Royal National Hospital
for Rheumatic Diseases
NHS Foundation Trust

Annual Report & Accounts for the ten month period ended 31 January 2015

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ten month period ended 31 January 2015

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Chair's Closing Statement

1 February 2015 marks a unique day in the life of the Royal National Hospital for Rheumatic Diseases NHS FT (RNHRD NHS FT). Ever since this great hospital was founded in 1738 it has been led by its own dedicated management team with a Board of Directors and Governors. From 1 February management of this hospital will transfer to the Royal United Hospitals Bath (RUH) following its authorisation as a Foundation Trust in November 2014.

The RNHRD NHS FT was authorised as a Foundation Trust on 1 April 2005. It is a specialist hospital with an international reputation for research and expertise in rheumatology, chronic fatigue and pain management, and also provides diagnostic imaging and measurement services. It has been the smallest acute specialist Foundation Trust hospital in England providing services at a national level.

The RNHRD NHS FT first recognised it was too small to be financially sustainable in the long term in 2008 and started to require financial support in 2011/12. Throughout this period of uncertainty the quality of services at the RNHRD NHS FT remained highly rated with high patient satisfaction and compliance in all standards during its last inspection by the Care Quality Commission (CQC) in December 2013.

Following a rigorous options appraisal exercise in 2012 the RNHRD NHS FT Board concluded that its preferred strategic solution was to join with the RUH. This was reaffirmed in June 2013, although this could only be achieved once the RUH had achieved Foundation Trust status.

The key benefits of this transaction both for our patient population and for the local health economy have been endorsed by the boards of the RNHRD NHS FT and the RUH. Patients will see the continuation of high quality and sustainable services in updated facilities, together with the preservation of existing clinical knowledge and skills and a continued focus on patient outcomes.

Our excellent staff will experience the benefits of being part of an enlarged organisation. The commitment expressed by the RUH to value and maintain the RNHRD NHS FT brand and combine the existing expertise of the two highly regarded research and development departments is expected to further enhance the research and development profile through improved grant funding and clinical fellowships.

I and my Board colleagues believe that this solution is in the best interests of patients at this time as it delivers against our stated goal to maintain high-quality services, and will address the financial challenges which have led to the development of the strategic plan for acquisition.

This hospital could not have maintained its excellent reputation without the remarkable dedication of all our staff, clinical, nursing, and support services. I salute them all for their considerable support, together with the many hours of service by our team of volunteers. I also recognise most warmly our many hundreds of patients who have continued to choose

our hospital over recent years, and I have been humbled by their words of support and endorsement of our care for them.

As we have debated our future at considerable length with all our stakeholders I pay particular tribute to the significant commitment and professionalism of all our staff so ably led by Kirsty Matthews over the past five years, of our Council of Governors for their time and energy as they challenged and supported us, and of my Board colleagues for exceptional contribution and scrutiny of the future delivery of our clinical services. I cannot thank them all enough for their support of this great hospital.

Luke March
Chair
Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

Accounting Officer's Introduction

Following acquisition of the Royal National Hospital for Rheumatic Diseases by the Royal United Hospitals Bath NHS Foundation Trust on 1st February 2015 it falls to my responsibility as the Accounting Officer for the acquiring organisation to present this part year Annual Report covering the period up to acquisition.

The information provided in the report was prepared in draft form by the former Board of Directors of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust. Accordingly, to the best of my knowledge and belief the information contained in this report represents an accurate picture of the FT up to the date of acquisition on 1st February 2015.

A draft of this report was reviewed pre-audit by the Board of Directors of the RNHRD at its last closed meeting on 28 January 2015 following robust scrutiny of relevant sections by its Board sub-committees.

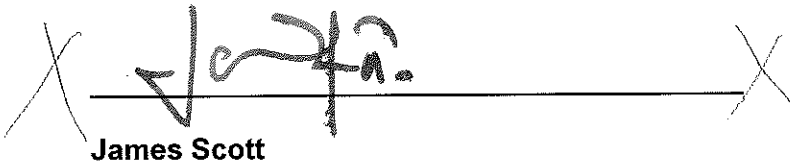
I would like to thank the directors and other colleagues of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust who contributed to the compilation of this report and provided the information it contains. More significantly, I would very much like to thank them and all the staff for their continued commitment to the delivery of high-quality, safe and effective services, during a challenging time for the organisation.

During 2014/15, this report shows that the organisation maintained a strong focus on quality and staff engagement. At the same time, although it did not become financially sustainable, the Trust did achieve a significant improvement in its financial position, finishing the year ahead of the previous year's financial position by approximately £0.4m before accounting for restructuring costs (operating deficit before restructuring costs £0.7m in 2014/15, £1.1m in 2013/14).

We have worked successfully together with the Royal National Hospital for Rheumatic Diseases for many years and over the period of this report developed a shared ambition for sustainability of its highly valued patient services along with some shared principles:

- Continuing to recognise and build on the brand and reputation of the RNHRD
- A future which continues to be clinically led
- Creating a centre of excellence, driven by evidence-based innovation, supported by a strong Research and Development offering
- Highest quality care provided from contemporary healthcare environments
- Staff supported to lead innovation.

Work to deliver on these is now underway.



James Scott

Chief Executive,
Royal United Hospitals Bath NHS Foundation Trust

29 April 2015

Strategic Report

Introduction

The Royal United Hospitals Bath NHS Foundation Trust (RUH) Board of Directors and Council of Governors approved the proposals for the acquisition of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RNHRD NHS FT) on 17 and 18 December 2014 respectively.

This followed approval by the RNHRD NHS FT Board of Directors, formally supported by the RNHRD NHS FT Council of Governors on the 27 November and 2 December 2014. In January 2015 a joint application was put forward to the health regulator Monitor with the plan that, pending their agreement, it was anticipated that the earliest the transaction would take place was the beginning of February 2015. The grant of application for acquisition was issued by Monitor on 28 January 2015 with an effective date of 1 February 2015.

To ensure the proposed acquisition delivered the shared ambition of maintaining and enhancing patient care, the RUH developed an integration plan with the RNHRD NHS FT to describe how all trust clinical services would continue to be provided in line with commissioner requirements.

The RNHRD NHS FT first recognised it was too small to be financially stable in the longer term in 2008 and when it started to require financial support in 2011/12 it carried out a rigorous options appraisal exercise identifying that joining with the RUH was its preferred strategic solution. In July 2012, the boards of the RUH and RNHRD NHS FT agreed to develop a proposal to come together as a single NHS Foundation Trust. Following enforcement undertakings from Monitor in April 2013 to ensure plans were in place to deal with the continuing financial issues, the strategic intent was reaffirmed in June 2013, with the mechanism identified as acquisition, once the RUH had achieved Foundation Trust status and subject to all regulatory conditions being satisfied.

In October 2013, in line with the requirement of the enforcement undertakings, the board of the RNHRD NHS FT submitted a strategic plan to Monitor, including an options appraisal, with regard to the proposed acquisition. A letter was then received from Monitor, dated 21 March 2014, which confirmed Monitor's support for the trust's preferred option to maintain continuity of service by transferring services to the RUH. The transaction project structure was agreed by the two boards early in 2014/15 and detailed planning for the delivery of a successful acquisition took place from April 2014 to January 2015. The RUH was formally authorised as a Foundation Trust on 1 November 2014. This enabled the RUH to commence the statutory transaction of acquisition of the RNHRD NHS FT.

Over this period the RNHRD NHS FT has continued to deliver high-quality services to our patient population whilst continuing to secure a strategic solution to ensure continuity of those high-quality patient services. The RNHRD NHS FT and the RUH have worked closely together over many years across the clinical and senior management teams to deliver an effective acquisition process that will secure benefits for the patients, both current and future, of the RNHRD NHS FT services. Acquisition of the trust by the RUH is therefore considered

the optimum solution to resolve the underlying issues that have led to the non-sustainable financial position.

The RNHRD NHS FT and the RUH agreed a set of overarching principles for the transaction which informed the transaction process accordingly and include:

Benefits to patients and communities served
The integration of the two trusts is anticipated to achieve a number of specific benefits for the patients and communities they jointly serve, principally:

Integration
In joining together, more integrated services will be developed. This will support further expansion of shared-care models, particularly for patients with multiple, and complex long-term conditions. In time, this is expected to lead to further development of new service models in areas such as therapies and self-management in line with the national direction of travel. Access to specialist expertise and diagnostics will also be extended.

Sustainability
Through integration of service models and closer working with community partners, services will be sustainable for the future, both financially and operationally. All clinical services are expected to continue in line with commissioner requirements.

The ability to fully integrate and align services on a single site with access to a wider range of corporate support for RNHRD NHS FT clinicians will improve efficiency and effectiveness, maintaining patient experience and quality of service delivery as well as increasing value for money from the public purse. Risks to ongoing financial stability which are naturally inherent in small-scale operations with peaks and troughs of demand and supply will also be significantly reduced.

Profile & people
The profile and brand of the RNHRD NHS FT is both nationally and internationally recognised. This will continue to be maintained and further developed ensuring that high-quality, innovative service models are supported and, in turn, promote further research investment in the local area and will ensure that the strong track record of both organisations in recruiting high-calibre staff can continue.

Service development
The plans for the future development of services have been produced jointly between the organisations and clinical teams. These plans take into account local concerns such as ensuring the development and delivery of a long-term strategy for valued local amenities, for example, hydrotherapy, as well as the wider direction of travel from commissioners, focusing on:

- delivering innovative care for patients across our community
- reducing reliance on bed-based models of care where appropriate
- increasing self-care through empowering our patients and supporting them with community-based delivery
- delivering quality and operational performance standards across all services, aligned with national best practice

- through delivery of all of the above, contain costs of service provision now and in the future.

Research and Development (R&D)
The combined organisation will have the second largest R&D portfolio amongst medium-sized hospitals.

As the RUH and RNHRD NHS FT have very different research areas, the acquisition will result at a simple level in the addition of the studies of both hospitals whilst maintaining recognition of both brands. The joining is, however, expected to also provide significant growth in research as bid writing, research culture and fund management are further strengthened alongside access to a larger population for clinical trials.

It is hoped to grow other existing research-active areas in the RUH, so that each year more areas are made substantive research areas. It is intended to bring much of the good practice of R&D at the RNHRD NHS FT to the merged hospital, such as a 'joint' impressive yearly R&D report and a new external website dedicated to R&D with monthly R&D newsletters.

Environment
The acquisition affords the opportunity to enhance the quality of the patient environment, ensuring its long-term fitness for purpose. Although it is recognised that the RNHRD building is highly regarded by patients, it is unlikely to support the sustainable provision of the current high-quality services in the longer term.

It is expected that services will continue to be delivered from the existing RNHRD building for at least the next three years, but that during this time work will be undertaken within wider estates plans at the RUH to develop purpose-designed environments which benefit patient experience and support improved efficiency and effectiveness of delivery through appropriate scaling, workflow design and co-location with other services. Opportunities for branding of elements of the new estate would also ensure that the long-term legacy of the RNHRD NHS FT can be protected.

Patient experience
The only change to patient experience on day one of acquisition is the relocation of endoscopy services to the RUH site, addressing challenges to the service as provided at the RNHRD NHS FT.

Support for the acquisition, based on the principles and vision, was sought and received from primary commissioners.

Background information

Founded in 1738 the Royal National Hospital for Rheumatic Diseases (RNHRD), also known as 'The Min', a reference to its original name 'The Mineral Water Hospital', is a specialist hospital in central Bath with an international reputation for research and expertise in specialist rehabilitation for complex long-term conditions. The core services the hospital provides are in rheumatology, pain management, and fatigue management i.e. Chronic Fatigue Syndrome/ME (CFS/ME) and post-cancer fatigue. It also provides diagnostic Clinical Imaging and Measurement services.

The RNHRD has a strong tradition of innovation. It was one of the earliest hospitals in the world to specialise in the treatment of rheumatic diseases, and was the first truly national hospital to be founded in Great Britain, admitting patients from all over the country. The specialist rehabilitation skills required for the management of rheumatic diseases led to the development of services for the management of chronic pain and fatigue. In 1991 it was one of the first wave of NHS trusts and in 2005 became a second wave NHS Foundation Trust.

