Royal United Hospital Bath NHS
NHS Trust

annual report 2005/2006

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Foreword from the Chairman and Chief Executive

The overall purpose of this annual report is to describe the progress the Trust has made over the year and to formally publish the accounts for the year 2005/06. On the whole, the Trust continued the good progress of recent years. However, there were some specific challenges particularly relating to financial pressures.

How we did in 2005/2006
The Trust continued to make progress across the range of key targets agreed at the beginning of the year. The highlights included:

- Reducing maximum waiting times for patients waiting for inpatient treatment to six months and for their first outpatient appointment to thirteen weeks
- 98% of patients attending our emergency department being seen, treated, admitted, transferred or discharged within four hours
- Maintaining excellent waiting times for those patients with cancer or suspected cancer
- Receiving a number of complimentary external expert reviews of services, including those for food and cleanliness, and those referred to below
- Making strides towards providing better working conditions for staff by gaining Improving Working Lives Practice Plus Status and implementing the new pay structure for staff called Agenda for Change
- Improving the cost efficiency of the Trust.

Involving and working with our partners
We need to demonstrate stakeholder involvement in decision making and partnership working if we are to be recognised as a responsive organisation. The Trust worked closely during 2005/06 with patient groups to develop health services for our patients and with staff groups to improve the working lives of staff. The reconfiguration of local health services will bring benefits in that we will be working with just one strategic health authority (SHA) in the future. However, we will continue to be a significant provider for three primary care trusts all with a choice of alternative providers.

Other key achievements
The RUH was rated in the top 18 performing hospitals in the UK and the best in the Avon, Gloucestershire and Wiltshire Strategic Health Authority (AGW SHA) by the Dr Foster Good Hospital Guide 2005. The findings are consistent with other national assessments of the RUH's care, including the CHKS Top 40 Hospitals award received in 2005 and 2006, and the Intensive Care national audit. Our breast unit also performed extremely well in the Dr Foster Breast Cancer Guide 2006. This national recognition is thanks to the hard work of our dedicated staff who are consistently providing high quality care to our patients.

The main pressures on the Trust in the year were financial. Disappointingly, the Trust overspent during the year by £7.3m. Achieving financial balance is the number one target for the RUH in 2006/07.

The main themes of the trust's objectives for 2006/07 are:

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

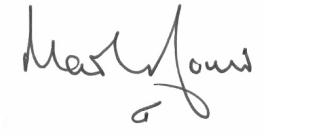
In particular we will be working towards the following:

- Financial balance
- A review of the urgent, non-elective and elective patient routes through the hospital system
- Reducing cancelled operations
- Reducing delayed transfers of care
- Reducing healthcare associated infection rates.

Financial issues will continue to be a challenge in 2006/07 as we will be expected to break even at the end of the year. To do this, we are working alongside staff and local healthcare partners to make substantial savings. We will be as open and transparent as we can through this process. We have already made good progress towards achieving key targets and have been successful in taking the first steps towards becoming a Foundation Trust.

We hope that you find this report informative. We are determined to keep up the excellent progress made over the last three years and to ensure that the Trust continues to offer quality, safe services for the people of Bath and North East Somerset, Gloucestershire, Wiltshire and Somerset.

Mike Roy
Chairman



Mark Davies
Chief Executive

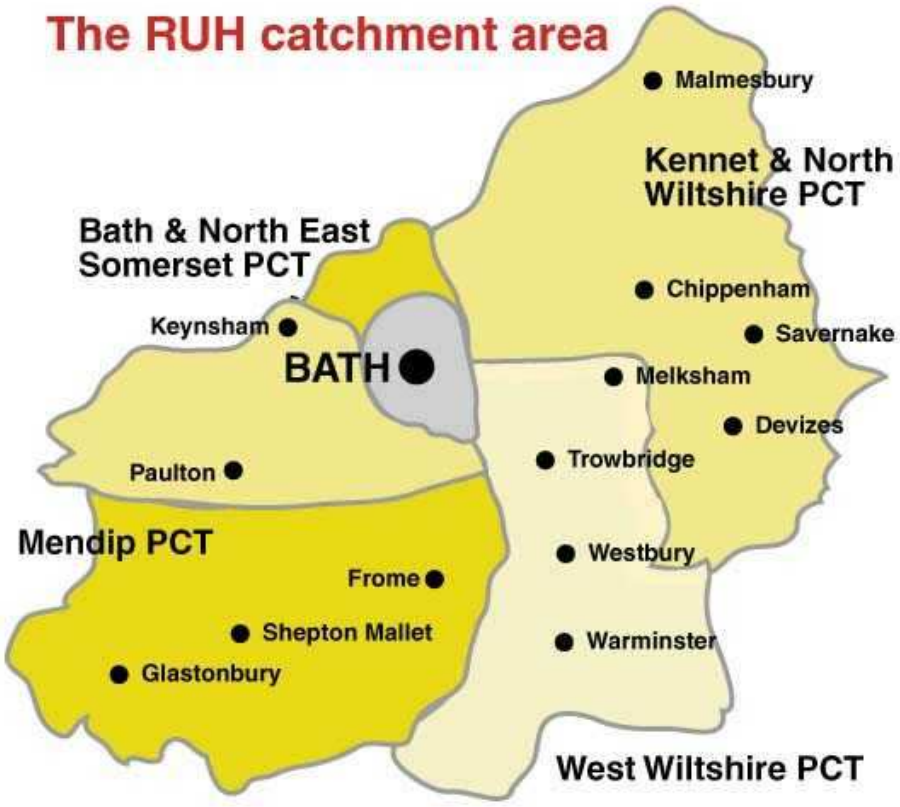
Operating and Financial Review - 2005/06

1. Nature, Objectives and Strategies of the Business

1.1 Introduction

The Royal United Hospital Bath NHS Trust (RUH) is based on one site on the north-western edge of the city of Bath. It serves the population of the city of Bath, the whole of Bath and North East Somerset (BaNES), the majority of the western half of Wiltshire and the Mendip area of Somerset. These populations are served by four PCTs (BaNES, West Wiltshire, Kennet and North Wiltshire and Mendip). The population naturally served by the hospital is approximately 450,000. The first three PCTs listed above have to date been within the AGW SHA, whilst Mendip was in Dorset and Somerset SHA. All PCTs will now be within the new South West Strategic Health Authority.

