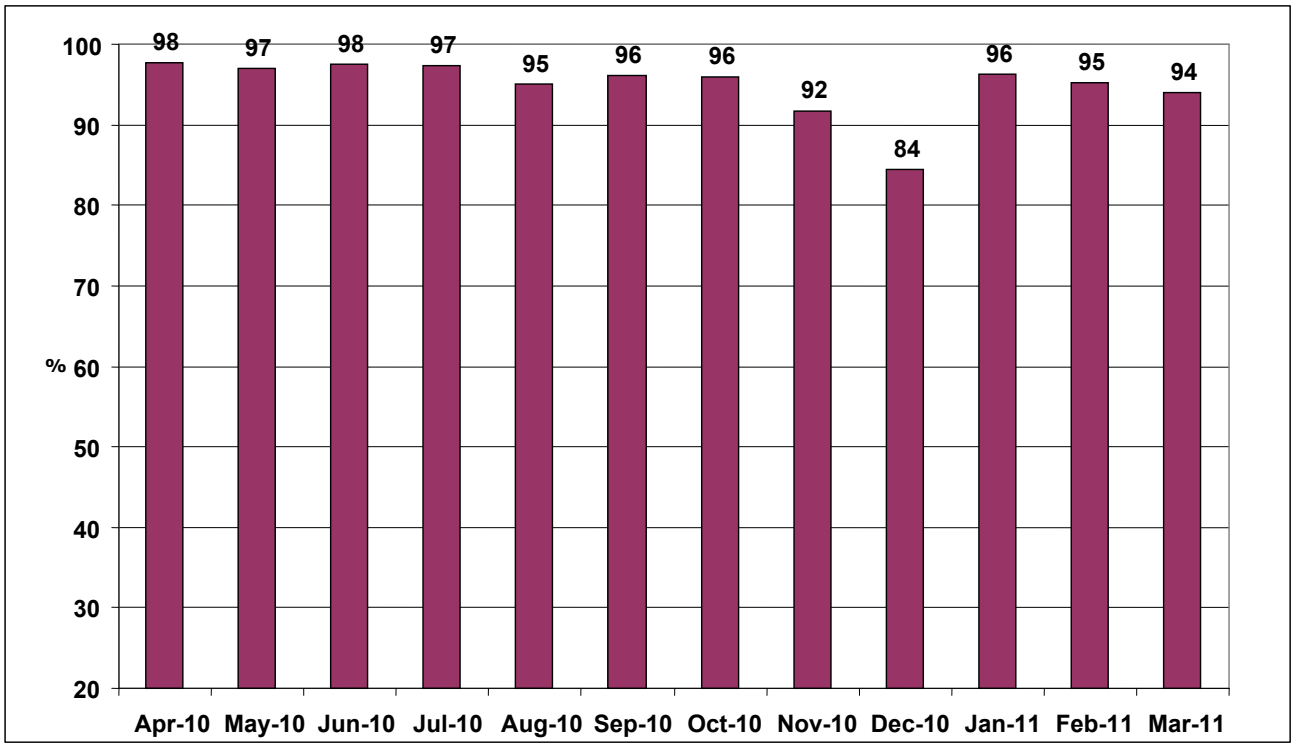

Figure 3: 2010/11 performance under the Better Payment Practice Code

Historic Deficit, Breakeven Duty and Legacy Debt

We have demonstrated financial stability since 2006/07, but we have a substantial historic accumulated deficit within Retained Earnings (formerly, the Income and Expenditure Reserve), standing at £40.3m at 31 March 2011.

Legislation requires the RUH 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 our breakeven duty.

Consequently, there are differences between the historic accumulated deficit and the breakeven duty deficit. The position stated for years up to 2008/09 are on a UK GAAP basis, and since then are 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
Impact of transition to IFRS	(10,285)	-
2008/09	5,600	7,405
2009/10	1,398	5,800
2010/11	4,143	4,195
Accumulated Deficit	**(40,282)**	**-**
Breakeven duty	**-**	**(12,679)**

Figure 4: The Trust's cumulative breakeven duty as at 31 March 2011

At the end of 2006/07, we 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%.