It has been a core principle throughout the RNHRD's evolution to combine clinical research and development with the focus on high-quality patient care to meet patient needs. Its clinical reputation is augmented by research. These factors have maintained, on a national and international basis, the RNHRD's reputation amongst patients and referrers for clinical excellence.

Principal activities

The RNHRD provides services in line with local, specialist and national commissioning intentions. It delivers a range of general and specialist outpatient and inpatient rheumatology and rehabilitation services, including services for inflammatory and non-inflammatory rheumatic disease, complex pain and fatigue management. These services support both the local population and attract referrals from across the UK, and are supported by clinical measurement and diagnostic imaging services.

Services are provided for children, adolescents, young adults and adults. The core clinical activities aim, through a specialist, multidisciplinary approach, to:

- address patient needs, limit disability and maximise quality of life
- equip patients with the skills and tools they need to be able to function to their optimum level
- reduce demand on health and social care post-discharge.

More information on the services provided is set out on pages 15-19. The RNHRD has an excellent reputation for research both nationally and internationally. Research informs the treatment programmes and contributes to a better understanding of many of the conditions that the hospital specialises in. Further information about Research and Development activities can be found on pages 27-29.

Business review

The RNHRD is proud of its legacy and of the very significant contribution the hospital has made to the development, in both the understanding and treatment, of the specialist services it provides. In spite of these attributes, the RNHRD NHS FT recognised that as the smallest Foundation Trust in England, the organisation was not financially sustainable as a stand-alone Foundation Trust and it was essential that the trust joined with a larger organisation where benefits of scale and greater financial stability would be achieved. This is the strategic intent to which the organisation worked throughout 2014/15 resulting in the approval of the grant of acquisition by Monitor at the end of January 2015 leading to the acquisition of the RNHRD NHS FT by the RUH NHS FT on 1 February 2015.

Developments and performance during 2014/15

The period to 31 January 2015 showed an increase in income of £1,012k across the services when compared to the same period for the previous year. Overall, the analysis of the percentage income by commissioner shows consistency with the previous year. Specialist commissioning continues at approximately 20% of total patient-related income, a reflection of the specialist, complex nature of the services provided.

Endoscopy activity continued to decline during 2014/15. This continued reduction in activity and the requirement to optimise operational delivery resulted in the proposal to relocate the service to the RUH with effect from 1 February 2015. Rheumatology inpatient services saw a significant increase in activity with much of this increase relating to referrals from out of area. Locally, additional funding was secured to develop a Rheumatology Coping Skills programme which is in accordance with the commissioning plans to support patients with self-management. Funding for the Macmillan Step Up programme was originally in place to December 2014, and an extension to 31 March 2015 was agreed with Macmillan to allow time for NHS funding for the programme to be secured.

Activity overview

Overall income relating to direct patient activity was £527k higher than planned for the ten months, which contributes to the over-performance against plan in the period. The 2014/15 commissioning intentions described planned activity at similar levels to 2013/14 for most services.

Following the transfer of commissioning of the Pain services from clinical commissioning groups (CCGs) to NHS England there has been a steady increase in the number of patients seen in the service, beyond that anticipated in the 2014/15 plan. This is in part due to patients who were previously unable to access the service, but clinically appropriate for the programme.

The issue of balance around clinical income and maintaining alignment with commissioning intentions remains one of the major challenges in the years ahead.

Activity across all services: Numbers of patients

Service area	2014/15 month 1 to month10 No of patients	2013/14 month 1 to month10 No of patients	% Difference month 1 to month10	2013/14 month 1 to month 12
Rheumatology admitted episodes	1,692	1,577	7%	2,268
Rheumatology outpatient attendances	16,671	17,260	-3%	20,864
Rheumatology day cases	1,492	1,378	8%	1,617
Therapy outpatients	9,830	8,289	19%	10,056
Pain management admitted episodes	102	76	34%	107
Pain management outpatient attendances	522	362	44%	423
CFS/ME adult outpatient attendances	903	822	10%	1,103
Macmillan Step Up outpatient attendances	290	164	77%	218
CFS/ME Paediatric outpatient attendances	2,075	1,828	14%	2,186
Endoscopy episodes	585	678	-14%	801
Clinical Measurement outpatient attendances	4,393	4,395	0%	5,270
CRPS inpatient bed days	975	1,063	-8%	1,235
CRPS outpatient attendances	573	649	-12%	792
BRIRS inpatient bed days	188	155	21%	180
BRIRS outpatient attendances	153	213	-28%	231

NB: Data excludes Dermatology and Orthopaedic outpatient attendances

Rheumatology

There was an increase in activity across Rheumatology services during 2014/15 compared with the same period in 2013/14. The majority of this was across inpatients and day cases and reflects an increasing proportion of specialist referrals from out of area. Rheumatology outpatient activity is slightly reduced when compared to last year. In addition there was a significant increase in therapy outpatient activity throughout the year. Referrals from General Practitioners (GPs) have increased during the ten-month reporting period.

Significant achievements of the rheumatology service during 2014/15 include:

- establishing the RNHRD NHS FT as a centre for the delivery of the RA Self-management Programme in collaboration with the National Rheumatoid Arthritis Society & Self-Management UK
- developing a Fibromyalgia Coping Skills Programme (FCSP) clinical database which is linked to a 2014/15 CQUIN

- initiating links with Wiltshire CCGs with a view to developing satellite centres to deliver FCSP and improve fibromyalgia patient pathways
- improved links with the National Institute for Health Research (NIHR) Clinical Research Network (CLRN) West of England
- continued collaborative working with the RUH to promote and develop an innovative hydrotherapy environment
- opening a new biologics day unit which has further improved the patient experience and patient confidentiality
- appointment of two associate specialist nurses to support biologics
- demonstrating appropriate case-mix of patients seen at the RNHRD with inflammatory rheumatic diseases
- progressing the Early Synovitis clinic and integration with the BSR National Clinical Audit
- developing a Lupus annual review clinic and an Early Inflammatory Back Pain clinic.

Pain Services

The RNHRD provides a number of specialist pain services as described below:

i) Pain management

The Bath Centre for Pain Services is a national and international provider of services for patients with highly complex conditions. Patients are predominantly from the NHS, however, private patient numbers are steadily increasing.

Activity in Pain Services for 2014/15 continues to be unevenly distributed across the year as previous years, with a peak in activity anticipated over the last quarter. The service has continued to see an increase in complexity of the patients being referred, which is reflective of the shift to treating appropriate patients closer to home and reinforces the need for highly specialist and intensive residential and ward-based treatment options for the more complex patient group. In addition, there has been an overall increase in referrals for children and young people.

There has been a shift in activity during the second half of the year with an increase in adult programme activity and a planned minor reduction in adolescent programme activity. The service ran three streams of activity throughout months nine and 10; in March 2015 there will be a four-week residential programme and an additional four-week ward-based programme running alongside each other with no clinical capacity for a third stream. The planned programmes are changed to accommodate the needs of the patients.

The majority of activity undertaken by the Pain Service is commissioned via specialist commissioning; an established pathway is in place and rigorously maintained but following the removal of the requirement for individual funding approval access for appropriate patients is now less complex and more timely. Referrals up to the end of month 10 increased by 12% against the same period 2013/2014.

Referrals continue to be triaged and only appropriate referrals are accepted. Assessment clinics remain full and if patients cancel their appointment, the slot is filled immediately.

Referrals are received for three categories of patients: adults (over 30 years), young adults (18-30 yrs) and adolescents (up to 18 yrs). Between 1 April 2014 and 31 January 2015 each of the patient group's conversion rates from referral to assessment was approximately 60% with assessment to treatment at around 75% and above. The main reason for a referral not to convert to an assessment is when the patient would not have followed the correct clinical pathway.

Significant achievements during 2014/15 include:

- flexible planning of programmes and treatment interventions in response to the changing referral patterns and so meeting the significant increase in demand
- delivering against the service's research and development, education and service development agendas
- developing interventions for complex patients requiring admission
- developing interventions for younger children
- obtaining grant funding for three studies, including an AHP internship
- leading and submitting a grant application for Research for Patient Benefit.

ii) Complex regional pain syndrome (CRPS)

The CRPS service provides services on a national and international basis. Patient numbers are predominantly from the NHS but private patient referrals are steadily increasing. The service has seen steady growth supported by good research and evidence-based outcomes. The clinical team continues to raise awareness of the condition, both nationally and internationally.

In 2014 the CRPS service moved to specialist commissioning; the referral pathway remains unchanged apart from the removal of the prior approval process. A significant difference is that the inpatient element of the service is now commissioned as a block contract, whilst the outpatient element remains variable.

Significant achievements during 2014/15 include:

- service lead Professor Candy McCabe was awarded the Florence Nightingale Foundation Chair in Clinical Practice Research in collaboration with UWE
- continued strong research activity within the service and hosted international collaborations; COMPACT (an international initiative to establish research outcomes measures in CRPS) and the RECOVERY study (an international initiative to explore what CRPS recovery means to clinicians and patients)
- provision of education events for clinicians around the country to learn more about CRPS and effective management of the condition.

iii) Breast Radiotherapy Injury Rehabilitation Service (BRIRS)

BRIRS is funded by highly specialised commissioning and, until recently, has been delivered in collaboration with The Christie NHS Foundation Trust, and Barts Health NHS Trust, with treatment delivery being led by the RNHRD NHS FT. The RNHRD is now the sole provider of this service.

Referrals are significantly less than the same period in 2013/2014, in part due to lack of activity through the subcontracted hospitals.

Significant achievements during 2014/15 include:

- continued research to evaluate the experience of patients undergoing treatment for breast cancer now compared with the cohort of women that have used BRIRS
- patients reported improvement in function and quality of life as high
- several abstracts accepted for presentation at conferences
- involvement in a steering group for a regional service to help patients recover from pelvic radiotherapy.

Fatigue Management Services

Significant achievements for Fatigue Management services are outlined below:

i) Adult Fatigue Management Services (CFS/ME, post-cancer fatigue and enduring fatigue in other long-term conditions)

Referrals remained consistent for the first half of the year against the same period during 2013/2014 for the trust's adult CFS/ME and cancer-related fatigue services. In addition, the Adult Fatigue Management Service has seen an increase in referrals for people with enduring fatigue linked to other medically stable long-term conditions, and a shift in referrals for people with complex needs where fatigue is significantly impacting everyday activities.

At the end of January first attendances are marginally under plan and it is likely that there will be an under performance at the end-of-year position. Follow-up activity is over planned levels and is likely to remain as an over-performance at the end of the year. The increase in follow-up activity can be attributed to an increased need to provide treatment on an individual basis over six sessions, and is reflective of the increase in complex patients.

Significant achievements during 2014/15 include:

- strengthened reputation for all three strands of the service as demonstrated by referral trends
- established effective self-referral for those with cancer-related fatigue
- embedded evidence-based Multiple Sclerosis fatigue management practice within the team
- growth of SKYPE interventions where appropriate
- continued recruitment of patient educators which has provided valuable experience to educate other patients and inform service development
- embedded cancer pathway working with acute sector colleagues at the RUH in the provision of end-of-treatment health and wellbeing days
- designed and implemented family and friends sessions to support carers and significant others
- continued delivery of research and development
- nominated as show case exemplar for NHS England National Rehabilitation Conference, March 2015.

ii) Fatigue Management Services – Paediatric CFS/ME

There has been an increase in activity of 14% in the ten months of 14/15 when compared to the same period last year and domiciliary assessments nearly doubled over the same period. During the same period, the service increased telephone follow-up assessments.

Significant achievements during 2014/15 include:

- establishment of five new clinics increasing accessibility for children and families
- recruitment of patients to the RECOVERY study.

Clinical Measurement and Imaging

Throughout 2014/15 the Clinical Measurement and Imaging department has continued to provide a range of specialist internal and external services including X-ray, bone mineral densitometry (BMD) and specialist imaging and measurement techniques for RNHRD patients.

Referrals in 2014/2015 have increased by approximately 8% against the same period in 2013/2014. At the end of month 10 all areas were performing above planned levels reflecting the increase in referral rates.