A map of the area served by the hospital is included below:



The hospital site is large with a large number of different buildings, some of which are outdated and some modern. The core building of the hospital, including its Theatres and ITU, was completed in 2001. Since that time a new A&E department has opened and there has been substantial refurbishment of the hospital's unplanned admission facilities (Medical Assessment Unit, Chest Pain Unit and Ambulatory Care Unit). The majority of services are provided from the main hospital site, but a number of outpatient and diagnostic services are also provided from community hospitals owned by PCTs and located across the PCT areas.

The Trust has had financial pressures throughout its existence. For some years these were viewed as a consequence of high costs within the Trust (reference costs in 2002/03 were 110) but for the last two years reference costs have been below 100 and for 2005/06 have been published at 90.

The Trust provides a traditional DGH-type service including medical, surgical, paediatric and diagnostic services. In addition, it provides a substantial volume of cancer related services, including chemotherapy and radiotherapy. The Trust does not currently provide maternity services although these are located on the hospital site with direct access to the main hospital buildings. Maternity services are currently delivered by West Wiltshire Primary Care Trust, which has given notice that it wishes to withdraw from this service by 2007. It is likely that the RUH will wish to provide these services in the future for its natural catchment population.

1.2 Population Characteristics

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

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

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

1.3 National Factors

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

Payment by Results (PbR)
The Trust is currently demonstrating a reference cost index of 90, i.e. 10 percentage points below the average, and therefore should see an income gain from the full operation of Payment by Results. Because the tariff is the same for inpatients and daycases, if treatment centres take on a greater proportion of day case and low patient risk work this could make it more difficult for the Trust to cover its costs, as it would be dealing with the more complex, and therefore more costly, cases. This could also cause the Trust's reference costs to increase.

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

Creating a Patient Led NHS
Creating A Patient-Led NHS outlined a vision of work shifting from acute hospitals to more local settings, such as community hospitals and GP practices. Local PCT strategies support this shift from the acute hospital setting. This could lead to new opportunities for the Trust to run services in the community, but will also require cost reduction on the main site.

1.4 Local Factors

Reconfiguration
The recent reconfiguration of health services in England has resulted in one Strategic Health Authority for the South West co-terminous with the Government Office. Within the old AGW SHA, the number of PCTs will reduce from twelve to seven, co-terminous with the local authorities. This configuration gives the Trust the advantage of working with only one Strategic Health Authority rather than the two with which it currently works. However, it means that the Trust will still be a significant provider for three different PCTs, each of which has a real choice of alternative providers. This continues the difficulties of pathway development and organisational links that have existed in the past. The Trust will need to work hard to maintain its market share and to ensure that the population it serves does not lose local services to more providers such as Bristol or Swindon.

Pathways for Change
The Wiltshire PCTs are currently undertaking public consultation on the reduction in the number of small community hospitals. Explicit within this consultation is the objective of moving healthcare provision from acute hospitals closer to home. The Trust needs to take the opportunity to explore the vertical integration of services whereby the Trust would take responsibility for running community hospitals/services.

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

Social Services
Working relationships between Social Services departments and PCTs are variable. Particular difficulties are being encountered in Wiltshire where both the Social Services department and PCTs are in significant financial difficulties. It is not therefore possible currently to see patient care responsibilities being jointly owned and 'bed blocking' within both community hospitals and acute hospitals is becoming a significant concern.

1.5 Competitive Position

NHS

BRISTOL HOSPITAL TRUSTS (United Bristol Hospitals NHS Trust (UBHT) and North Bristol NHS Trust (NBT))
A proportion of the BaNES population sees UBHT as its natural district general hospital provider with well established patient flows. For the most part, however, the Bristol hospitals Trusts are used by patients for their more specialist services. The area of greatest competition with the RUH is specialist surgery related to cancer care – urology and gynaecology – where the service provided by the RUH achieves good clinical outcomes, but where there is pressure from Improving Outcomes Guidance (IOGs) to centralise. The Trust believes that there is scope to work in joint teams and therefore meet the spirit of the guidelines without a physical centralisation of surgical activity.

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

Non-NHS

SHEPTON MALLET TREATMENT CENTRE (SMTC)
This independent sector treatment Centre was procured within wave one of the Department of Health's IS-TC programme. It provides a variety of lower

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

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

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

2. Development and Performance in the Trust in 2005/06

How did we do in 2005/2006?

Following the one star awarded to the Trust in 2004/05, staff made huge efforts to improve performance under the Healthcare Commission's new assessment process for 2005/06 – the Annual Health Check. Despite the fact that greater weight was given to achieving financial balance and the introduction of four new access targets that reduced waits even further, the Trust is predicting an overall rating of Fair.

The emergency care target that 98% of patients should be seen, treated and admitted, transferred or discharged within four hours continued to be a great challenge in 2005/06. During the year, emergency attendances rose by 0.6% and admissions were up by 1.2% compared to 2004/05.

In the first three quarters of the year, the Trust achieved the target of 98% and was the second best performing Trust towards this standard in the country in quarter two, dealing with 50% more attendances than the other top Trust.

However, performance slipped in Q4 as a result of an unprecedented number of emergency admissions coupled with ward closures due to the D&V virus. In spite of all this the Trust is still on target to achieve for the whole year[1].

2005/06 saw the introduction of more stringent wait times targets. In December 2005 the target for elective patients waiting longer than the standard reduced from 9 to 6 months and the target for outpatients waiting longer than the standard from 17 to 13 weeks. The Trust did not have a single breach for either of these new targets. Given that 9,392 patients were treated and 81,046 outpatients were seen over this period, this is a remarkable achievement.

In addition, new wait time targets were introduced for diagnostic tests such as MRI, CT and Ultrasound where the Trust has reduced from a maximum wait of 52 weeks to 20 weeks during 2005/06.

Cancer also took a more prominent role in the Healthcare Commission's assessment with three wait times targets monitored. The 31 day target (from decision to treat to first definitive treatment) and the 62 day target (from GP referral to first definitive treatment) came into effect in the final quarter. Along with the two week wait standard the trust comfortably achieved the 31 day target for all cancers. The 62 day target proved more difficult and the Trust particularly struggled in the first two months of the quarter getting an overall score of 90.4% for Jan-Mar 06. The 95% target for this indicator was therefore not achieved, but this was consistent with the rest of the country with an England average of 91.1%.