We will repay our legacy debt and recover our remaining deficit over the next two years, ending in 2013. We will make surpluses in each of these years to achieve this.

Future financial plans

Our financial forecasts are shown below. These are based on the terms of the loan agreement, along with income, expenditure and capital projections.

The forecast for the next two years is part of our medium term financial plan, and is shown below:

	UK GAAP basis	IFRS basis		
Historical financial information	**2007/08 £m**	**2008/09 £m**	**2009/10 £m**	**2010/11 £m**
Revenue[1]	193.4	209.2	222.3	215.6
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Net surplus	**1.9**	**5.8**	**1.4**	**4.1**
Adjustments to arrive at the Trust's Statutory Breakeven Duty				
Impact of transfer to IFRS	0	(0.2)	0	0
Reversal of impairments	0	1.8	4.4	0.1
Position against Breakeven duty	**1.9**	**7.4**	**5.8**	**4.2**

Figure 5: Rescheduled loan repayments and recovery of breakeven duty

Our future financial plans require the RUH to ensure that key financial risks are addressed. The main financial risks which are anticipated to affect the RUH in 2011/12 and beyond are:

• the delivery of the required surpluses in 2011/12 and 2012/13 to meet the terms of the loan and recovery of the historic deficit

• the delivery of efficiency savings to meet the financial targets

• the level of income we 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 and that the revenue implications can be offset by additional savings.

We have identified a number of factors which will strengthen our ability to manage our financial risks:

• we are working in partnership with our commissioning primary care trusts to agree a satisfactory contract and to minimise uncertainties around our income position

• we will spend less if we deliver less activity; savings in variable costs will help offset changes in income;

• we have plans in place for the delivery of efficiency savings, and the requirements of the Department of Health's work programme: Quality, Innovation, Productivity and Prevention (QIPP). The plans are monitored through our performance framework and by our Efficiency Board

• business plans for the 2011/12 financial year were reviewed by our Trust Board.

Capital investment

Our Trust Board has approved a long term Capital Investment Strategy which will resolve the longstanding backlog maintenance issues affecting the Trust over the coming five years. The strategy has been developed by our Capital Prioritisation Group, which is chaired by our Director of Planning and Strategic Development. The Group has representation from across the Trust and its recommendations are presented to Management Board for approval and ratified by the Trust Board.

Trust Board Membership

	Name	Position	Tenure	Voting	Board sub-committees	Attendance at Board
	Brian Stables	Chairman	4 years	Yes	Ex-officio member of all Trust Board committees	11/11
	James Scott	Chief Executive	Substantive	Yes	Management Board Ex-officio member of all other Trust Board committees	9/11
	Michael Earp	Non-Executive Director and Vice Chairman	4 years	Yes	Audit Committee Remuneration Committee Clinical Governance Committee Charities Committee	11/11
	Moira Brennan	Non-Executive Director	4 years	Yes	Audit Committee Charities Committee Remuneration Committee Whistle blowing contact	9/11
	Stephen Wheeler	Non-Executive Director	2 years	Yes	Charities Committee Audit Committee Remuneration Committee Non-Clinical Governance Committee Whistle blowing contact	11/11
No photo available	Peter Stoate	Non-Executive Director (22/7/10 to 3/1/11)	4 years	Yes	None	0/4
	John Waldron	Medical Director (to 31/10/10)	Substantive	Yes	Management Board Clinical Governance Committee	4/4

	Name	Position	Tenure	Voting	Board sub-committees	Attendance at Board
	Tim Craft	Medical Director (from 01/08/2010)	Substantive	Yes	Management Board Clinical Governance Committee	7/11
	James Rimmer	Director of Operations	Substantive	Yes	Management Board Non-Clinical Governance Committee	10/11
	Francesca Thompson	Director of Nursing	Substantive	Yes	Management Board Charities Committee Clinical Governance Committee	11/11
	Catherine Phillips	Director of Finance	Substantive	Yes	Charities Committee Management Board Audit Committee	11/11
	Brigid Musselwhite	Deputy Chief Executive & Director of Planning and Strategic Development	Substantive	No	Management Board Non-Clinical Governance Committee	11/11
	Lynn Vaughan	Director of Human Resources	Substantive	No	Management Board Non-Clinical Governance Committee	11/11
	Howard Jones	Director of Facilities	Substantive	No	Management Board Non-Clinical Governance Committee	10/11

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 2010/11 the following individuals were Non Executive Directors:

Brian Stables
Stephen Wheeler
Michael Earp
Moira Brennan
Peter Stoate (from 22 July 2010 to 3 January 2011)

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), Department of Health 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 arrangement provides for directors to receive annual inflation uplift provided that 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.