Significant achievements during 2014/15 include:

- extended Integrated Clinical Environment (ICE) electronic requesting and reporting of direct access BMD referrals to all GP practices in-line with GP feedback
- completed implementation of electronic requesting for RUH radiology
- direct referrals from RUH fracture clinic to DEXA investigation agreed and implemented for patients under both B&NES and Wiltshire CCGs
- completed feasibility study measuring left-right temperature difference of limbs over 24hrs with CRPS patients
- continuing to recruit and assess patients for a pilot study with North Bristol NHS Trust to investigate the effect of parenteral osteoporosis treatments on fat metabolism.

Position of the business at dissolution 31 January 2015

Financial analysis

From a financial perspective, 2014/15 saw a continuation of the challenges from the previous year with a recognition that the trust would not be able to produce a balanced plan, and would therefore be in breach of its provider licence. Funding to support the trust's cashflow position through the year was agreed with Monitor in the form of a drawdown facility of Public Dividend Capital, of which £1m was accessed in January 2015. With this assistance, the trust was able to successfully manage its cashflow, without compromising its responsibility to suppliers, ending the period with a cash balance of £852k, a reduction of £800k against the opening cash position of £1,652k.

Our financial objectives as an NHS Foundation Trust

The overarching financial objective for 2014/15 was to deliver the financial plan, continuing the successful minimisation of the underlying deficit and delivering efficiencies across the organisation wherever possible. In order to achieve this aim the specific objectives were as follows:

- To deliver the financial plan for 2014/15, to include:

- delivering activity plans to maximise income
- managing cash throughout the year
- production of timely and accurate forecasting
- working with commissioners to deliver on Quality Innovation Productivity and Prevention (QIPP)

- Increasing productivity and reducing costs in addition to the QIPP targets.

In the period to 31 January 2015, the trust recorded a retained deficit for the 10 months of £1,505k, including restructuring costs of £698k. The deficit before restructuring costs of £807k for the 10 months was achieved against a deficit as described in the trust's 2014/15 Annual Plan of £2,205k for 12 months. This compares to a deficit of £1,125k in 2013/14. As part of the improved performance against plan, the trust delivered a cost improvement programme of £368k during the 10 months. The trust successfully managed cost improvements and efficiencies to maintain the operating performance at a similar level to prior period, despite the tariff deflation and pay inflation that occurred.

Business model

The RNHRD's business model is based around the core service provision of Rheumatology, Pain and Fatigue Management in a predominantly outpatient setting. There is one inpatient ward, with a capacity of 20 beds, and a day-case unit. In addition, there are a number of residential programmes, which are not ward-based with patients attending these programmes staying in residential beds close to the hospital. It has a small diagnostics and clinical measurement provision to support the patient population, but does not provide any emergency services. Approximately one third of the income in-year relates to high-cost drugs, and this is matched by expenditure of the same value.

There has been no significant change in core objectives and activities over 2014/15. Given the financial challenges faced by the trust and in line with the enforcement undertakings from Monitor, it was the strategic intent of the RNHRD NHS FT to be acquired by the RUH once they were authorised as a Foundation Trust and subject to all conditions being satisfied. The acquisition was successfully completed at 1 February 2015.

Due to the specialist nature of the services, patients can be referred from across the UK, and this is reflected in the analysis of income by commissioners. Of the patient-related income, 23% is from the contract with B&NES, 24% Wiltshire, 23% NHS England, with the balance being non-contract activity.

Income overview

Income across all services has been affected by year-on-year tariff reductions, with 2014/15 seeing an average of 1.5% reduction in tariff when compared to 2013/14. This deflation is anticipated to continue and was described in the operational plan for the years 2014/15 through 2015/16, where the annual impact is assessed to be approximately 1.5% which equates to £136k per annum.

Rheumatology and diagnostic services fall under the national 'Payment by Results' system which is based on a single tariff across all providers on a per-case basis. Other services are based on a local tariff due to their specialist nature. This included the CRPS service from 2014/15, which has previously been recorded and charged within the rheumatology services.

All the contracts, with the exception of BRIRS, and CRPS inpatients, are variable and therefore income is totally aligned to the volume of activity within these services.

Details of activity income by service area is provided in note 2 to the Accounts. Further analysis of all patient related and other income is provided in notes 3 to 4 to the Accounts.

Overall, the amount of income the trust received from the provision of goods and services for the purposes of the health service in England was greater than its income for the provision of goods and services for any other purpose. The RNHRD's income is primarily from NHS clinical activities, but it also received income from education, training and research, private patients and non-clinical services such as running conferences and from catering services. The income generated from additional activities serves to enhance patient care and further knowledge and understanding of the conditions treated at the trust.

The increase in income is aligned to the increases in activity as shown in the activity overview on page 15. There was an increase in rheumatology inpatient, day case and therapy services activity over the 10 months, with rheumatology outpatient attendances reducing over the same period. Pain, CRPS and CFS/ME services have all seen increased activity leading to higher income; while BRIRS inpatient activity has increased CRPS inpatient activity and both services' outpatient attendances have fallen.

Private patient income makes up a small but important element of the total, and this is a potential area for expansion.

The R&D income at RNHRD is proportionately greater than average as a percentage of revenue. Again, this is a reflection of the specialist nature of the services at the trust, and the strength and depth of relationships with educational institutions, as a number of clinical staff have joint appointments. R&D income in 2014/15 is slightly lower than 2013/14 - the grants may span a number of years, with income falling due at various stages of the research.

During 2013/14 a number of projects were identified to which income from Charitable Funds could contribute. However, due to the size and complexity of these projects, they commenced during 2014/15. This has led to an increase in income from Charitable Funds to the trust in 2014/15 when compared to 2013/14.

Expenditure overview

The RNHRD NHS FT sought to deliver efficiencies through 2014/15, and to maintain tight control over expenditure and vacancy management. The budget for 2014/15 was based on the previous year's budget, adjusted for specific expected increases such as inflation, and changes to service delivery, and also included project costs associated with the planned acquisition. There was a £310k budget for cost improvements and this has been exceeded by £58k, with actual savings of £368k, contributing to the reduction in deficit when compared to plan.

Expenditure in-year was significantly below plan as a result of close cost management and appropriate vacancy control. Staff costs increased over the previous year due to pay inflation, annual increments awarded. These inflationary pressures will continue in 2015/16. Communication to stakeholders, including staff, on the financial position was a key objective for the executive team. This was led through the Chief Executive's all-staff briefing sessions.

There was a strong focus on engaging with managers for monthly outturn forecasting of activity and expenditure to support the information presented to the board and available in the public domain. In addition to the detailed analysis provided to the board sub-committees, the key operational and financial information was cascaded through the organisation at management meetings and team briefing sessions. This enabled staff and stakeholders to understand and contribute to the strategic plans for the trust. Further, the format of the information was further developed in the service line presentation, which helped to determine where efficiencies could be delivered, and contribution increased.

Detail of expenditure is provided in note 5.1 to the Accounts.

The RNHRD NHS FT expected to incur a deficit during the financial year 2014/15 and as a result required additional external funding from the Department of Health.

There was close management of debtors to maximise the cash position, with most income to the trust forming part of an NHS contract and therefore received promptly. Total debtors more than 30 days past their due date amounted to £252k, compared to £310k at 31 March 2014 (notes 14.1 and 14.2 of the Accounts).

At the beginning of the financial period the trust had net current assets (being the amount in the bank plus the amount owed to the trust by debtors, e.g. customers and commissioners, less the amount the trust owes to creditors such as suppliers) of £296k. As at 31 January 2015, the trust had net current liabilities of £11k.

Capital expenditure in 2014/15

Capital expenditure during 2014/15 focused on maintaining safety and upgrading essential equipment. Capital expenditure in the 10 months was £257k, compared to £58k during 2013/14.

Disclosures relating to market values of non-current assets are included in the Accounts on pages 129-130. As a consequence of a revaluation of the property assets by Boshier and Company, Chartered Surveyors, at 31 January 2015, an increase in the overall value of freehold buildings of £250k was recognised in the Statement of Comprehensive Income and Statement of Taxpayers' and others' Equity. The value of land remains unchanged.

Better Payment Practice Code

Measure of compliance	**2014/15**		**2013/14**	
Non-NHS trade invoices	Number	£000	Number	£000
Total bills paid in the year	**3,061**	**6,979**	3,720	7,475
Total bills paid within target	**1,947**	**4,222**	2,615	5,415
Percentage of bills paid within target	**63.61%**	**60.50%**	70.30%	72.44%

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

Financial governance and outlook

The trust was found to be in significant breach of its terms of authorisation by Monitor in May 2012 and remained so until dissolution of the Foundation Trust upon acquisition. In April 2013 under the new Foundation Trust Provider Licence regime, Monitor wrote to the RNHRD NHS FT specifying enforcement undertakings on its provider licence, and actions to include submission of a strategic plan to resolve the underlying financial issues. The trust was also required to report monthly to Monitor on the financial position, and to submit weekly a rolling cashflow forecast for the three months ahead.

At the end of quarter three, the trust achieved a Continuity of Services Risk Rating of 3, and a Governance Risk Rating of red against Monitor's Risk Assessment Framework.

Local commissioners have been engaged with healthcare providers in determining the future requirements of the local health economy, within the context of their future funding expectations. This is anticipated to result in demand management by GPs, and a move to provision of more services within the community, which could impact the trust over the coming years. Nationally the NHS has to make £20 billion savings over the next three years. There is recognition that there needs to be significant change across the health sector to deliver these savings, which come on top of year-on-year reductions in national tariff.

Against this financial climate for health services, the operational plan submitted to Monitor for 2014/15 through 2015/16 showed the trust continuing to be in deficit. The overarching financial objective for the year was to deliver the financial plan for 2014/15, minimising the underlying deficit and delivering efficiencies across the organisation, and the operational plan includes challenging cost improvement and efficiency targets.

Losses and special payments

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis. (See note 27 to the Accounts).

Going concern

International Accounting Standards (IAS1) requires the Directors to assess, as part of the Accounts preparation process, the Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trust Annual Reporting Manual paragraph 3.20, the financial statements should be prepared on a going-concern basis unless the Directors either intend to apply to the Secretary of State for the dissolution of the Foundation Trust without the transfer of the services to another entity, or have no realistic alternative but to do so.

The trust transferred its services, by way of an acquisition, to another NHS Foundation Trust with effect from 1 February 2015, thereby assuring the ongoing delivery of those services. Consequently, these Accounts have been prepared as final closing Accounts of the Foundation Trust on a going-concern basis, and the Directors of the acquiring organisation have confirmed that all the services will transfer and continue for the foreseeable future and at least the next 12 months.

External auditors

The external auditor for RNHRD NHS FT is: PricewaterhouseCoopers LLP, 31 Great George Street, Bristol, BS1 5QD. The total cost of audit services for the 10 months was £75k. This was for the statutory audit of Accounts for the 10 months ended 31 January 2015 (£57k) and planned non-audit work (£18k). All amounts are inclusive of VAT.

Accounts

Full details of the trust's 2014/15 financial position can be found in the trust's audited consolidated Accounts (from page 87 of this report). The Accounts have been prepared under a direction issued by Monitor under the National Health Service Act 2006. The accounting policies are set out in note 1 of the Accounts. Accounting policies for pensions and other retirement benefits are set out in note 6, page 125-126 to the Accounts. Disclosures in relation to the going concern assumption can be found in note 1.2 to the Accounts.

The trust's employees

The trust employs 345* staff and directors, (which equates to 233.38 full-time equivalents), 63 of these employees are on Bank contracts (zero hours).

*Correct as of the 30/03/2015 based on a reporting date of 31 January 2015.

Environmental matters

Recognising the need to operate economically and ethically the trust was committed to reducing its carbon emissions and taking actions to reduce its impact on the environment. As an example, it continued to manage its waste using segregation to support recycling, reduce incineration, avoid the unnecessary treatment of non-hazardous waste as hazardous thereby reducing energy use and carbon emissions, and reduce overall waste. The hospital procured gas and electricity through a contract that stipulates that a proportion of electricity must be generated from 'green' sources.

Principal risks and uncertainties

The trust faces a number of operational, strategic and financial risks. These are described in more detail in the Annual Governance Statement on pages 91 to 100 of this report.