The Trust's performance in other existing targets which contributed to the prediction of a fair rating included; agreeing with 100% of patients in advance a date for inpatient/day case operations and outpatient appointments, seeing patients with suspected angina within two weeks of referral to the rapid access chest pain clinic, and ensuring provider information is in place to support Choice.

Hospital cleanliness remains a key issue for the public and has been heightened by concerns around hospital acquired infections. RUH staff have worked tirelessly to address this, as confirmed by the 2005 Peat assessment where the trust was rated "Good" for hospital cleanliness.

In December the Dr Foster Hospital Guide was published in which 159 hospitals in England were rated on four key aspects of care - quality of treatment provided, overall patient satisfaction, efficient use of funds, and waiting times. The RUH was rated amongst one of the top hospitals in the country and in fact the highest rated within the Avon, Gloucestershire and Wiltshire area.

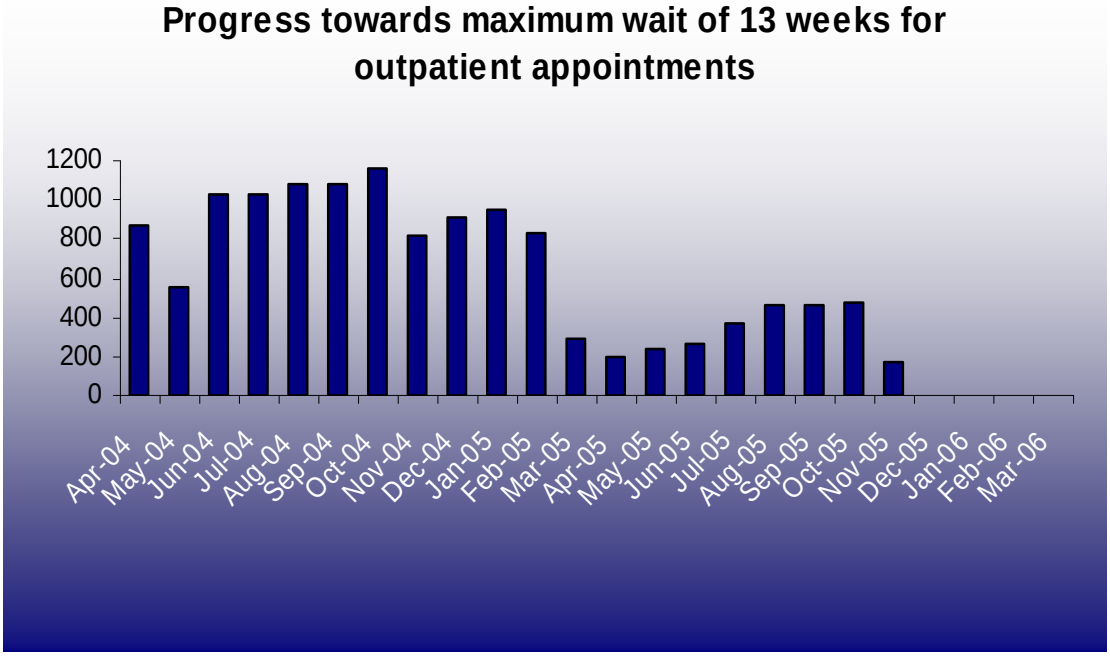
[1] Target indicator methodology is still being finalised for the 2005/06 ratings, therefore prediction is based on current guidance available

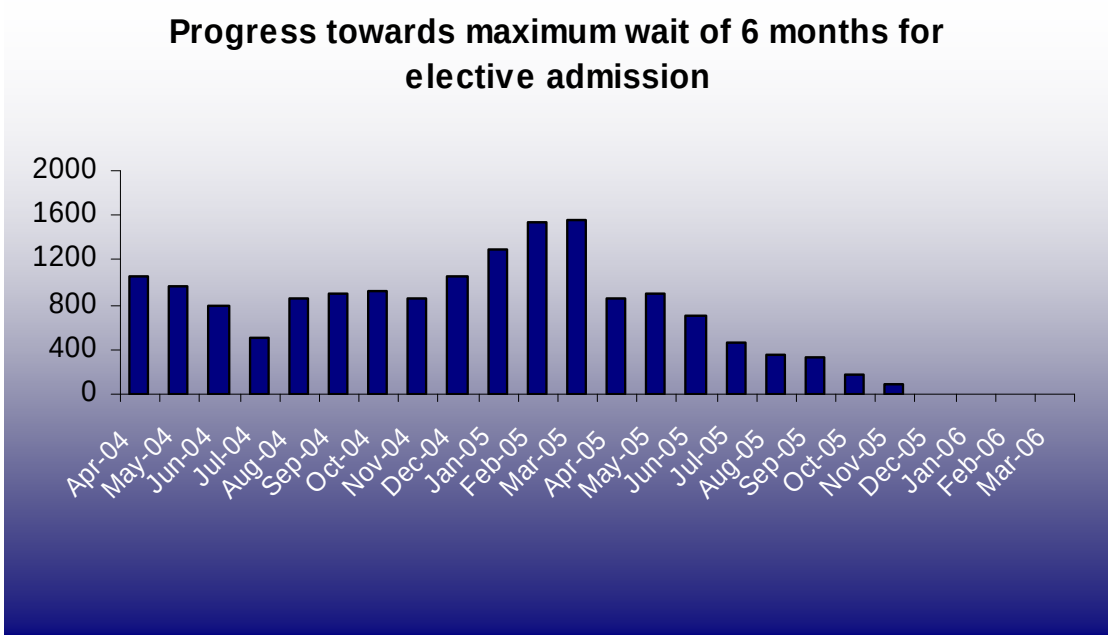
We received many letters of praise and thanks from grateful patients and many thank you letters were published in local newspapers as evidence of the high level of patient care provided. Furthermore, in May 2006 we were named one of the top 40 hospitals for the second year running following an independent comparative report by CHKS into clinical effectiveness and outcomes, efficiency and patient/carer experience.