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 on the opposite page.

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
Tim Craft	Medical Director [1]	01/08/2010	Substantive	6 months	None	As above with respect to Medical Director responsibilities
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

[1] Tim Craft's substantive appointment is as a Medical Consultant, to which Consultant Contract termination liabilities apply.

Emoluments Disclosure

		2010-11				2009-10		
Name	Title	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Benefits in Kind (rounded to the nearest £000) £000	Date of Starting (S) or Leaving (L)	Salary (bands of £5,000) £000	Other Remuneration* (bands of £5,000) £000	Benefits in Kind (rounded to the nearest £000) £000
James Scott	Chief Executive	155-160				155-160	10-15	
Tim Craft[1]	Medical Director	20-25	85-90		01/08/10 (S)			
Howard Jones	Director of Estates and Facilities	95-100				95-100	0-5	
Brigid Musselwhite	Deputy Chief Executive and Director of Planning and Strategic Development	95-100				95-100	5-10	
Catherine Phillips	Director of Finance	110-115				110-115	0-5	
James Rimmer[2]	Director of Operations	95-100				75-80		
Francesca Thompson	Director of Nursing	90-95				90-95	5-10	
Lynn Vaughan	Director of Human Resources	85-90				85-90	5-10	
John Waldron[1]	Medical Director	25-30	80-85		31/10/10 (L)	35-40	130-135	
Brian Stables	Chairman	20-25			01/04/10 (S)			
Moira Brennan	Non-Executive Director	5-10				5-10		
Michael Earp	Non-Executive Director	5-10				5-10		
Peter Stoate	Non-Executive Director	0-5			22/07/10 (S), 03/01/11 (L)			
Stephen Wheeler	Non-Executive Director	5-10				5-10		

* A performance related payment was paid in 2009/10 which related to performance in 2008/09.

No Directors received any benefits in kind (2009/10: none).

[1] John Waldron's and Tim Craft's substantive appointments are as Medical Consultants. Their remuneration is therefore split between their responsibilities as Medical Director (Salary) and that earned in their substantive appointments (Other remuneration)

[2] James Rimmer's employment at the Trust commenced during the 2009/10 financial year and consequently his salary for 2009/10 was for part of the year.

Pensions Disclosure

Name	Title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31st March 2011 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31st March 2011 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31st March 2011 £000	Cash Equivalent Transfer Value at 31st March 2010 £000	Real increase in Cash Equivalent transfer Value £000	Employer's contribution to stakeholder pension £000
James Scott	Chief Executive	0 - 2.5	5 - 7.5	50 - 55	155 - 160	888	961	(73)	0
Tim Craft	Medical Director	2.5 - 5	12.5 - 15	55 - 60	165 - 170	991	1,001	(10)	0
Howard Jones	Director of Estates and Facilities	0 - 2.5	2.5 - 5	40 - 45	130 - 135	1,019	1,049	(30)	0
Brigid Musselwhite	Deputy Chief Executive and Director of Planning and Strategic Development	0 - 2.5	2.5 - 5	25 - 30	85 - 90	433	471	(38)	0
Catherine Phillips	Director of Finance	0 - 2.5	5 - 7.5	25 - 30	80 - 85	328	367	(39)	0
James Rimmer	Director of Operations	0 - 2.5	5 - 7.5	25 - 30	75 - 80	342	371	(29)	0
Francesca Thompson	Director of Nursing	0 - 2.5	2.5 - 5	20 - 25	65 - 70	419	437	(18)	0
Lynn Vaughan	Director of Human Resources	0 - 2.5	2.5 - 5	20 - 25	60 - 65	423	433	(10)	0
John Waldron	Medical Director	(5) - (7.5)	(15) - (17.5)	55 - 60	175 - 180	1,235	1,445	(210)	0

Non-Executive directors do not receive pensionable remuneration (2008/09: nil). The Trust did not contribute to any Director's stakeholder pension scheme (2008/09: nil).