Principal risks facing the trust in 2014/15 included:

- Loss of key personnel – business continuity risk
- Delay in Rheumatology follow-ups
- Failure to meet provider licence conditions due to risks detailed in and 4, 6 & 7
- Risk to occurrence of the potential acquisition by the RUH
- Risk to RNHRD brand on acquisition by RUH
- Failure to meet cash targets and/or obtain funding required to meet the cash shortfalls forecast.

Future trends

Commissioning meetings for 2015/16 with local and national commissioning groups were based on the underlying assumption that activity at the RNHRD NHS FT would remain constant and consistent with the current year 2014/15.

Longer term commissioning plans for rheumatology services across the local area point to a model which is more community-based, and forms part of a fully integrated musculoskeletal service. More broadly, commissioners are keen to work with the RNHRD to look at ways in which the growing demand for trust services can be managed, ensuring services remain affordable to the wider health economy.

Social, community and human rights

All trust policies and procedures were based on national employment legislation, adhered to the NHS constitution staff pledges and contained an equality and diversity impact assessment – to ensure upholding of social, community and human rights principles. During 2014/15 the trust had no social, community or human rights violation issues.

Strategy

RNHRD Vision:

'To transform the lives of people affected by complex long-term conditions'

RNHRD's strategic objective:

'To deliver against a strategic plan that is in the best interest of patients, maintains service continuity and delivers high quality and safe services whilst addressing the underlying financial issues that have led to the RNHRD NHS FT's non-compliance with its licence.'

Strategic plan

The RNHRD NHS FT continued to face significant and long-standing financial challenges during 2014/15 as a result of which it could not continue in its current organisational form and needed to secure plans to change. Following a rigorous options appraisal exercise in 2012, the RNHRD NHS FT identified its preferred strategic solution was to join with the RUH.

In April 2013 under the new Foundation Trust Provider Licence regime, Monitor wrote to the RNHRD NHS FT specifying enforcement undertakings on its provider licence. The principal actions were to submit by the end of June 2013 a strategic intent for resolving the financial issues, followed by the submission of a realistic and deliverable strategic plan by the end of September 2013. Both intent and plan *'must aim to deliver a solution that is in the best interests of patients and maintains high quality services, whilst addressing the financial issues that have led to the RNHRD NHS FT's non-compliance with its Licence'.*

The strategic intent was reaffirmed in June 2013, with the route identified as acquisition, once the RUH had achieved Foundation Trust status and subject to all conditions being satisfied.

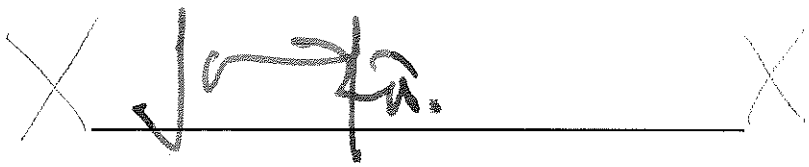
The trust's strategic plan was submitted to Monitor for consideration in October 2013. Following a period of robust evaluation, key stakeholder engagement and consideration of the plan, it was agreed that the RNHRD NHS FT would continue to proceed with the RUH as its preferred strategic partner to ensure continuity of its high quality services through acquisition of the RNHRD NHS FT once the RUH has achieved FT status, and subject to all conditions being satisfied. This was concluded through the issuing of the Grant of Acquisition by Monitor on 28 January 2015 with acquisition of the RNHRD NHS FT by the RUH on 1 February 2015.

The number of male and female employees

Information about the number of male and female employees is outlined in the table below:

		Directors	Employees
Gender	Male	5	58
	Female	5	277
Total		10	335

NB: Correct as at 30/03/2015



James Scott

Chief Executive,
Royal United Hospitals Bath NHS Foundation Trust

29 April 2015

Directors' Report

This report is presented in accordance with the NHS foundation trust Code of Governance and the NHS foundation trust annual reporting manual 2014/15 published in March 2015. The Directors have responsibility for preparing the annual report and accounts and consider that, taken as a whole, they are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. A review of the trust's business during 2014/15 can be found in the strategic report on pages 10 - 26.

Directors

The Directors of the RNHRD NHS FT who served, and their positions, up to 31 January 2015 were:

Name	Role
Luke March	Chair / Non-Executive Director
Mike Attenborough-Cox	Non-Executive Director
Christopher Johns	Non-Executive Director Senior Independent Director
Sir Peter Spencer KCB	Non-Executive Director Vice Chair
Bernard Galton	Non-Executive Director (from 1 June 2014)
Kirsty Matthews	Chief Executive
Dr Ashok Bhalla	Medical Director (until 31 July 2014)
Dr Ellie Korendowych	Medical Director (from 1 August 2014)
Tracey Cotterill	Director of Finance
Rayna McDonald	Director of Operations and Clinical Practice, Director of Infection Prevention and Control and Deputy Chief Executive
Hayley Sewell	Director of Governance

Research and development

2014/15 has been a year of growth in many aspects for R&D at the RNHRD with a growing team, significant new grant awards and commercially funded trials. The number of projects on the National Institute for Health Research (NIHR) portfolio projects also continued to grow but there has been a reduction in the number of patients recruited to studies in-year when compared with previous years. Figures to the end of January 2015 are estimated at 470 with an anticipated recruitment figure at the end of March 2015 of 600.

This reduction can be attributed, in part, to a change in the balance of observational studies to interventional studies requiring more complex visits and often more visits per patient. In contrast to previous years there was no set NIHR network recruitment target for individual trusts, but the R&D committee had set an aspirational target of 775 new patients recruited to NIHR Portfolio studies for 2014/15 in the annual plan.

In 2014/15 there were 35 projects on the NIHR portfolio, an increase of two from 2013/14 and exceeding the local target set at 30. This included five interventional studies (non-industry sponsored). New areas of NIHR Portfolio research which commenced in 2013/14 have continued to expand with further research in paediatric and adult chronic fatigue and hypermobility.

The trust saw continued success in RNHRD-led and collaborative grant applications with six new grants, totalling £2.5m, awarded over 2014/15 which include:

- Prof Neil McHugh was awarded a five-year NIHR Programme grant of £1,969,581 to work in collaboration with eight academic and NHS partners studying early detection to improve outcome in patients with undiagnosed psoriatic arthritis (PsA)
- Prof Neil McHugh, Charlotte Cavill £85,300 (Celgene). An assessment of the resource utilisation and costs associated with patients with PsA and the association with disease severity (Health Assesment Questionnaire)
- Dr Phil Hamman was awarded a BSR fellowship to complete a PhD with the University of Bath and in conjunction with the BSR Biologics Registry (based at University of Manchester) £190,876
- Dr Victoria Flower and Dr John Pauling were awarded a grant from the Raynaud's and Scleroderma Association for Dr Flower to complete a PhD with the University of Bath £187,245
- Prof Candy McCabe £32,000 – Balgrist Foundation (Switzerland) to carry out an international project, COMPACT, CRPS Outcome Measures for Pain in Clinical Trials
- Sarah Wilson, Physiotherapist – NIHR Clinical Academic PhD preparatory grant £10,000.

The trust continued to review applications to Charitable Funds for small/pilot projects. These included projects in a variety of areas including:

- Breast Radiation Injury Rehabilitation
- Ankylosing Spondylitis and Psoriatic Arthritis
- Pain
- Chronic Fatigue Syndrome
- Scleroderma.

Significant progress in the use of research management software across all areas of the trust's portfolio has been achieved, along with the development of IT solutions to collect patient reported outcome measures for both clinical and research use.

Researchers were supported by the trust to engage in higher degrees and research training and several have been working towards PhD and Masters degrees and include Dr Will Tillett, awarded a PhD from the University of Bath based on his work at the trust into work disability for people with psoriatic arthritis. Dr Tillett returned to the trust as Consultant Rheumatologist in August 2014.

The trust also supported projects which were not NIHR registered and these included several carried out by students or pilot studies collecting important data to substantiate external grant applications, for example, those funded by the Royal National Hospital for Rheumatic Diseases Charitable Fund. The trust continued to work closely with local universities and other NHS trusts to nurture links and extend research collaborations.

There was significant growth in the research team with two data entry staff joining the database team and two senior healthcare assistants joining the research nurses to improve research delivery and patient recruitment. During 2014 the long-standing collaborative work with the Bath Institute for Rheumatic Diseases (BIRD) went through several changes as the charity moved their lab-based services to the RUH and the RNHRD set up blood sample processing from research trials and DNA preparation on site. Investment also took place to

ensure the bio-banks, previously housed in the BIRD building, were appropriately accommodated within the RNHRD.

Policies for potential and existing disabled employees

The trust operated within an equal opportunities policy framework and was recognised as a 'two-ticks' disability friendly employer. In November 2014 the Equality Delivery System which was implemented in 2011/12 was audited and it continued to meet relevant publication duties as set down in the Equality Act 2010.

In line with legislation, the trust made reasonable adjustments and offered appropriate training for colleagues or job applicants with disabilities. In addition, all RNHRD NHS FT policies and procedures carried a full equality and diversity impact assessment.

Information and involvement of employees

In order to achieve a common awareness of issues and matters affecting the trust, and to involve employees in decision making as appropriate, employees were regularly kept informed as to the performance of the trust. Formal mechanisms to ensure they were informed and involved included:

- the Links Partnership Committee (employees representative body) which met monthly
- monthly Senior Management Group meetings
- the involvement of employee representatives on the Council of Governors
- Chief Executive monthly face-to-face briefings open to all staff which was followed up by a written briefing.

In addition, to support the annual business planning process, a series of business planning meetings took place across the trust in order to engage employees in business planning, to achieve a common awareness of financial and economic factors affecting the trust, and to raise awareness of the important part they play in helping the trust to achieve its organisational goals.

Financial risk management

There are no branches of the RNHRD outside the UK, and there was no exposure to the trust associated with Financial Instruments.

Political or charitable donations

In 2014/15 the trust did not make any political or charitable donations.

Enhanced Quality Governance Reporting

This section gives a brief overview of the arrangements in place to govern service quality and signposts to where quality governance and quality are discussed in more detail in the Annual Report.

The RNHRD NHS FT Board was requested by the Board of Directors of the RUH to provide a statement of assurance regarding quality governance at acquisition.

The following statement was recorded as approved by the RNHRD NHS FT board in its final closed meeting on Wednesday 28 January 2015:

> *"In line with the Monitor Q3 2014/15 return the RNHRD NHS Foundation Trust Board note that:-*
>
> *"Up to the 28th January 2015, and, as far as the Board can reasonably be aware, the RNHRD Trust Board is satisfied that there is clear accountability for quality of care throughout the RNHRD NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate."*

The trust had regard to Monitor's quality governance framework in arriving at its overall evaluation of the organisation's performance, internal control and board assurance framework and a summary of action plans to improve the governance of quality.

Further detail can be found on the following pages of this annual report:

- Information on how the trust used its Foundation Trust status to develop its services and improve patient care can be found on pages 10-19
- Performance against key healthcare targets can be found on page 67-73
- Arrangements for monitoring improvements in the quality of healthcare and progress towards meeting any national and local targets, incorporating Care Quality Commission assessments and reviews and the trust's response to any recommendations made can be found on page 61-81
- Progress towards targets as agreed with local commissioners and details of key quality improvements can be found on pages 62-64 and 67
- Information on new or revised services can be found on pages 10-19
- Information on service improvements following staff or patient surveys/comments and Care Quality Commission reports can be found on page 62-64 and page 67
- Information on improvements in patient/carer information can be found on page 79
- Information on complaints handling can be found on page 77-79.

The trust met all the key quality performance indicators in Monitor's Risk Assessment Framework throughout 2014/15 with the exception of the maximum time of 18 weeks from point of referral to treatment in aggregate for non-admitted patients in August 2014 (target 95%, actual was 94.29%).

Stakeholder relations

The RNHRD NHS FT worked in partnership with a range of NHS trusts to facilitate the delivery of high-quality patient care. These partnerships included service level agreements with the RUH for delivery of a wide range of support services such as Microbiology, Pharmacy, library facilities and specialist medical and nursing staff who provide care in conjunction with RNHRD NHS FT staff. It employed a range of specialist staff from other NHS trusts to support the delivery of specialist paediatric services, orthopaedics and dermatology. During 2014/15, it continued to work in partnership with Macmillan and NHS England Specialist Commissioning to deliver services for cancer survivors.