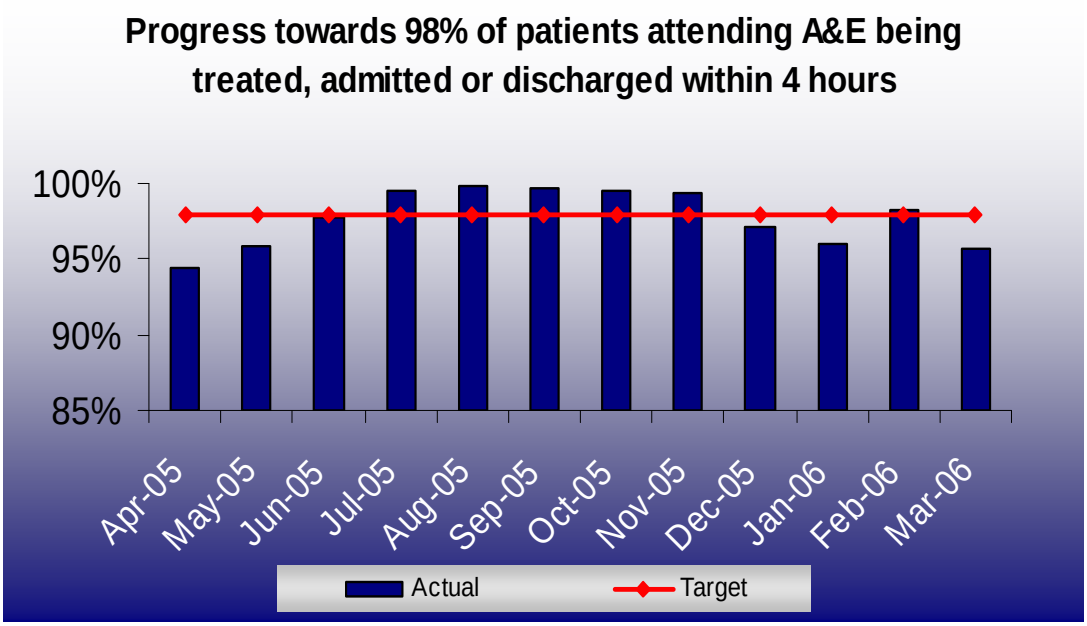
The following figures indicate the route our patients took to receive their treatment:

- 68,958 patients (68,522 in 2004/05) attended the emergency department and there were 31,793 non-elective admissions (31,417 in 2004/05)
- 7,318 patients were admitted for elective inpatient procedures (188 less inpatients than in the previous year - a fall of 2.5%)
- 23,323 patients were treated for elective day case procedures (588 more day cases than in the previous year – a rise of 2.6%)
- 249,157 patients were seen in our outpatient departments (2,051 less outpatients than in the previous year – a fall of 0.8%)

Our progress towards meeting the year end targets







Progress towards reducing cancelled operations and maximum 2 week RACPC wait

Additional Indicators	Q1 2005/06	Q2 2005/06	Q3 2005/06	Q4 2005/06
Cancellations as % of elective admissions	1.9%	0.6%	2.5%	2.9%
Waiting times for RACPC - seen within 2 weeks	96.5%	98.8%	97.1%	99.4%

As in the previous year, the huge rise in demand on emergency services over the winter months and the challenging financial climate have continued to place additional pressures on services throughout the hospital. The hard work, dedication and commitment of staff and local healthcare partners meant that the Trust was able to meet these challenges, maintaining the Trust's performance and achieve improvements in performance over last year.

In 2005/06, the Trust was assessed against 7 Key National Targets and Standards.

The Trust's current performance against operational efficiency indicators is as follows:

10 High Impact Changes	**Rating** **(Red, Amber, Green)**
Day case as norm	G
Access to diagnostics	R
Variation in discharge	A
Variation in admission	A
Outpatients new to follow-up ratios	G
Use of therapeutic care bundles	G
Long term conditions	R
Reduce queues	A
Use process mapping	A
Redesign workforce	A
Asset Utilisation	
2005/06 bed occupancy levels (trust wide, year end)	R (95.7%)
Overall elective theatre utilisation	A (77.8%)
Theatre cancellation rates	R (2.1%)
Outpatient DNA rate	G (6.5%)
Average length of stay	G (3.9 elective IP, 6.3 non-elective)
Financial	
Reference cost index	G (90)
Recurrent balance	R
Historic debt	R
Workforce	
Sickness absence	G (4.3% - Feb. 06)
Turnover	A (16.6% - March 06)

3. Development and Performance of the Trust in the Future

3.1 2006/07 Operational Objectives

On an annual basis the Trust reassesses its operational objectives in the light of its own strategic direction and the developing external environment in which it works. The Trust has defined twenty-six operational objectives for the year that support its strategic direction, seek to address the external environment and take into account the SWOT analysis undertaken in October 2005. They address the following themes:

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

3.2 Service Development Plan – 2006/07 and Beyond

Service Profile
The Trust's service focus will remain on supporting the unplanned acute care needs of the population it serves and in delivering cancer care and more specialist (non-treatment centre) planned care to its current population.

The Trust does not predict withdrawing from any main hospital specialties over this five year period. It is likely that through this period it will work with other organisations in partnerships and sub-contracting relationships to deliver care differently in different locations. Thus a number of specialties may provide services across the primary and secondary care spectrum on behalf of RUH whereas for others, staff may be sub-contracted to provide care on behalf of another provider.

It is likely that within 2006/07 the Trust will be tendering to provide maternity services to the populations of its four main PCTs following the withdrawal of West Wiltshire PCT from the provision of the service. Public consultation is currently taking place on the future model of care for maternity services and the predicted sizes and locations of maternity centres. The existing model of care is not affordable within national tariff and the service receives a subsidy from commissioners. In the future the model of care will either need to be redefined to be affordable within tariff or commissioners will need to commit to a continuation of an appropriate subsidy for the service. No change will be made in the provider of this service until 2007/08. Currently no account of this change is taken in the Trust's activity profiling.

Activity Volumes
It is predicted that there is an underlying annual growth in demand for elective and non-elective care of around 1% per annum. This arises from a combination of population growth, an increase in life expectancy and evidence

that the ageing population is living longer with more chronic health care needs (i.e. healthy years are not growing at the same rate as life years).

The combined implications of an increasingly informed public taking advantage of patient choice, the operation of new market entrants (e.g. Wave II IS-TC) and the movement of services out of acute hospitals closer to home will all place pressures upon the trust in terms of service shifts out of the DGH setting.