Pension details have only been disclosed for those Directors in post during 2009/10. Balances for those in post during 2008/09 can be obtained from the 2008/09 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 or decrease in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the change 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. In his budget of 22 June 2010, the Chancellor announced that the annual increase of public sector pensions would change from the Retail Prices Index to the Consumer Prices Index from 1 April 2011. The new CETV factors provided by the Government Actuaries Department are therefore lower than the previous factors used and as a consequence there has been a reduction in CETVs disclosed.

James Scott, Chief Executive, 8th June 2011

Reporting of staff exit packages

The Trust is required, in line with Department of Health guidelines, to report exit packages which have been agreed with former staff as part of this report.

	2010/11				2009/10			
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band (total cost)	Of which, number where special payments have been made (totalled)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band (total cost)	Number of departures where special payments have been made (totalled)
<£20,001	0	11	11 (£49,000)	0	2	10	12 (£39,000)	0
£20,001-£40,000	0	0	0	0	0	0	0	0
£40,001-£100,000	0	0	0	0	0	0	0	0
£100,001-£150,000	0	0	0	0	1	0	1 (£146,000)	0
£150,001-£200,000	0	0	0	0	0	0	0	0
Total number of exit packages by type (total cost)	0	11 (£49,000)	11 (£49,000)	0	3 (£164,000)	10 (£21,000)	13 (£185,000)	0

ANNUAL ACCOUNTS 2010/11

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 RUH and our 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. (Contact details below)

The following statements are attached at Appendix 1:

- Summary Financial Statements
- Statement of Internal Control
- Directors Statements
- Independent Auditor's 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
Malvern House
Combe Park
Bath
BA1 3NG
01225 428331
E-mail: ruh-tr.FOIRequests@nhs.net

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

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

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 RUH, and our 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 our other Non-Executive Members. The Audit Committee seeks confirmation on an annual basis that the audit function is independent from management. During the year, the external auditor was paid £182,000 for their work (2009/10: £179,000). 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 2010/11, as far as the Directors are aware there is no relevant audit information of which our auditors are not aware of. Our 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 we have 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

We have taken all reasonable steps to comply with the requirements set out in the Code of Conduct for NHS managers, and have 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 RUH or any other NHS organisation, please contact the counter fraud helpline on 0800 028 4060.

Openness and accountability

We are committed to ensuring that we operate within an open and transparent environment, where this does not conflict with our legal responsibilities. We are compliant with the requirements of the Freedom of Information Act. The Annual Report and Accounts provides the public with a comprehensive review of our 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 we disclose details of staff sickness absences. This disclosure is included below:

	2010/11 Number	2009/10 Number
Total days lost	26,945	41,303
Total staff years[1]	3,327	3,406
Average working days lost[2]	8.10	2.13

[1] The number of equivalent years of staff service worked during the current year based on the number of working days in a year.
[2] The number of working days lost on average for each employee. This is calculated by dividing the total number of days lost by the total of staff years. Data used in this calculation is on a calendar year basis, for the years ended 31 December 2009 and 31 December 2010 and are used as approximations of the information related to the financial years.

NHS Trust Manual for Accounts

The operating and financial review has been prepared in accordance with the NHS Trust Manual for Accounts for 2010/11, as directed by the Secretary of State.

DIRECTORS' INTERESTS

Executive Directors

Medical Director: Tim Craft
Director and share holder of Anaesthetic Medical Systems (AMS) Ltd
Member of Bath Anaesthetic Group LLP

Director of Planning and Stategic Development: Brigid Musselwhite
President of Bath Chamber of Commerce

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

Non Executive Directors

Moira Brennan
Trustee of the Royal Mail Senior Executive Pension Scheme

Michael Earp
Board Consultant to "Coalescence Consulting" (a health and social care services consultancy)

Brian Stables
Director of Profex Associates Ltd - Management Consultancy

Stephen Wheeler
Chair of Trustees of the Evaluation Trust

APPENDIX 1: SUMMARY FINANCIAL STATEMENTS (AUDITED)