Statement as to disclosure to auditors

Insofar as the Board of Directors is aware, there is no relevant information of which the auditors are unaware, and the Directors have taken all of the steps that they should take as Directors to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Remuneration report

Annual statement on remuneration

The 2014/15 remuneration for the Executive and non-voting Directors was decided by the Remuneration Committee in accordance with the existing terms and conditions of service of those Directors. In order to help determine the appropriate increases in pay for the year commencing 1 April 2014 for the Executive Directors and non-voting Directors the Remuneration Committee commissioned the Hay Group to conduct an external salary survey to complement the routine information received such as the pay and employment conditions of other trust employees, market and NHS factors relating to remuneration, and the trust's size and complexity. On receipt of the Hay report the committee satisfied itself that the advice received was objective and independent.

Knowing that the trust had been served with enforcement undertakings which were likely to result in the trust entering into a transaction agreement with another NHS Foundation Trust during the 2014/15 year the Remuneration Committee was keen to retain the services of the existing Executive Directors. At a meeting held on 28 March 2014, at which the remuneration for 2014/15 was approved, the Remuneration Committee also agreed to pay a one-off retention bonus to the Chief Executive Officer, the Director of Finance and the Director of Operations provided they were still in post and not working a notice period as at 30 November 2014. The Committee considered that by the operational nature of these roles the job-holders were more likely to seek alternative appointments in the short term. All three Executive Directors met these requirements and received their retention payments.

When it became apparent that the trust was on course to complete a transaction agreement with the RUH before the end of the financial year the Remuneration Committee supported a request to increase the hours of the Chief Executive Officer to full time from 1 November 2014 to 30 January 2015 to enable them to meet the increased demands of the role in delivering against the requirements of the transaction.

As the trust was acquired with effect from 1 February 2015 there are no forward looking elements contained in this report.

Senior managers' remuneration policy

The Service Contracts Obligations, as per section 7.41, are set out on the following pages.

Service contracts obligations

As outlined in the Annual Statement the Remuneration Committee agreed to make a retention bonus payment to three executive officers provided they satisfied certain conditions. These conditions were met and the sums paid were as follows:

- Chief Executive Officer - £5,945
- Director of Finance - £4,375
- Director of Operations - £4,279

Policy on payment for loss of office

Non-Executive Directors were appointed and reappointed in accordance with the terms and conditions of office decided by the Council of Governors at a general meeting as stated in the constitution. Executive Directors were on permanent employment contracts, with terms and conditions consistent with those for Agenda for Change. Directors were covered by the redundancy and retirement provisions of the NHS Pension Scheme. No payments for loss of office were approved either by the Remuneration Committee or the trust board in the period 1 April 2014 to 31 January 2015.

On the acquisition of the RNHRD NHS FT by the Royal United Hospitals Bath NHS Foundation Trust on 1 February 2015, the employment of the four Executive Directors and the five Non-Executive Directors ceased. Provision for the costs associated with loss of office is included in the Accounts for the 10 months to 31 January 2015 and is accordingly disclosed as below. All payments for loss of office were redundancy entitlements and contractual notice calculated in accordance with NHS Agenda for Change regulations.

Performance of the board and senior management team was assessed through the trust's annual appraisal system whereby staff were set individual objectives and development plans which supported delivery of the organisation's strategy and performance targets. The major collective objective for the board in 2014/15 was to find a solution to the enforcement undertakings and this was successfully achieved.

Historically, the Chair led the annual appraisal of the Non-Executive Directors with input from the Council of Governors. The Senior Independent Non-Executive Director led on the annual appraisal of the Chair with input from the Council of Governors. The Non-Executive Directors received the notice of termination of contract in December 2014, their notice periods ending on 31 March 2015.

Annual Report on Remuneration

Service contracts

Name	Role	Appointed/Reappointed	Current length of Term	Notice period
Luke March	Non-Executive Director Chair from 1 April 2014	March 2014	12 months	3 months
Mike Attenborough-Cox	Non-Executive Director	August 2013 reappointed March 2014	1 year	3 months
Christopher Johns	Non-Executive Director	October 2007 reappointed October 2010 reappointed October 2013 reappointed April 2014	1 year	3 months
Sir Peter Spencer KCB	Non-Executive Director	December 2007 reappointed December 2010 reappointed December 2013 reappointed April 2014	1 year	3 months
Bernard Galton	Non-Executive Director	Appointed June 2014	9 months	3 months
Kirsty Matthews	Chief Executive	April 2009	N/A	3 months
Tracey Cotterill	Director of Finance	June 2013	N/A	3 months
Dr Ashok Bhalla	Medical Director	August 2011 to July 2014	3 years	3 months
Dr Ellie Korendowych,	Medical Director	August 2014	3 years	3 months
Rayna McDonald	Director of Operations and Clinical Practice	May 2010	N/A	3 months
Hayley Sewell	Director of Governance	July 2005	N/A	3 months

Remuneration Committee

Membership of the Remuneration Committee was made up of the trust's Chair and the other Non-Executive Directors. In March 2014 the Remuneration Committee agreed the remuneration to be paid to the Executive Directors and non-voting Directors for the financial year commencing 1 April 2014. During the year the Remuneration Committee met on 6 November 2014 and agreed a request to increase the hours of the Chief Executive Officer to full-time for the period 1 November 2014 to 30 January 2015.

The Remuneration Committee:

Name	Position	Attendance at meetings
Luke March	Chair	1/1
Chris Johns	Senior Independent Non-Executive Director	1/1
Sir Peter Spencer	Non-Executive Director	1/1
Bernard Galton	Non-Executive Director	1/1
Mike Attenborough- Cox	Non-Executive Director	0/1

Director and governor expenses

Details relating to the expenses of the trust's Directors and Governors, during the reporting period, are as follows:

Directors	2014/15	2013/14
Number of Directors holding Office at any time in the period	11	13
Average Number of Directors holding Office during the period	10	10
Total Number of Directors receiving Expenses in the period	3	12
Aggregate sum of Expenses paid to Directors in the reporting period (Nearest £100)	£300	£10,400

Governors	2014/15	2013/14
Number of Governors holding office at any time in the period	28	36
Total number of Governors receiving expenses in the period	2	1
Aggregate sum of expenses paid to Governors in the reporting period (Nearest £100)	£500	£0

NB: four of the elected Governors are staff representatives and are paid a salary and expenses if applicable for their normal staffing duties not as Governors. Any such amounts have been excluded from this analysis.

Pensions and remuneration

Accounting policies for pensions and other retirement benefits are set out in note 1.5 and 6.1 to the Accounts. Pension benefits are based on a retirement age of 60, no Director had contractual pension rights to additional benefits in the event of early retirement. Directors were all members of the NHS Pension Scheme and were entitled to the benefits allowed to all members. Details of senior employees' remuneration are disclosed below. This is subject to audit, but the remainder of the remuneration report is not subject to audit.

Remuneration of senior employees:

	Salary including accrued leave £'000		Taxable Benefits £'00		Increase in value of Pension Related Benefits £'000		Total £'000	
	2014/15	2013/14	**2014/15**	2013/14	**2014/15**	2013/14 restated*	**2014/15**	2013/14 restated*
Executive Directors								
Kirsty Matthews, Chief Executive	80-85	85-90	0	0	37.5-40.0	15.0-17.5	115-120	100-105
Dr Ashok Bhalla, Medical Director (to July 2014)	20-25	135-140	0	100	0	0	20-25	135-140
Dr Ellie Korendowych Medical Director (from August 2014)	45-50	Not a director	0	Not a director	140.0-142.5	Not a director	185-190	Not a director

Tracey Cotterill, Director of Finance (from June 2013)	75-80	60-65	0	100	35.0-37.5	N/A	115-120	60-65
Rachel Hepworth, Director of Finance (to July 2013)	0	20-25	0	0	0	15.0-17.5	0	35-40
Rayna McDonald, Director of Operations and Clinical Practice, Deputy Chief Executive	70-75	75–80	0	0	20.0-22.5	5.0-7.5	95-100	80-85
Hayley Sewell, Director of Governance	55-60	60–65	0	0	22.5 - 25.0	7.5-10.0	80-85	70-75
Non-Executive Directors								
Luke March Chair	25-30	0-5	0	0	0	0	25-30	0-5
Peter Franklyn, Chair (to August 2013)	0	10-15	0	0	0	0	0	10-15
Eugene Sullivan Chair (from August 2013 to March 2014)	0	30-35	0	0	0	0	0	30-35
Stephen Cole (to August 2013)	0	0-5	0	100	0	0	0	0 -5
Christopher Johns	5-10	5-10	0	100	0	0	5-10	5–10
Sir Peter Spencer KCB	5-10	5-10	0	100	0	0	5-10	5–10
Niall Bowen (to March 2014)	0	5-10	0	0	0	0	0	5-10
Mike Attenborough-Cox (from August 2013)	5-10	5-10	0	600	0	0	5-10	5-10
Bernard Galton (from June 2014)	5-10	0	0	0	0	0	5-10	0

NB: The calculation of the increase/(decrease) in the value of Directors' pension-related benefits is determined in accordance with the 'HMRC' method.

*the 2013/14 figures for the increase in value of pension-related benefits have been re-presented following deduction of employee contributions.

The notional movement in the value of pension benefits of Directors was funded by a combination of trust pension contributions, the Director's contribution and Government underwriting of scheme liabilities. The cost to the trust of funding its share of these obligations is disclosed in note 5.4 to the Annual Accounts.

Pensions Disclosure, all amounts in £'000 in 2014/15:

Name and Title	Real increase in pension at age 60 at 31January 2015 (bands of £2,500)	Real increase in lump sum at age 60 at 31 January 2015 (bands of £2,500)	Total accrued pension at age 60 at 31 January 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 January 2015 (bands of £5,000)	Cash equivalent transfer value at 31 January 2015	Cash equivalent transfer value at 1 April 2014	Real increase in cash equivalent transfer value
Kirsty Matthews, Chief Executive	0 - 2.5	0 – 2.5	10 – 15	5 – 10	165	127	36
Dr Ellie Korendowych, Medical Director (from August 2014)	5.0 – 7.5	17.5 – 20.0	25 - 30	85 - 90	455	339	111
Hayley Sewell, Director of Governance	0 – 2.5	2.5 – 5.0	15 – 20	45 – 50	282	248	32
Rayna McDonald, Director of Operations and Clinical Practice, Deputy Chief Executive	0 – 2.5	2.5 – 5.0	15 – 20	55 – 60	303	276	23
Tracey Cotterill, Director of Finance	0 – 2.5	5.0 – 7.5	5 – 10	25 – 30	157	115	41

Non–executive members do not receive pensionable remuneration. Directors who have reached retirement age are not included above.

Pension details have only been disclosed for those Directors in post during 2014/15. Balances for those in post during 2013/14 can be obtained from the 2013/14 Annual Report and Accounts.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest-paid Director in the RNHRD NHS FT in the ten months to 31st January 2015 was £80k - 85k. This was 3.8 times the median remuneration of the workforce, which was £21,486. The median total remuneration has decreased from 5.8 in 2013/14, because the highest paid Director did not work full time

throughout the year and the Medical Director was not the highest paid Director. A comparable ratio against a full-time equivalent of the highest paid Director would be 4.3.