Combined, the Trust predicts the following changes to its service volumes over the next five years. These have been shared at a summary level with local PCTs:

Activity volume changes – 2006/07 – 2010/11

Non-elective admissions	+0.5% growth per annum (1% population growth and -0.5% demand management)
Elective admissions	+1% growth per annum
Patient Choice	-2% per annum in Treatment Centre HRGs 0% net change in complex inpatient HRGs 0% net change in paediatric HRGs
IS-TCs	Full year effect of Shepton Mallett TC 06/07 Wave II IS-TC – notional reduction in Treatment Centre and HRGs up to a value of £2.5m (£1.86m 08/09, £2.5m 09/10 onwards)
Outpatients	-5% per annum in specific specialties due to a shift to primary care (Dermatology, ENT, Diabetes, General Surgery, Orthopaedics, Ophthalmology, Cardiology, Respiratory)
Direct Access	+1% per annum
Achievement of 18 weeks	Profiled reduction in waiting times to achieve maximum 18 week wait by end of 2008 – different allocations of time to outpatients, diagnostics and inpatient waits dependent on PCTs

Information Technology

The Trust is an early implementer of a new Patient Administration System procured within the Connecting for Health programme (CfH). Current information systems at the Trust are cumbersome and difficult to manipulate. The new system is due to go live within 2006/07, although the precise date is not yet confirmed as there remain substantial issues in respect of reporting and A&E management. The system will deliver opportunities for improved operational systems, including real time bed management. The system will integrate with *Choose and Book* software and will facilitate the operation of direct booking at the Trust.

The Trust intends to rationalise its buildings and concentrate acute hospital activities within a smaller footprint on the site. The central core of the RUH and the new A&E department will provide the focus for acute activities and services in peripheral areas will be relocated. The Trust does not intend to deliver this programme through a PFI project, but to make incremental changes over time. The first phase is intended to be the relocation and replacement of the Trust pharmacy to enable robotics to be installed and a more efficient service to be provided. In addition the Trust is improving its car parking facilities for patients and staff. There will be more spaces combined with 'pay on exit' car parks, which will provide greater protection for patient parking and increase income.

Commissioner Support

At the highest level, PCTs remain committed to the RUH as a main provider of the full range of DGH-type services. All local PCTs were involved in the development of the trust's strategic direction and supported the outputs of this process. BaNES PCT is committed to managing a balanced and sustainable portfolio of providers. It is keen to ensure that the development of practice-based commissioning does not shift spending patterns within the health economy and lead to pressures within the Trust which might compromise the services that it would wish the hospital to deliver. The PCT is managing the pace of change and proposals for change are considered through a system-wide analysis of costs and benefits.

The Trust has agreed heads of terms in 2006/07 with the Wiltshire PCTs and BaNES PCT. Whilst understanding one anothers' strategies at the highest level, there is limited joint working in the delivery of pathways of care across organisational boundaries. Addressing this is a high priority for the Trust. Issues which are hindering progress in joint working and which need to be resolved include:

- the implementation of split tariff;
- the historical financial basis of provider-to-provider agreements;
- historical debt and an understanding of its origins.

The operation of *Payment by Results* should make the financial basis of the relationships between PCTs and the Trust more straight forward. However, it is likely that the reconfiguration of PCTs will result in a further year of instability before any strong partnership working can emerge.

4. Financial Review

4.1 In 2005/06, there were 7 Key National Targets the Trust had to achieve. One of these targets was to achieve financial balance.

In order to meet the Key National Target of financial balance, the Trust set 4 corporate objectives:

i) To set realistic annual budgets and achieve expenditure within them.

ii) To have SLAs for 2005/06 agreed with BaNES PCT by 31.5.05 and with Wiltshire and Mendip PCTs by 31.7.05.
iii) To deliver Agenda for Change within the available resources.
iv) To safeguard 2005/06 income within elective surgery within the context of Patient Choice and Plurality of Provision.

In 2005/06 the Trust recorded a deficit of £7,339,000. This equates to 4.4% of the Trust's income.

A summary of the Trust's financial performance over the past 4 years is set out in Table 1 below:

Historical financial information	**2002/03 £m**	**2003/04 £m**	**2004/05 £m**	**2005/06 £m**
Income	121	147	160	166
Pay expenditure	-89	-97	-107	-115
Non pay expenditure	-45	-43	-44	-46
SURPLUS/-DEFICIT before INTEREST	**-13**	**7**	**9**	**5**
Net interest, depreciation & dividend	-12	-9	-10	-12
NET DEFICIT	**-25**	**-2**	**-1**	**-7**
Financial support received	0	-10	-10	-5
Other one-off factors (net)	0	-5	-2	-1
NORMALISED DEFICIT	**-25**	**-17**	**-13**	**-13**
Key financial indicators	**%**	**%**	**%**	**%**
Reference Cost Index (RCI)	110	93	90	-
Cost improvements as % of clinical income	-	6	9	10
Increase in admitted patient care spells	-	-	3	2

The Trust has continued in 2005/06, to implement a vigorous financial recovery plan so that it can achieve financial balance in the longer term. In 2005/06, the Trust had a target financial recovery plan of £24m, of which it achieved £20m. The shortfall in achievement contributed to the Trust's deficit in 2005/06. The savings achieved amounted to 10% of the Trust's clinical income.

The impact of the cost improvement plans can be seen in the reducing reference cost index, and the increasing proportion of savings achieved (see Table 1 above).

Details of the Trust's financial recovery plans are reported to the Trust Board every month, and have been closely monitored and reviewed by the Strategic Health Authority (SHA). Copies of Board papers are available on the Trust's web site.

The Trust received planned income of £4,821,000 from AGW SHA, via the PCTs' Commissioner Guarantee Income scheme in 2005/06.

4.2 Accumulated Deficit and Breakeven Duty

As shown on the balance sheet the Trust has a substantial accumulated deficit on the income and expenditure reserve, standing at £43.1m.

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

Table 2

	In Year Deficits £'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
2003/04	-1,968
2004/05	-946
2005/06	-7,339
Accumulated Deficit	**-43,182**

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

Due to the size of the deficit incurred by the Trust in 2002/03 financial year, the SHA agreed to extend the Trust's breakeven to 5 years. This means that the deficits incurred in 2002/03 and subsequently will need to be recovered by 31st March 2007. It should be noted that the Trust's balance sheet deficit (£43.1m) includes deficits prior to 2002 and consequently is larger than the amount to be recovered in by 2007 under the statutory breakeven duty of £35m.