STATEMENT OF COMPREHENSIVE INCOME

	2010/11	2009/10
	£000	£000
		(Restated)
Revenue		
Revenue from patient care activities	**196,021**	202,129
Other operating revenue	**20,340**	22,019
Operating expenses	**(206,836)**	(216,577)
Operating surplus	**9,525**	7,571
Finance costs:		
Investment revenue	**29**	48
Other gains and (losses)	**83**	(22)
Finance costs	**(1,014)**	(1,433)
Surplus for the financial year	**8,623**	6,164
Public dividend capital dividends payable	**(4,480)**	(4,766)
Retained surplus for the year	**4,143**	1,398
Other comprehensive income		
Impairments charged to the Revaluation and Donated asset reserves	(786)	(32,394)
Gains on revaluation	3,532	0
Receipt of donated and government granted assets	1,913	475
Reclassification adjustments:		
Transfers from donated and government grant reserves	(775)	(1,144)
Total comprehensive income for the year	**8,027**	(31,665)

Reported NHS financial performance position		
Retained surplus for the year	**4,143**	1,398
Impairment charges made to the Statement of Comprehensive Income not considered part of the organisation's operating position	**52**	4,402
Reported NHS financial performance position	**4,195**	5,800

STATEMENT OF FINANCIAL POSITION

	31 March 2011 £000	31 March 2010 £000 (Restated)	31 March 2009 £000 (Restated)
Non-current assets			
Property, plant and equipment	**154,328**	145,836	180,519
Intangible assets	**706**	760	255
Other financial assets	**82**	121	165
Trade and other receivables	**1,626**	1,762	1,476
Total non-current assets	**156,742**	148,479	182,415
Current assets			
Inventories	**3,182**	3,139	3,309
Trade and other receivables	**9,570**	11,026	13,926
Other financial assets	**82**	61	55
Cash and cash equivalents	**2,000**	690	1,470
Total current assets	**14,834**	14,916	18,760
Total assets	**171,576**	163,395	201,175
Current liabilities			
Trade and other payables	**(12,038)**	(9,973)	(13,813)
Other liabilities	**0**	(24)	(24)
Department of Health Working capital loan	**(7,200)**	(7,000)	(6,800)
Borrowings	**(231)**	(233)	(246)
Provisions	**(1,733)**	(1,844)	(1,175)
Net current liabilities	**(6,368)**	(4,158)	(3,298)
Total assets less current liabilities	**150,374**	144,321	179,117
Non-current liabilities			
Borrowings	**(345)**	(497)	(649)
Department of Health Working capital loan	**(6,500)**	(13,700)	(20,700)
Provisions	**(2,066)**	(1,688)	(743)
Other liabilities	**0**	0	(24)
Total assets employed	**141,463**	128,336	157,001
Financed by taxpayers' equity:			
Public dividend capital	**135,545**	130,445	127,445
Retained earnings	**(39,237)**	(44,425)	(45,860)
Revaluation reserve	**38,957**	37,256	69,302
Donated asset reserve	**6,198**	5,060	6,114
Government grant reserve	**0**	0	0
Total Taxpayers' Equity	**141,463**	128,336	157,001

8th June 2011
James Scott, Chief Executive

STATEMENT OF CASH FLOWS

	2010/11 £000	2009/10 £000 (Restated)
Cash flows from operating activities		
Operating surplus	**9,525**	7,571
Depreciation and amortisation	**8,748**	9,299
Impairments and reversals	**52**	4,402
Transfer from donated asset reserve	**(754)**	(1,127)
Transfer from government grant reserve	**(21)**	(17)
Interest paid	**(990)**	(1,419)
Dividends paid	**(4,435)**	(4,723)
Decrease/(increase) in inventories	**(43)**	170
Decrease/(increase) in trade and other receivables	**2,268**	2,614
(Decrease)/increase in trade and other payables	**2,365**	(4,372)
(Decrease)/increase in other current liabilities	**(24)**	(24)
Increase/(decrease) in provisions	**205**	1,703
Net cash inflow from operating activities	**16,896**	14,077
Cash flows from investing activities		
Interest received	**29**	48
Payments for property, plant and equipment	**(14,654)**	(10,831)
Proceeds from disposal of plant, property and equipment	**106**	28
Payments for intangible assets	**(131)**	(595)
Net cash outflow from investing activities	**(14,650)**	(11,350)
Net cash inflow before financing	**2,246**	2,727
Cash flows from financing activities		
Public dividend capital received	**5,100**	3,000
Loans repaid to the Department of Health	**(7,000)**	(6,800)
Other capital receipts	**1,216**	458
Capital element of finance leases	**(252)**	(165)
Net cash outflow from financing	**(936)**	(3,507)
Net decrease in cash and cash equivalents	**1,310**	(780)
Cash and cash equivalents at the beginning of the financial year	**690**	1,470
Cash and cash equivalents at the end of the financial year	**2,000**	690