One employee received remuneration in excess of the highest paid Director. Remuneration ranged from £10k-£15k to £160k-165k. Total remuneration includes salary, non-consolidated performance-related pay, and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions

Payments for loss of office

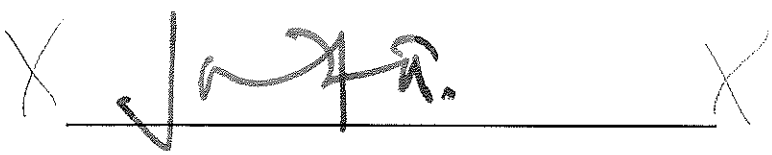
All figures in £'000

Name	Redundancy	Payment in lieu of notice / contractual notice period	Total payment for loss of office
Kirsty Matthews, Chief Executive	44	28	72
Tracey Cotterill, Director of Finance	0	21	21
Rayna McDonald, Director of Operations and Clinical Practice, Deputy Chief Executive	127	21	148
Hayley Sewell, Director of Governance	135	21	156
Luke March, Chair	0	6	6
Mike Attenborough-Cox, Non-Executive Director	0	2	2
Sir Peter Spencer, Non-Executive Director	0	2	2
Christopher Johns, Non-Executive Director	0	2	2
Bernard Galton, Non-Executive Director	0	2	2

The payments detailed above were made in February 2015, except for those relating to the Chief Executive and the Director of Governance, who were paid throughout their contractual notice periods. These directors were not required to work during this period and redundancy payments will be made following the contractual notice period.

Off-payroll disclosures

There were no off-payroll engagements as of 31 January 2015.



James Scott

Chief Executive,
Royal United Hospitals Bath NHS Foundation Trust

29 April 2015

NHS Foundation Trust Code of Governance

The Board of the Directors of the RNRHD NHS FT reviewed this Statement at their final closed meeting on 28 January 2015 and recorded the following in the minutes of that meeting:

'The Chair of the Audit Committee confirmed that the Audit Committee had reviewed the specific requirements and endorsed the draft assessment of compliance of our Board and Governors with the Code of Governance. The Board ***approved*** *the Code of Governance.'*

The RNHRD NHS FT has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. Particular provisions within the Code and FT ARM addressed in this report are as follows:

Code of Governance reference or FT ARM	Summary	Page Reference
A.1.1	The Schedule of Matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The Annual Report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by each of the Boards and which are delegated to the executive management of the Board of Directors.	44, 46-50
A.1.2	The Annual Report should identify the Chairperson, the Deputy Chairperson (where there is one), the Chief Executive, the Senior Independent Director (see A.4.1) and the Chairperson and members of the Nominations, Audit and Remuneration Committees. It should also set out the number of meetings of the Board and those committees and individual attendance by Directors.	51-57
A.5.3	The Annual Report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The Annual Report should also identify the nominated lead governor.	46-49
FT ARM	The Annual Report should include a statement about the number of meetings of the Council of Governors and individual attendance by governors and directors.	46-48
B.1.1	The Board of Directors should identify in the Annual Report each non-executive director it considers to be independent, with reasons where necessary.	52-53
B.1.4	The Board of Directors should include in its Annual Report a description of each director's skills, expertise and experience. Alongside this, in the Annual Report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS Foundation Trust.	51-54
FT ARM	The Annual Report should include a brief description of the length of	34

	appointments of the non-executive directors, and how they may be terminated.	
B.2.10	A separate section of the Annual Report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	56-57
FT ARM	The disclosure in the Annual Report on the work of the Nominations Committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	57
B.3.1	A chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the Annual Report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next Annual Report.	52
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The Annual Report should contain a statement as to how this requirement has been undertaken and satisfied.	59-60
FT ARM	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the Annual Report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the Foundation Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	50
B.6.1	The Board of Directors should state in the Annual Report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	51, 55
B.6.2	Where there has been external evaluation of the board, the external facilitator should be identified in the Annual Report and a statement made as to whether they have any other connection to the trust.	51
C.1.1	The Directors should explain in the Annual Report their responsibility for preparing the Annual Report and Accounts, and state that they consider the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the Annual Report).	91-100
C.2.1	The Annual Report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	99
C.2.2	A trust should disclose in the Annual Report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	55
C.3.5	If the Council of Governors does not accept the Audit Committee's recommendation on the appointment, reappointment or removal of an external auditor, the Board of Directors should include in the Annual Report a statement from the audit committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	N/A
C.3.9	A separate section of the Annual Report should describe the work of the	55-56

	Audit Committee in discharging its responsibilities. The report should include: □ the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; □ an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and □ if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	
D.1.3	Where an NHS Foundation Trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the Annual Report should include a statement of whether or not the director will retain such earnings.	N/A
E.1.5	The Board of Directors should state in the Annual Report the steps they have taken to ensure that the members of the Board, and in particular the Non-Executive Directors, develop an understanding of the views of governors and members about the NHS Foundation Trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	46-50
E.1.6	The Board of Directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of Member engagement and report on this in the Annual Report.	46-50
E.1.4	Contact procedures for Members who wish to communicate with Governors and/or Directors should be made clearly available to members on the NHS Foundation Trust's website and in the Annual Report.	49
FT ARM	The Annual Report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	58-60
FT ARM	The Annual Report should disclose details of company directorships or other material interests in companies held by Governors and/or Directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS Foundation Trust. As each NHS Foundation Trust must have registers of Governors' and Directors' interests which are available to the public, an alternative disclosure is for the Annual Report to simply state how members of the public can gain access to the registers instead of listing all the interests in the Annual Report.	51-54

During 2014/15 the Trust **complied** with the following requirements detailed in the Code of Governance:

Code of Governance reference	Summary
A.1.4	The Board should ensure that adequate systems and processes are maintained to measure and monitor the NHS Foundation Trust's effectiveness, efficiency and economy as well as the quality of its health care delivery
A.1.5	The Board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance
A.1.6	The Board should report on its approach to clinical governance.
A.1.7	The Chief Executive as the accounting officer should follow the procedure set out by Monitor for advising the Board and the Council and for recording and submitting objections to decisions.
A.1.8	The Board should establish the constitution and standards of conduct for the NHS Foundation Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life
A.1.9	The Board should operate a code of conduct that builds on the values of the NHS Foundation Trust and reflect high standards of probity and responsibility.
A.1.10	The NHS Foundation Trust should arrange appropriate insurance to cover the risk of legal action against its directors.
A.3.1	The Chairperson should, on appointment by the Council, meet the independence criteria set out in B.1.1. A Chief Executive should not go on to be the Chairperson of the same NHS Foundation Trust.
A.4.1	In consultation with the Council, the Board should appoint one of the independent Non-Executive Directors to be the senior independent director.
A.4.2	The Chairperson should hold meetings with the Non-Executive Directors without the executives present.
A.4.3	Where Directors have concerns that cannot be resolved about the running of the NHS Foundation Trust or a proposed action, they should ensure that their concerns are recorded in the Board minutes.
A.5.1	The Council of Governors should meet sufficiently regularly to discharge its duties.
A.5.2	The Council of Governors should not be so large as to be unwieldy.
A.5.4	The roles and responsibilities of the Council of Governors should be set out in a written document.
A.5.5	The chairperson is responsible for leadership of both the Board and the council but the Governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.
A.5.6	The Council should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns.
A.5.7	The Council should ensure its interaction and relationship with the Board of Directors is appropriate and effective.
A.5.8	The Council should only exercise its power to remove the chairperson or any Non-Executive Directors after exhausting all means of engagement with the Board.
A.5.9	The Council should receive and consider other appropriate information required to enable it to discharge its duties.
B.1.2	At least half the Board, excluding the Chairperson, should comprise Non-Executive Directors determined by the Board to be independent.
B.1.3	No individual should hold, at the same time, positions of Director and Governor of any NHS Foundation Trust.
B.2.1	The Nominations Committee or Committees, with external advice as appropriate, are responsible for the identification and nomination of executive and Non-Executive Directors.
B.2.2	Directors on the Board of Directors and Governors on the Council should meet the "fit and proper" persons test described in the provider licence.
B.2.3	The Nominations Committee(s) should regularly review the structure, size and

	composition of the Board and make recommendations for changes where appropriate.
B.2.4	The Chairperson or an independent Non-Executive Director should chair the Nominations Committee(s).
B.2.5	The Governors should agree with the Nominations Committee a clear process for the nomination of a new Chairperson and Non-Executive Directors.
B.2.6	Where an NHS Foundation Trust has two Nominations Committees, the Nominations Committee responsible for the appointment of Non-Executive Directors should consist of a majority of Governors.
B.2.7	When considering the appointment of Non-Executive Directors, the Council should take into account the views of the Board and the Nominations Committee on the qualifications, skills and experience required for each position.
B.2.8	The Annual Report should describe the process followed by the council in relation to appointments of the Chairperson and Non-Executive Directors.
B.2.9	An Independent External Adviser should not be a Member of or have a vote on the Nominations Committee(s).
B.3.3	The Board should not agree to a full-time Executive Director taking on more than one non-executive directorship of an NHS Foundation Trust or another organisation of comparable size and complexity.
B.5.1	The Board and the Council of Governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.
B.5.2	The Board and in particular Non-Executive Directors, may reasonably wish to challenge assurances received from the Executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the Board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.
B.5.3	The Board should ensure that Directors, especially Non-Executive Directors, have access to the independent professional advice, at the NHS Foundation Trust's expense, where they judge it necessary to discharge their responsibilities as Directors.
B.5.4	Committees should be provided with sufficient resources to undertake their duties.
B.6.3	The Senior Independent Director should lead the performance evaluation of the chairperson.
B.6.4	The Chairperson, with assistance of the Board Secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for Non-Executive Directors relevant to their duties as Board members.
B.6.5	Led by the Chairperson, the Council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the Council, for the removal from the Council of any Governor who consistently and unjustifiability fails to attend the meetings of the Council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.
B.8.1	The Remuneration Committee should not agree to an Executive member of the Board leaving the employment of an NHS Foundation Trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the Board first having completed and approved a full risk assessment.
C.1.2	The Directors should report that the NHS Foundation Trust is a going concern with supporting assumptions or qualifications as necessary.
C.1.3	At least annually and in a timely manner, the Board should set out clearly its financial, quality and operating objectives for the NHS Foundation Trust and disclose sufficient information, both quantitative and qualitative, of the NHS Foundation Trust's business and operation, including clinical outcome data, to allow Members and Governors to evaluate its performance.
C.3.1	The Board should establish an audit committee composed of at least three members who are all independent non-executive directors.
C.3.3	The Council should take the lead in agreeing with the audit committee the criteria for

	appointing, re-appointing and removing external auditors.
C.3.6	The NHS Foundation Trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS Foundation Trust.
C.3.7	When the Council ends an external auditor's appointment in disputed circumstances, the Chairperson should write to Monitor informing it of the reasons behind the decision.
C.3.8	The Audit Committee should review arrangements that allow staff of the NHS Foundation Trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.
D.1.1	Any performance-related elements of the remuneration of Executive Directors should be designed to align their interests with those of patients, service users and taxpayers and to give these Directors keen incentives to perform at the highest levels.
D.1.2	Levels of remuneration for the Chairperson and other Non-Executive Directors should reflect the time commitment and responsibilities of their roles.
D.1.4	The Remuneration Committee should carefully consider what compensation commitments (including pension contributions and all other elements) their Directors' terms of appointments would give rise to in the event of early termination.
D.2.2	The Remuneration Committee should have delegated responsibility for setting remuneration for all executive Directors, including pension rights and any compensation payments.
D.2.3	The Council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.
E.1.2	The Board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between Governors and any local consultative forums.
E.1.3	The Chairperson should ensure that the views of Governors and Members are communicated to the Board as a whole.
E.2.1	The Board should be clear as to the specific third party bodies in relation to which the NHS Foundation Trust has a duty to co-operate.
E.2.2	The Board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.

Council of Governors

This Foundation Trust has a framework of local and national accountability through members, and of governance through our Council of Governors and Board of Directors. Our Council of Governors has an invaluable role in representing members' views, contributing to the trust's strategic direction and ensuring that the Board of Directors meets its terms of authorisation.

Relationship with the Board of Directors

The Board of Directors is collectively responsible for the exercise of the powers and the performance of the trust. The role of the Board of Directors is to provide active leadership of the trust. It is responsible for the operational running of the trust and for ensuring compliance with terms of authorisation, constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.

The board sets the trust's strategic aims, but in setting forward plans takes into consideration the views of the Council of Governors. The board is responsible for ensuring that the necessary finance resources are in place for the NHS Foundation Trust to meet its objectives.

The Council has established a policy for engagement with the Board of Directors for those circumstances when they have concerns.