To meet the breakeven duty, the Trust is required to make a surplus of £35m by 31st March 2007. The recovery of this amount is a considerable challenge for the Trust and health community. The Trust does not have definitive plans for the recovery of this amount and is in discussion with its local health partners, the SHA and the DoH to identify how this issue will be resolved.

4.3 Accumulated Cash Deficit

The deficits incurred by the Trust have resulted in cash management issues, which have been resolved up until March 2006 through a mixture of careful working capital management, and cash brokerage.

The Trust's cash brokerage in 2005/06 was £36.7m, which was paid to the trust via its external financing limit.

Under the new NHS financial regime, the Trust anticipates that it will receive loans to fund its underlying cash flow shortfall. The loans will attract an interest charge, currently stated at 5% and will need to be recovered through further cost improvements. The repayment term has still to be agreed with the SHA, but is expected to be 25 years.

4.4 Financial Targets in 2005/06

As well as the breakeven duty, the Trust had other financial targets to meet in 2005/06. Brief details of these are set out below, they are also included in the attached full set of accounts.

External Financing Limit (EFL)
The EFL sets out the amount of cash that the Trust is expected to hold at the end of the financial year. To meet the EFL, the Trust must manage its cashflow and borrowing requirements. During the 2005/06 financial year the Trust was able to manage within its cash requirements, and meet this target.

Capital Resource Limit (CRL)
The CRL is the maximum amount that the Trust can in invest in fixed assets during the year. In 2005/06 the Trust underspent its CRL by £5,000.

Capital Cost Absorption Rate
The Trust is required to make a return on the assets it employs of 3.5%. In 2005/06 the Trust achieved a return of 3.46% and met its CRL target.

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

	2005/06	2004/05
	£000	£000
Management Costs	6,836	6,141
Income	158,261	151,276
Cost as a percentage of income	4.32%	4.06%

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

Better Payment Practice Code - Measure of Compliance

	2005/06 Number	2005/06 £000
Total Non-NHS trade invoices paid in the year	49,844	33,964
Total Non NHS trade invoices paid within target	42,949	27,022
Percentage of Non-NHS trade invoices paid within target	86%	80%
Total NHS trade invoices paid in the year	2,018	10,087
Total NHS trade invoices paid within target	1,530	5,749
Percentage of NHS trade invoices paid within target	76%	57%

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

4.5 Capital Expenditure

Under the current financial regime, the Trust receives an annual allocation of central funds for capital investment. In 2005/06 the Trust's basic capital allocation was £4.5m, equivalent to 3% of its existing asset base. The Trust also received further capital allocations for specific items such as major items of equipment or building works.

The Trust's capital investment in 2005/06 is set out in **Table 3** below.

Table 3

	2005/06 £m
Buildings maintenance	4
Equipment	1
Special projects & allocations	4
Total Capital Investment	**9**

4.6 Future Capital Expenditure

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

- internally generated resources (e.g. cash generated by the abolition of the Trust's external financing limit);
- capital receipts, which the Trust will be at liberty to retain for its own use;
- allocations of public dividend capital previously agreed;
- NHS loans.

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

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

The Trust's projected capital investment for the next five years is set out in **Table 4** below.

Table 4

Forecast capital investment	**06/07 £m**	**07/08 £m**	**08/09 £m**	**09/10 £m**	**10/11 £m**
Buildings maintenance	2	2	2	2	2
Equipment	5	4	5	4	4
Other projects	2	3	2	1	1
Total Capital Investment	9	9	9	7	7

4.7 Future Financial Plans

The Trust has completed the first cut of its financial forecasts based on a set of assumptions. The forecasts for the next 5 years are shown in **table 5** below:

Table 5

Forecast financial information	**2006/07 £m**	**2007/08 £m**	**2008/09 £m**	**2009/10 £m**	**2010/11 £m**
Income	166	169	169	171	174
Gain from PbR	10	11	13	13	13
Pay expenditure	-110	-112	-113	-114	-116
Non pay expenditure	-52	-53	-53	-54	-55
EBITDA	**14**	**15**	**16**	**16**	**16**
Depreciation	-8	-8	-9	-9	-9
PDC dividend	-5	-5	-5	-5	-6
Net interest	-1	-2	-2	-2	-1
NET DEFICIT	**0**	**0**	**0**	**0**	**0**
Financial support received	0	0	0	0	0
Other one-off factors (net)	0	2	2	2	2
NORMALISED EARNINGS	**0**	**2**	**2**	**2**	**2**
Key financial indicators	**%**	**%**	**%**	**%**	**%**
Cost improvements as % of clinical income	8	3	3	3	3
Increase in patient spells %	3	1	-3	-2	0

Future Income and Payments by Results

The Trust has calculated its future clinical income streams based on its estimate of future activity at national tariff. The activity assumptions underpinning the income projections are set out in section 3.

In the earlier years of the forecast, the Trust has assumed that not all the activity that is necessary to meet the total wait targets will be a) commissioned at the trust, or b) paid for in full by the Trust's commissioners, and therefore the projected income has been reduced in 2007 & 2008.

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

In the later years of the forecast, from 2009 onwards, activity and clinical income reduces as patient's choice and the second wave of the IS-TC programme start to take effect.

This is shown in **Table 6**:

Table 6

Forecast clinical income at nominal prices	06/07 £m	07/08 £m	08/09 £m	09/10 £m	10/11 £m
Clinical income based on activity modelling	164	165	162	159	161
Reduction for PbR transition	-3	-1	0	0	0
Reduction for activity to meet total wait targets commissioned elsewhere	-3	-3	0	0	0
Total clinical income	**158**	**161**	**162**	**159**	**161**

Future Cost Improvements and Financial Recovery Plans

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

- **existing financial recovery plans**: these are built into the budgets that form the basis of the 2006/07 forecast outturn. The savings in the financial recovery plan amount to £13m. Plans are being identified for these savings and they will be recurrent.

- **savings required to balance cash-releasing efficiency saving reductions inherent in the national tariff**: these are percentages of the Trust's clinical income, based on SHA guidance on the levels of efficiency to be built into the tariff uplift each year;

- **cost reductions that may be necessary to offset reductions in income from activity**: these are based on a marginal cost of 50% over the next 5 years.

Future Risk Assessments

The Trust has assessed its risks for 2006/07 under the headings clinical, financial and governance risks.