Comparative balances for 2009/10 have been restated to reflect donated assets as 'Other capital receipts'. This has increased the payments recognised for Property, Plant and Equipment by £458,000 with a corresponding increase in 'Other capital receipts'. Additionally, changes in trade and other payables, and in provisions have been restated to reflect the reassessment of certain accruals as provisions.

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 2010/11 and our performance is reviewed by the SHA and PCTs on a regular basis.

The Bath & Wiltshire Health Community, which consists of the RUH, the primary care trusts, NHS Bath and North East Somerset (BaNES) and NHS Wiltshire, has continued to worked hard in 2010/11 to improve relationships across the organisations and the Chief Executives meet regularly. The PCTs, Overview and Scrutiny Panel, Public and Local Involvement Networks (LINk) and other partner organisations have worked closely with the RUH and have agreed the areas of work where focus is required. They have been involved in several aspects of our activities particularly related to patient experiences. Some examples of this are:

- staff from the RUH regularly attend the BaNES LINk, to present on relevant topics;
- a Patient Experience Quarterly Report is regularly reported to the Patient Experience Group (PEG), which includes patients, the public and local commissioners;
- there are close links with 'Bath People First' and ethnic minority groups in the local community, which has led to involvement from these groups in core RUH business;
- there is extensive community engagement involved with the process of compiling and reporting the Trust's Quality Accounts; and
- a representative, nominated by the LINk, 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 RUH for the year ended 31 March 2011 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 Governance Committee; and the Audit Committee.

The Trust Board has approved the risk management

processes and defined the objectives for managing risk. We have a Trust-wide Risk Register. All new significant risks are reviewed by the Management Board at each meeting and quarterly by the Trust Board. All risks are reviewed by the Trust Board on an annual 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 to the Trust Board.

Each clinical specialty has a forum for discussing risk management and clinical governance issues. Each clinical specialty has a nominated lead for risk management, clinical effectiveness, research & development, education and training, and patient and public Involvement.

Guidance on risk management 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 our 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 Care Quality Commission's Essential Standards of Quality and Safety.

Lessons learned from incident investigations are communicated to the relevant Assurance Committee through the Risk Management and the Health and Safety quarterly reports and result in the development of hospital-wide practice change where appropriate.

Incidents are dealt with as per the process identified in the Incident Reporting and Management Policy and Procedure; including the Management of Serious Untoward Incidents.

Lessons learned from complaint investigations are communicated throughout the RUH.

4. 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 Strategic Framework for Risk Management includes a clear risk management process. If a risk cannot be resolved at a local level the risk can be referred through the operational management structure to the Management Board or ultimately to the Trust Board. 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'. Risks are reviewed to ensure that any inter-dependencies are understood along with the cumulative effect of risks. The level of exposure to risks is also assessed, and an acceptable level of exposure is assigned to each risk. In assessing our response, due regard is paid to the financial, service delivery and reputational consequences of risks. The Head of Risk and Assurance and the Trust Board Secretary act as gate keepers to the Risk Register to ensure consistency of scoring, as well as the accuracy and currency of the register.

Strategic risks outside the remit of our local governance groups are entered onto the Risk Register and are reviewed by the operational management groups which includes the Trust Board and the

Management Board. The Trust Board reviews each new significant risk and either explores the solutions or accepts the risk. Existing significant risks are reviewed quarterly 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 LINk and the local council-led Overview and Scrutiny Committees. In addition, we hold 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 2010/11 by both the Trust Board and the Patient Experience Group (PEG).