The Council of Governors and Board of Directors interaction and relationship is appropriate and effective. Two governors are in attendance at each open board meeting and Audit Committee meeting and Executive and Non-Executive Directors attend the Council of Governors meetings, and present information to these meetings to enable interaction with the Council of Governors.

Council of Governors

The Council of Governors provides a direct link to our community and represents the interest of members and stakeholder organisations in the stewardship and development of the trust, and ensures that the trust is responsive to the needs and values of all stakeholders: patients, public, staff and partner organisations. The Council of Governors holds the board to account for the performance of the trust. The council feeds back information about the trust, its vision and its performance to the members and stakeholder organisations which appointed them.

The Council of Governors roles and responsibilities are set out in the Governors' Standing Orders document. The trust's constitution details the set process for the removal of a Governor who consistently fails to attend the meetings of the Council of Governors. In addition the Council of Governors has statutory responsibilities which are set out on pages 49-50.

Representatives from the Council of Governors attend the board meetings on a rotational basis and present the views of the council and the members. Non-Executive Directors attend formal Council of Governors meetings. This allows individual members of the board to understand the views of the Council of Governors. Further feedback is directed to the board through the Chair of the board who regularly meets with the lead Governor.

Governors of the council are appointed or elected for a two- or three-year period. At the end of this period, elected Governors have the opportunity to stand for re-election and appointed Governors may be re-appointed by their organisation for a further two- or three-year period. During 2013/14 the constitution was amended to allow the length of a Governor's term of office to be extended by one year in exceptional circumstances, for example, in the case of planned merger, acquisition, separation/dissolution, when an elected Governor is coming to the end of their period of office.

Governors held an Annual Members' Day on 2 October 2014 where, with the Board of Directors, they updated members on the future plans for the hospital and the potential acquisition and asked members what was important to them regarding the future provision of RNHRD NHS FT services. The information they gained has fed into discussions with the RUH Board of Directors and clinical service leads. Governors have also canvassed the opinion of patients, through monthly coffee mornings and walk rounds and drop-in sessions. Appointed Governors represented key partner organisations, who represent the patients and the conditions treated at the hospital. These Governors attended Council of Governors meetings and provided the opinion of the people they represent to the Board of Directors.

Constituencies

The Council of Governors is made up of three constituencies as well as appointed partnership organisations as follows:

- The Public constituency is made up of non-patient members.
- The Patient constituency is made up of patients of the trust.
- The Staff constituency is made up of employees of the trust.

The table below shows the composition of the Council of Governors between 1 April and 31 January 2015, the constituency or organisation each Governor represents, how the Governors were elected/appointed and the length of office. There have been 10 formal meetings of the Council of Governors between 1 April 2014 and 31 January 2015. Attendance by Governors, Directors and Non-Executive Directors is also shown in the table below:

Elected governors – public constituency

Name	Date elected / re-elected	Term of Office	Attendance at formal meetings (out of 10)
Favre Armstrong	01/04/2011	3 *	10/10
Hilary Elms	01/04/2011	3 *	8/10
David Hawkins	07/03/2014	3	9/10
Mary-Jane Middlehurst	07/03/2014	3	8/10
Francis Ring	01/04/2011	3 *	6/10
Ben Rogers	01/04/2011	3 *	8/10

Elected governors – patient constituency

Name	Date elected / re-elected	Term of Office	Attendance at formal meetings
Robert Slade (Nominated Lead Governor)	01/04/2011	3 *	9/10
Donn Boyland	01/04/2011	3 *	10/10
Judith Plante Cleall	01/04/2011	3 *	5/10
Judy Coles	01/04/2011	3 *	9/10
Stewart Entwistle	07/03/2014	3	8/10
Kathy Hawkins	30/07/2013	3	9/10
Roger Mason	30/07/2013	3	8/10
Christine Owen	07/03/2014	3	7/10
Vivienne Pozo	01/04/2011	3 *	6/10
Jackie Vincent	23/05/2013	3	6/10

Elected governors – staff

Name	Date elected / re-elected	Term of Office	Attendance at formal meetings
Yvonne Glenn	01/04/2011	3 *	5/10
Nikki Frayling	23/11/2012	3	7/10
Dr Philip Hamann	23/11/2012	3	8/10
Mary Wisker (from 22/09/14)	22/09/2014	3	5/6

Appointed governors

Name	Organisation	Appointed / re-appointed	Term of Office	Attendance at formal meetings
Gordon Taylor	Bath University	03/11/2013	2	5/10
Sarah Green	UWE	01/04/2014	2	3/10
Dr Anthony Clarke	B&NES Council	21/05/2010	3*	6/10
Peter Haines	Headway	25/03/2013	2	6/10
Ali Taylor	BIRD (from 13/06/14)	13/06/2014	2	8/9
Jo Hunt	Arthritis Care (until 01/12/14)	24/04/2012	2	0/7
Debbie Cook	National Ankylosing Spondylitis Society	20/11/2011	2*	3/10
Sue Meadows	National Osteoporosis Society	28/02/2013	2	6/10

*Following a change to the trust's constitution, to extend the length of a Governor's term of office by one year in exceptional circumstances, for example in the case of planned merger, acquisition, separation/dissolution, when an elected Governor is coming to the end of their period of office, these Governors have agreed to extend their term of office.

Directors' attendance

Name	Position	Attendance at formal meetings (out of 10)
Luke March	Trust Chair & Chair of the Council of Governors	10/10
Mike Attenborough-Cox	Non-Executive Director	3/10
Bernard Galton	Non-Executive Director (from 02/06/2014)	5/9
Christopher Johns	Non-Executive Director	7/10
Sir Peter Spencer KCB	Non-Executive Director	6/10
Kirsty Matthews	Chief Executive	8/8
Tracey Cotterill	Director of Finance	9/10
Dr Ashok Bhalla	Medical Director (until 31/07/2014)	1/3
Dr Ellie Korendowych	Medical Director (from 01/08/2014)	3/7
Rayna McDonald	Director of Operations and Clinical Practice	7/10
Hayley Sewell	Director of Governance	9/10

Elections to the Council of Governors

The following elections were held between 01 April 2014 and 31 January 2015:

Staff governor elections

In September 2014 the trust completed a successful uncontested nomination process for one staff seat of the Council of Governors.

Vacancies on the Council of Governors

The vacancies on the Council of Governors at the end of January 2015 were as follows:

Constituency	Vacancies
Public	3
Patient	0
Staff	0
Appointed	4

The Council of Governors met formally 10 times and informally once between 1 April 2014 and 31 January 2015. Governors are requested to attend all of these meetings. In addition to this time commitment for Council of Governors meetings, the trust holds an Annual Members' Day, which the council is asked to attend. The Council of Governors also has the opportunity to be involved in sub-groups and promotional work.

All Governors complete an annual declaration of interest. This information is available from the Membership Support Team:

RNHRD NHS Foundation Trust
FREEPOST SN1301
Upper Borough Walls
Bath
BA1 1RL
Telephone: 01225 465941 x295
Email: nhsft@rnhrd.nhs.uk, Website: www.rnhrd.nhs.uk

The Monitor Code of Governance and the trust's constitution set out various powers of, and obligations upon, Council Governors, as summarised below:

Statutory duties

The statutory duties of NHS Foundation Trust governors are set out in the National Health Service Act 2006 and the Health and Social Care Act 2012. The duties are as follows:

From the National Health Service Act 2006

- appoint and, if appropriate, remove the chair;
- appoint and, if appropriate, remove the other non-executive directors;
- decide the remuneration and allowances, and the other terms and conditions of office, of the chair and the other non-executive directors;
- approve the appointment of the chief executive;
- appoint and, if appropriate, remove the NHS Foundation Trust's external auditor; and
- receive the NHS Foundation Trust's Annual Accounts, any report of the auditor on them and the Annual Report.

In addition, in preparing the NHS Foundation Trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors.

From the Health and Social Care Act 2012

- Hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.
- Represent the interests of the members of the Trust as a whole and of the public.
- 'Significant transactions' must be approved by the Governors. Approval means that more than half of the governors voting agree with the transaction. The Trust may choose to include a description of 'significant transactions' in the Trust's constitution.
- The Council of Governors must approve an application by the Trust to enter into a merger, acquisition, separation or dissolution. In this case, approval means more than half of all governors agree with the application.
- Governors must decide whether the Trust's private patient work would significantly interfere with the Trust's principal purpose i.e. the provision of goods and services for the health service in England or the performance of its other functions.
- The Council of Governors must approve any proposed increases in private patient income of 5% or more in any financial year. Approval means more than half of the governors voting agree with the increase.
- Amendments to the Trust's constitution must be approved by the Council of Governors. Approval means more than half of the governors voting agree with the amendments. Amendments will no longer need to be submitted to Monitor for approval.

Additional rights and powers

- The Council of Governors may require one or more of the Directors to attend a governors' meeting for the purpose of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and for deciding whether to propose a vote on the Trust's or Directors' performance).

Members of the Board of Directors attended the Council of Governors' ten formal meetings. The Chief Executive provided updates to the council on the present work of the trust and the Finance Director provided information on the present financial situation. The council had the opportunity to put questions to the Chief Executive and Finance Director and feed-in their views and opinions. Members of the clinical teams presented their forward plans for 2014/15.

Representatives from the Non-Executive Directors attend the Council of Governors' formal meetings. In addition representatives from the Council of Governors attend open board meetings and the Audit Committee. Non-Executive Directors also attend, with the rest of the board, the Annual Member's Day to meet members. Other Directors attend Governors meetings to provide information on governance, quality and operational issues.

Changes to the constitution

In October 2014 changes were made to the constitution regarding the submission of postal votes for Governors who are unable to attend a meeting where a vote will take place.

Board of Directors

Statement about the balance, completeness and appropriateness of the membership of the board

The board structure remained unchanged in 2014/15. The board consisted of five Non-Executive Directors, of whom one was the Chair, and four Executive Directors. The Director of Governance attended the board meetings in a non-voting capacity.

Governance requirements were met through the Chair's and Non-Executive Directors' roles on committees and their attendance at board meetings. There was a clear separation of the roles of the Chair and the Chief Executive. The Chair had responsibility for the running of the board and the Council of Governors, setting the agenda for the trust and for ensuring that all Directors were fully informed of matters relevant to their roles.

All of the Non-Executive Directors were considered to be independent in accordance with the NHS Foundation Trust Code of Governance.

Members of the board had a wide range of experience from both the public and private sectors. The Chair and Non-Executive Directors had combined experience of health and social care, business delivery, corporate finance, education, the charitable sector, the armed forces and the civil service. Executive Directors had extensive experience in the NHS and private sector. Short biographies are detailed below.

Non-Executive Director appointments to the board could be terminated at the wishes of the incumbent, or by the Council of Governors ratified by a two-thirds majority. A term of office for Non-Executive Directors was usually three years. However, in exceptional circumstances the Nominations Committee could make appointments on a fixed-term basis as per recent appointments. All Non-Executive Directors were independent Directors in line with the NHS Trust Code of Governance. The trust holds a public Register of Interests which is available from the Chief Executive's Office.

The Chair conducted appraisals of the Chief Executive. The Chair and Governors, forming the Nominations Committee, also conducted the appraisals of the Non-Executive Directors in 2014/15. The Executive Directors were appraised by the Chief Executive.

During 2013/14 the board conducted a review against the Code of Governance requirements and was satisfied with compliance of the board and governors with the Code of Governance.

The board was satisfied as to its balance, completeness and appropriateness.

The Board of Directors

Luke March, Chairman

Luke March was appointed in March 2014 and took on the role of Chair of the Trust from April 2014 for a period of 12 months. Formerly Chair of Salisbury NHS Foundation Trust he was previously deputy chair of Barts and The London NHS Trust. He has served as Chair of the National Friends of Citizens' Advice Bureaux, and is now also Deputy Lieutenant of Wiltshire. He is Chairman of the National Churches Trust and a lay Canon on the Chapter of Salisbury Cathedral. He has also been Chairman of the Audit Committee of the Financial Services Compensation Scheme, Corporate Governance Director of BT Group, Group Company Secretary of TSB Group, and most recently Group Compliance Director of Royal Mail Group. He has been a Non-Executive Director in the NHS since 1988. Luke also chaired the trust's Council of Governors, the trust's Remuneration Committee, and the Charitable Fund Committee.