In high level terms, the highest risks for the Trust relate to the following:

- management of historic debt
- delivery of financial recovery plan
- management of patient flow through the hospital
- control of infection
- *Connecting for Health* implementation
- partnership working through reconfiguration

All of these areas have been recognised within the Trust's 2006/07 corporate objectives.

The most substantial risk facing the Trust is in relation to the management of its historic debt and the effect that this debt burden has on the Trust's recurrent financial position if it is translated to a loan with interest and principal repayment requirements. If interest and repayment are required in advance of the Trust being in receipt of full funding under *Payment by Results* it is highly unlikely that the Trust will achieve recurrent balance and will face the accumulation of new debt.

5. Remuneration Report

Membership of the Remuneration committee
All, and only, Non Executive Directors are members of the committee. The committee is quorate with 3 members although it is intended to increase this to 4 for 06/07.

During 2005/6 the following individuals were Non Executive Directors:

Mike Roy- Chairman
Maura Poole
Steve Wheeler - started 01/12/05
Jonathon Lloyd
Jeff Manning - left 30/11/05
Richard Weatherhead
Michael Earp

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

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

Progression is determined by the committee for:

- Annual inflation considerations in line with nationally published indices (RPI/CPI), DH guidance and other nationally determined NHS pay settlements

- Specific review of individual salaries in line with independently obtained NHS salary survey information, other labour market factors where relevant , e.g. for cross sector, functional disciplines, internal relativities and equal pay provisions. Such review is only likely where an individual Director's portfolio of work or market factors change substantially.

- One or more Executive Directors may benefit from protected historical pay/ benefits packages from 'closed' schemes.

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

There is no specific intention to alter this policy for future years albeit that the Remuneration committee may develop alternative approaches as changing contexts dictate.

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.

Details of service contracts

Details of Service Contract for Executive Directors

Name	Post Title	Date of Contract	Unexpired term	Notice period	Provision for compensation for early termination	Other termination liability
John Williams	Director of Finance	19/04/2004	Substantive	6 months	None	Statutory entitlements in the event of unfair dismissal. Balance of holidays due to be paid on termination. Entitlements under NHS Whitley Council and NHS pension scheme.
Stephen Holt	Director of Facilities	26/11/2000	Substantive	3 months	None	As above.
Diane Fuller	Director of Patient Care Delivery	01/09/2005	Substantive	6 months	None	As above.
Lynn Vaughan	Director of Human Resources	01/07/2004	Substantive	6 months	None	As above.
Brigid Musselwhite	Director of Planning and Strategic Development	01/03/2004	Substantive	6 months	None	As above.
John Waldron	Medical Director*	01/09/2002	17 months**	3 months	None	As above.
Mark Davies	Chief Executive	03/12/2003	Substantive	6 months	None	As above.

*** Mr Waldron's substantive appointment is as a Consultant ENT Surgeon**
**** As at 31/03/06**

There have been no significant awards to past senior managers, during 2005/06.The salary and pension entitlements of Senior Management are shown in the following table.

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

A) Remuneration

Name and Title	2005-06				2004-05		
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Date of Starting(S) or leaving (L)	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100
Mark Davies - Chief Executive	145-150	0	0		140-145	0	0
John Williams - Director of Finance	110-115	0	0		100-105	0	0
John Waldron - Medical Director	55-60	95-100	0		45-50	85-90	0
Corinne Thomas - Director of Nursing	65-70	0	0	L 12/02/2006	75-80	0	0
Brigid Musselwhite - Director of Planning and Strategic Development	80-85	0	0		75-80	0	0
Stephen Holt - Director of Facilities	75-80	0	0		65-70	0	0
Lynn Vaughan - Director of Human Resources	75-80	0	0		70-75	0	0
Diane Fuller - Director Of Patient Care Delivery.	40-45	0	0	S 01/09/2005	0	0	0
Carol De Halle - Acting Director of Nursing.	0-5	0	0	S 13/02/2006	0	0	0
Deborah Gray - Acting Director Of Nursing.	0-5	0	0	S 13/02/2006	0	0	0
Jenny Barker - Director of Operations	0-5	0	0	L 10/04/2005	85-90	0	0
Mike Roy - Chairman	15-20	0	0		15-20	0	0
Maura Poole - NED	5-10.	0	0		5-10	0	0
Steve Wheeler - NED	0-5	0	0	S 01/12/2005	0	0	0
Jonathan Lloyd - NED	5-10.	0	0		5-10	0	0
Jeff Manning - NED	0-5	0	0	L 30/11/2005	5-10	0	0
Richard Weatherhead - NED	5-10.	0	0		5-10	0	0
Michael Earp - NED	5-10.	0	0		0-5	0	0

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

B) Pension Benefits

Name and title	Real increase in pension and related lump sum at age 60 (bands of £2500) £'000	Total accrued pension and related lump sum at age 60 at 31 March 2006 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2006 £000	Cash Equivalent Transfer Value at 31 March 2005 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Mark Davies - Chief Executive	7.5-10	190-195	679	612	37	0
John Williams - Director of Finance	17.5-20	215-220	964	852	64	0
John Waldron - Medical Director	17.5-20	140-145	565	469	74	0
Corinne Thomas - Director of Nursing	5-7.5	105-110	381	339	21	0
Brigid Musselwhite - Director of Planning and Strategic Development	2.5-5	75-80	236	212	13	0
Stephen Holt - Director of Facilities	2.5-5	105-110	395	362	17	0
Lynn Vaughan - Director of Human Resources	12.5-15	50-55	213	145	45	0
Diane Fuller - Director Of Patient Care Delivery.	12.5-15	65-70	201	150	19	0
Carol De Halle - Acting Director of Nursing.	7.5-10	65-70	241	195	4	0
Deborah Gray - Acting Director Of Nursing.	10-12.5	45-50	163	121	4	0
Jenny Barker - Director of Operations	5-7.5	90-95	304	264	1	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Remuneration Report (continued)

---------- Acting Chief Executive Date: 4th July 2006

6. Annual Accounts 2005/06

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 annual accounts.

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

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

The following statements are attached:

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

Audit
The independent auditors statement is included within the Summary Financial Statements.

In respect of the preparation of the accounts for 2005/06, as far as the Directors are aware there is no relevant audit information of which the Trust's auditors are unaware. The Trust's Directors have taken all steps that they ought to have taken as Directors to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

NHS Trust Manual for Accounts

The operating and financial review has been prepared in accordance with the NHS Trust Manual for Accounts for 2005/06 , as directed by the Secretary of State.