4.2 Assurance Framework

The Assurance Framework is a process by which we gain assurance that we have 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. Risks are managed at the most appropriate level, and are reviewed by the next level of management.

The Assurance Framework was developed using our corporate objectives for 2010/11. The framework focused on patient and public safety, effectiveness, efficiency, workforce 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 and our Assurance Committees regularly throughout the year. Internal Audit reviewed the Assurance Framework in March 2011 and an assessment of significant assurance was provided.

Control measures are in place to ensure that all our 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.

We have undertaken a climate change risk assessment and developed an Adaptation Plan, to support our emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009, to ensure that our obligations under the Climate Change Act are met.

The Assurance Framework has highlighted a number of gaps in control and assurance as at 31 March 2011. These and the related actions are below:

	Gap in control/ assurance	Actions to address
1	Implementation of Millennium Patient Administration system	The RUH has a robust plan for the implementation of Millennium which is overseen by the Trust Board. Millennium is due to be implemented during the Summer of 2011.
2	Workforce plans to support financial position	Development of a Workforce Strategy by April 2011 supported by a QIPP workforce model and project management support to operational areas.
3	Meeting the NHS Constitution with regards to 18 week referral to treatment times	Development of a 'referral to treatment' recovery plan to ensure 90% of admitted patients and 95% of non-admitted patients are treated within 18 weeks. Performance notices are available in the contract should commissioning intentions not meet the activity required to deliver these NHS Constitution rights

During the previous financial year (2009/10), we received limited assurance from certain internal audits. These have been reviewed during the current financial year and the issues remain. The main issues highlighted related to Health and Safety concerns surrounding our records management; and the processes in place to manage consultants' contracts. A work plan is in place to address these issues. These are not, however, judged to have resulted in a material gap in assurance and consequently have not been included in the above table. All other reviews commissioned during 2010/11 have resulted in either moderate or significant assurance being provided to us.

In 2011/12, our major risks are the achievement of financial savings and associated workforce changes required to deliver the savings. These risks have also been highlighted by the Trust's External Auditors, who have recommended further work in ensuring that there are robust operational delivery plans in place.

4.3 Quality and Safety

During the year, we implemented a Quality Improvement Strategy. Ultimate responsibility for quality rests with the Trust Board. As part of the Strategy, we formed a Quality Board in 2009/10. The Quality Board leads on the quality agenda across the RUH and is responsible for implementing the strategic direction for quality improvements. It reports directly to the Trust's Management Board. Members of the Quality Board also sit on the Trust's Clinical and Non-Clinical Governance Committees.

From April 2010 health and adult social care providers have to be registered with the Care Quality Commission (CQC) and this requires compliance with the new Essential standards of safety and quality set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009. These standards allow Trusts to measure the quality of services they provide and ensure that Trusts are accountable for meeting the regulations. Areas identified from the CQC Quality and Risk Profile and internal reviews as requiring improvement will inform the Quality Work Plan.

The transition of NHS regulation from the Healthcare Commission to the CQC required us to assess our compliance 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.

During the year, our internal auditors reviewed our arrangements for compliance with the CQC's requirements, and provided assurance that those arrangements are robust.

We recognise 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. We are aware of our responsibilities in assuring that we have suitable systems and arrangements in place to ensure that the Code is being observed.

The CQC undertook a responsive visit to the Trust in February 2011. The focus of the visit was on communication with patients with Learning Difficulties and Dementia. There were no significant concerns arising from the visit.

During 2009/10, we were not able to confirm full compliance with the same-sex accommodation requirements, relating specifically to the Medical Assessment Unit. Full compliance with the requirements was achieved by 31 May 2010 through the delivery of a robust action plan. We are fully compliant with the CQC essential standards of quality and safety.

4.4 Information Governance

Information Governance within the RUH is managed and controlled through the implementation of our Information Governance strategy which is owned by the Trust Board. The strategy is delivered through an action plan which looks to improve the way we handle and manage information within the hospital. The action plan is firmly based on the requirements given in the NHS Information Governance Toolkit and national legislation, policies and directives.

In 2009/10 we had an overall compliance score of 80% (Green). In June 2010 the Information Governance Group set a new target of 88% against a new version of the Information Governance toolkit, Version 8. This new toolkit has a reduced number of requirements, 45 reduced from 62, but many of these are combined and many contain a more stringent set of standards to be achieved. As a result the overall compliance score for 2010/11 has been assessed as 81%. Under the previous scoring system this would have been graded as green, however a change in scoring means that if any one requirement does not reach level 2, then the overall result must be classed as "not satisfactory". There is one initiative which this year has not reached the required level. This requirement relates to 'pseudonymisation' (making patient information anonymous when identification is not critical for patient care). This area is already subject of an action plan which will form a key part of the focus for next year's Information Governance agenda.

Within the Information Governance toolkit, 22 of the 45 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 22 and is thus compliant. This means that whilst being classed as "not satisfactory" our Information Governance systems are nevertheless viewed as "Trusted".

During the year there has been effective reporting of Information Governance incidents and near misses. Details are set out below of one serious untoward incident (SUI) that was graded as significant (level 3). This incident has been fully investigated, and lessons learnt and shared.

Date of Incident (Month)	Nature of Incident	Nature of Data Involved	Number of people potentially affected	Notification Steps
22 June 2010	35 Patient Radiology reports, including 3 Oncology letters sent to the wrong address in error.	32 copy Radiology reports and 3 copy Oncology letters intended for patients' GPs.	35	Caldicott Guardian informed

Further Action on Information Risk	All radiology administration staff were advised, in writing, about the incident and how mail should be processed in order to prevent a recurrence. Steps were taken to ensure that the methodology that led to the error could not be repeated. The learning from this incident has been cascaded via senior secretaries and the Trust Information Asset Owners.

4.5 NHS Pension Scheme

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.

4.6 Continuous Improvement

Our commitment to continuous improvement is enshrined by the Quality Improvement Strategy. 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. These are reviewed by the Clinical Outcomes Group, the Quality Board, our Management Board or the Trust Board as appropriate to ensure continuous improvement.

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:

- CQC registration
- internal audit reports
- external audit reports
- auditors' Value for Money Assessment:
- CQC planned and responsive visits
- National Health Service Litigation Authority assessments;
- self assessments on CQC's Essential Standards of Quality and Safety
- clinical audits;
- patient and staff surveys;
- improving working lives practice assessment
- 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 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.

We have an ongoing process to assess compliance with the CQC's Essential Standards of Quality and Safety. No issues have been identified from this process which would affect our registration. Improvements identified through this process have been incorporated into action plans which are subject to rigorous review. There are no significant control issues to report.

In 2011/12, our major risks are the achievement of financial savings and associated workforce changes required to deliver the savings. These risks will be monitored throughout 2011/12.

The Trust Board has a vital role in ensuring that we have an effective system of internal control. 2010/11

has seen further improvements in the system of 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.

8th June 2011
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 us

• our expenditure and income 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.

8th June 2011
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 RUH 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 Trust Board

8th June 2011
James Scott, Chief Executive

8th June 2011
Catherine Phillips, Director of Finance

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

I have examined the summary financial statement for the year ended 31 March 2011 which comprises 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 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

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 our report if we become aware of any misstatements or material inconsistencies with the summary financial statement.

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 our 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 2011.

8th June 2011 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.
Exit packages	A financial arrangement with an employee which will result in a termination of their contract of employment with the Trust. This can be the result of a MARS scheme, redundancy, severance agreement, or pay in lieu of notice.
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.
MARS	Mutually Agreed Resignation Scheme. The Scheme enables individual employees - in agreement with their employer - to choose to leave their employment voluntarily, in return for a severance payment. It is not a redundancy.
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.
Redundancy	Termination of employment of an employee or a group of employees for business reasons.
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:

Royal United Hospital NHS Trust
Combe Park
BATH
BA1 3NG
Telephone: 01225 824033
E-mail: trustboard@ruh.nhs.uk

Website: www.ruh.nhs.uk

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Jeśli chcesz tę informację w twoim języku, prosimy o kontakt z 01225 825656.

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