7. Directors Interests

Chairman Mike Roy
Governor of Bath Spa University
Member, Bristol Employment Tribunal

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

Non Executive Directors

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

Richard Weatherhead
Director of 5 Lansdown Place West Management Company Ltd

Michael Earp
Director of Softmedia Productions Ltd

Stephen Wheeler
Chair of Trustees of the Evaluation Trust

Appendix 1 Summary Financial Statements

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 March 2006

	2005/06	2004/05
	£000	£000
Income from activities	**149,942**	144,404
Other operating income	**16,070**	15,741
Operating expenses	**(167,896)**	(157,399)
OPERATING (DEFICIT) SURPLUS	**(1,884)**	2,746
Cost of fundamental reorganisation/restructuring	**0**	0
(loss) Profit on disposal of fixed assets	**(8)**	7
(DEFICIT) SURPLUS BEFORE INTEREST	**(1,892)**	2,753
Interest receivable	**227**	164
Other finance costs - unwinding of discount	**(19)**	(8)
Other finance costs - change in discount rate on provisions	**(11)**	0
(DEFICIT) SURPLUS FOR THE FINANCIAL YEAR	**(1,695)**	**2,909**
Public Dividend Capital dividends payable	**(5,644)**	(3,855)
RETAINED (DEFICIT) FOR THE YEAR	**(7,339)**	(946)

NOTE TO THE INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 March 2006

	31 March 2006	31 March 2005
	£000	£000
Retained deficit for the year	**(7,339)**	(946)
Financial support included in retained (deficit) for the year - NHS Bank	**0**	9,379
Retained deficit for the year excluding financial support	**(7,339)**	(10,325)

Financial support is income provided wholly to assist in managing the NHS Trust's financial position. Internally generated financial support is financial support received from within the local health economy, consisting of the area of responsibility of Avon, Gloucester and Wiltshire Strategic Health Authority. The support was given as part of a recovery package agreed with the SHA.

BALANCE SHEET AS AT 31 March 2006

	31 March 2006	31 March 2005
	£000	£000
FIXED ASSETS		
Tangible assets	**171,854**	164,616
CURRENT ASSETS		
Stocks and work in progress	**3,395**	3,086
Debtors	**9,141**	10,774
Cash at bank and in hand	**464**	464
	13,000	14,324
CREDITORS: Amounts falling due within one year	**(12,034)**	(10,787)
NET CURRENT ASSETS	**966**	3,537
TOTAL ASSETS LESS CURRENT LIABILITIES	**172,820**	168,153
PROVISIONS FOR LIABILITIES AND CHARGES	**(819)**	(1,508)
TOTAL ASSETS EMPLOYED	**172,001**	166,645
FINANCED BY:		
TAXPAYERS' EQUITY		
Public dividend capital	**166,610**	158,885
Revaluation reserve	**42,459**	38,280
Donated asset reserve	**6,114**	5,323
Income and expenditure reserve	**(43,182)**	(35,843)
TOTAL TAXPAYERS EQUITY	**172,001**	166,645

Signed:  (Chief Executive)

Date: 4th July 2006

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 March 2006

	2005/06 £000	2004/05 £000
Deficit /Surplus for the financial year before dividend payments	**(1,695)**	2,909
Unrealised surplus on fixed asset revaluations/indexation	**4,656**	23,533
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	**899**	442
Total recognised gains and losses for the financial year	**3,860**	26,884
Total gains and losses recognised in the financial year	**3,860**	26,884

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 March 2006

	2005/06 £000	2004/05 £000
OPERATING ACTIVITIES		
Net cash inflow from operating activities	**6,084**	1,448
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:		
Interest received	**227**	164
Net cash inflow from returns on investments and servicing of finance	**227**	164
CAPITAL EXPENDITURE		
(Payments) to acquire tangible fixed assets	**(9,291)**	(9,821)
Net cash outflow from capital expenditure	**(9,291)**	(9,821)
DIVIDENDS PAID	**(5,644)**	(3,855)
Net cash outflow before management of liquid resources and financing	**(8,624)**	(12,064)
Net cash outflow before financing	**(8,624)**	(12,064)
FINANCING		
Public dividend capital received	**10,742**	17,446
Public dividend capital repaid (not previously accrued)	**(3,017)**	(5,413)
Other capital receipts	**899**	465
Net cash inflow from financing	**8,624**	12,498
Increase in cash	**0**	434

Statement on Internal Control 2005/06

Royal United Hospital, Bath, NHS Trust

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

A copy of the statement of internal control is included within the Trusts annual accounts and is available by contacting John Williams, Director of Finance.

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

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

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

4th July 2006 Date Chief Executive

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 1977 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure of the trust for that period. In preparing those accounts, the directors are required to:

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

- make judgements and estimates which are reasonable and prudent

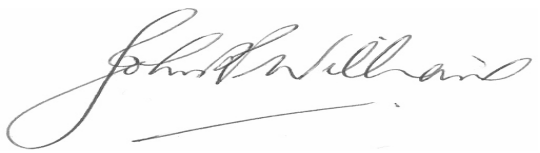
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board:

4th July 2006 Date Chief Executive



4th July 2006 Date Finance Director

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

We have examined the summary financial statements for the year ended 31 March 2006 which comprise the Income and Expenditure Account, the Balance Sheet, the Statement of Total Recognised Gains and Losses and the Cashflow Statement. We have also audited the information in the Trust's Remuneration Report that is described as having been audited.

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

Respective responsibilities of directors and auditors

The directors are responsible for preparing the Annual Report, including the Remuneration Report. Our responsibility is to audit the part of the Remuneration Report to be audited and to report to you our opinion on the consistency of the summary financial statements within the Annual Report with the statutory financial statements. We also read the other information contained in the Annual Report and consider whether it is consistent with the audited summary financial statements. This other information comprises only the Directors' report, Operating and Financial Review and the unaudited part of the Remuneration Report. We consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statements. Our responsibilities do not extend to any other information.

Basis of opinion

We conducted our work in accordance with Bulletin 1999/6 'The auditors' statement on the summary financial statement' issued by the Auditing Practices Board.

Opinion

In our opinion:

- the summary financial statements are consistent with the statutory financial statements of the Trust for the year ended 31 March 2006; and
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
31 Great George Street, Bristol BS1 5QD

Date: 6 July 2006