Bernard Galton, Non-Executive Director (from June 2014)

Bernard Galton was appointed as Non-Executive Director in June 2014. Bernard is a Chartered Fellow of the Chartered Institute of Personnel and Development and has operated at executive board level for 15 years within the public sector. Bernard currently holds a role in the Welsh government, where he is Director General, Workforce and Organisational Development for NHS Wales. Bernard's previous roles in the Welsh government include Director General, Corporate Services and HR Director. He has also held roles as HR Director and Company Secretary at the Defence Aviation Repair Agency and senior management roles in the Ministry of Defence.

Mike Attenborough-Cox, Non-Executive Director

Mike Attenborough-Cox was appointed as Non-Executive Director in August 2013 and was reappointed in March 2014 for a further 12 months. Mike, a qualified accountant and internal auditor, was a partner at Mazars LLP for 13 years. Mike has extensive experience of working with public sector organisations, having been appointed UK national public services partner at Mazars in 2001. Previous roles include 12 years as an independent member of Hampshire Police Authority including three years as Chair. Mike is currently Financial Advisor to the Executive and Board of the United Kingdom Central Authority for the Exchange of Criminal Records, Chair of the Joint Audit Committee of the Police and Crime Commissioner and Chief Constable for Hampshire, and a member of the Foreign and Commonwealth Officer Services Department, and of the Audit Committee of the Royal Institute of Chartered Surveyors. Mike was Chair of the RNHRD NHS FT Finance and Activity Committee.

Christopher Johns, Non-Executive Director – Senior Independent Non-Executive Director

Chris was appointed in October 2007 for a period of three years, he was reappointed for a further three years in 2010 and in 2013 he was reappointed until the end of March 2014, which was extended for a further 12 months. In September 2010 he became the Senior Independent Non-Executive Director. Chris has a background in the management and regulation of social care. He has worked extensively in local and central government, national commissions, management consultancy and in the voluntary sector, and has a BA and MSc in Management Development as well as professional qualifications in management and social work. Chris has

recently completed a tenure as senior lecturer at Cardiff Metropolitan University and is a Trustee of Tubbs Charity. Chris was the trust lead for health and safety, and was the lead Non-Executive Director for Integrated Governance and Quality Assurance (including infection control) at the RNHRD NHS FT, and sat on this committee.

Sir Peter Spencer KCB, Non-Executive Director – Vice Chair

Peter was appointed in December 2007 for a term of three years which in December 2010 was extended for a further three years, then further extended in December 2013 until the end of March 2014, which was then extended for a further 12 months. In September 2010 Peter became Vice-Chair. Peter had a distinguished career in the Royal Navy where he finished his service as Second Sea Lord and Commander in Chief Naval Home Command. In 2003 he retired from the Royal Navy and became a senior civil servant in the Ministry of Defence, as Chief of Defence Procurement, until April 2007. He was then Chief Executive of the charity Action for ME from May 2007 until September 2012. He was appointed as a Public Appointments Assessor in April 2012. Peter was Chair of the RNHRD NHS FT Audit Committee.

Kirsty Matthews, Chief Executive Officer

Kirsty was appointed interim Chief Executive Officer by Monitor in April 2009 and then Chief Executive following an interview process in August 2010. Prior to her appointment as Chief Executive, Kirsty had served as interim Chair appointed by a Monitor intervention in December 2008 and as a non-executive director from December 2007. Kirsty was previously director of strategy for a private healthcare provider and has a background in general management in the NHS and business development in the private sector. Kirsty is educated to Masters Degree level.

Tracey Cotterill, Director of Finance

Tracey Cotterill was appointed Director of Finance in June 2013. She is a member of the Chartered Institute of Management Accountants and has a Masters Degree in Business Administration. She has worked for a variety of NHS provider bodies as well as private sector organisations. Tracey has over 25 years' financial experience including delivering change, and establishing financial processes and controls.

Dr Ashok Bhalla, Medical Director (until July 2014)

Dr Ashok Bhalla joined the hospital as a consultant in rheumatology and metabolic bone disease in 1988, and was appointed Medical Director in August 2011. He trained in Manchester and London, and completed a medical fellowship in the US at Harvard Medical School and Massachusetts General Hospital. Dr Bhalla's specialist interests include inflammatory arthritis, osteoporosis and other metabolic bone diseases, chronic pain and fibromyalgia. He helped to establish the hospital's pain management service. Dr Bhalla is active in research and has presented original work at national and international meetings.

Dr Ellie Korendowych, Medical Director (from August 2014)

Dr Ellie Korendowych trained in rheumatology in Cambridge and Oxford and was appointed as a consultant here in March 2005. She has a number of clinical and research interests. Her major research thus far has been in psoriatic arthritis (PsA) about which she has published widely and led national workshops. Dr Korendowych also has a clinical and research interest in connective tissue diseases, particularly lupus, Sjogrens syndrome and systemic sclerosis.

Rayna McDonald, Director of Operations and Clinical Practice, Director of Infection Prevention and Control, and Deputy Chief Executive

Rayna was appointed as Director of Operations and Clinical Practice at the RNHRD NHS FT in May 2010. She has over 27 years' experience of working in public sector healthcare and has held senior management posts in a number of acute trusts in Wales, Hampshire, Bath and Devon. In addition, Rayna has held a range of clinical and academic positions in various NHS and academic organisations. She is a Registered General Nurse, a graduate of the NHS Management Training Scheme, and holds a Postgraduate Diploma in Management (Health) and a degree in nursing. Rayna has published and presented research papers at a variety of international nursing conferences.

Hayley Sewell, Director of Governance

Hayley was appointed to the board in 2005 and has responsibility for governance. She has over 25 years' experience in the NHS and completed the NHS Clinical Strategist Programme at INSEAD in 2003. Hayley gained an MSc from King's College London in 1994 and began her NHS career as a chartered physiotherapist.

A full declaration of interests of the members of the board is available from the Board Secretary.

Board of Directors' attendance

Name	Trust Board (From 10 meetings)	Audit Committee (From 4 meetings)	Remuneration Committee (From 1 meeting)
Luke March	10/10	3/4	1/1
Mike Attenborough-Cox	7/10	4/4	0/1
Christopher Johns	10/10	1/1	1/1
Sir Peter Spencer KCB	9/10	4/4	1/1
Bernard Galton	6/8	0/3	1/1
Kirsty Matthews	9/10	-	-
Tracey Cotterill	10/10	-	-
Dr Ashok Bhalla	4/4	-	-
Dr Ellie Korendowych	6/7	-	-
Rayna McDonald	9	-	-
Hayley Sewell	10	-	-

Audit Committee

Sir Peter Spencer was Chair of the Audit Committee. Mike Attenborough-Cox and Chris Johns (for the May 2014 meeting only) and Bernard Galton (NED from June 2014) were the other two non-executive members. The Chief Executive, Director of Finance and Director of Governance were in attendance at the meetings along with two Governors. The Chair of the Board of Directors, Luke March, was also in attendance at 3/4 committee meetings in 2014/15. There were four meetings of the Audit Committee over this period:

Name	Role	Attendance at meetings
Sir Peter Spencer KCB	Chair of Audit Committee	4/4
Mike Attenborough-Cox	NED	4/4
Chris Johns	NED	1/1
Bernard Galton	NED	0/3

During 2014/15, up to the date of the acquisition on 1 February 2015, the Audit Committee continued to discharge its responsibilities in accordance with its terms of reference and the requirements of the Code of Governance and the Audit Code for Foundation Trusts. In particular the main performance evaluation activities were:

- Strategic risk management with particular emphasis on mitigating risks to health standards and risks to the financial status of the trust
- The trust outsourced the internal audit function to Baker Tilly who were tasked against an agreed programme of audits prioritised on a risk basis. The trust evaluated and continuously improved the effectiveness of its risk management and internal controls processes through the review of all risks rated moderate and above at each audit meeting, including an in-depth review of one risk and the assurance framework 6 monthly together with:
    - Reviewing minutes from the sub-committees with responsibility for risk namely the Finance and Activity Committee and Integrated Governance and Quality Assurance Committee
    - Considering the major findings of internal audit investigations (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
    - Conducting the annual self-assessment against the Code of Governance and producing an action plan for implementing further improvements.
- The Audit Committee reviewed feedback from the local Counter Fraud Service and ensured that there was in place an up-to-date anti-fraud and bribery policy and whistle blowing policy to allow staff of the trust, and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters
- Feedback from the representatives from the Council of Governors who attended Audit Committee meetings

- Private discussions with the internal and external auditors to get their feedback on Audit Committee processes and effectiveness
- Tracking the implementation of a consolidated list of all audit recommendations. This was reported at every meeting of the Audit Committee
- Reviewing its terms of reference.

There were no significant issues identified within the external audit review for the committee to consider in relation to the month 8 financial statements.

The Audit Committee endorsed the risks identified in the external audit plan including risk arising from the acquisition of services by Royal United Hospitals Bath NHS Foundation Trust and therefore the Going Concern basis of preparation of the RNHRD Accounts, risk of fraud in revenue and expenditure recognition and judgemental risk in relation to property valuation.

The Audit Committee assessed the effectiveness of the external audit process through the annual assessment of the external auditor and following the results of this assessment made a recommendation to the Council of Governors about the re-appointment of the external auditor.

The external auditor was independently re-appointed by the Council of Governors on 20 September 2014, following the recommendation by the Audit Committee.

The planned external audit services value was £75K, inclusive of VAT, for 2014/15, including non-audit services.

The tender for external audit was last conducted in 2006/7. The committee did not re-tender external audit services due to repeated incremental delays, outside the control of the trust, in the expected timeline for acquisition by another NHS organisation.

To ensure the independence of its external auditors, the trust was careful not to commission relevant PricewaterhouseCoopers staff to perform operational roles. This assurance was also maintained by the firm's own internal practices.

Nominations Committees

Executive appointments

There was one executive appointment in 2014/15 for the position of Medical Director following the completion by Dr Ashok Bhalla of his term of office on 31 July 2014. Historically this had been an internal appointment and all consultants were invited to apply for the role.

The Nominations Committee for the appointment of the Medical Director consisted of:

Name	Position	Attendance at meetings
Luke March	Trust Chair	1/1

Kirsty Matthews	CEO	1/1
Rayna McDonald	Director of Operations and Clinical Practice	1/1
Dr Tim Craft	External assessor	1/1
Judy Coles	Governor representative	1/1

Dr Ellie Korendowych was appointed with effect from 1 August 2014.

Non-executive appointments

A Nominations Committee of the Council of Governors is responsible for the appointment, appraisal and remuneration of the Chair and other Non-Executive Directors of the trust board. One Nominations Committee meeting, chaired by the trust Chair, was held in April 2014 to appoint a non-executive director. The Nominations Committee for the appointment of the non-executive director consisted of:

Name	Position	Attendance at meetings
Luke March	Trust Chair	1/1
Chris Johns	NED/Senior Independent Non-Executive Director (SINED)	1/1

Name	Position	Attendance at meetings
Robert Slade	Lead Governor	1/1
Yvonne Glenn	Governor	1/1
Hilary Elms	Governor	1/1
Favre Armstrong	Governor	1/1

Bernard Galton was the successful applicant and took up his role on 1 June 2014.

The process followed by the Nominations Committee in relation to this appointment was:

- A review of the Board of Directors' skill-mix and size prior to the recruitment and appointment of Bernard Galton
- Agreement to the use of advertising on NHS Jobs and the RNHRD NHS FT website. In February 2014 an open advertising campaign on NHS Jobs and the RNHRD NHS FT website was used as part of the recruitment process
- Preparation of a short-list of applicants and interview the identified candidates
- Recommendation to the Council of Governors the appointment of the preferred candidate, stating how this individual had demonstrated the appropriate range of skills, experience and qualifications to undertake the role. This resulted in the Council of Governors approving the appointment of Bernard Galton.

Membership

Membership

Membership was free; there were no obligations for people who sign up as a member. On the registration form there were three levels of membership:

Level 1 Keep in touch. All members receive a regular newsletter and information.

Level 2 Get involved. Some members choose to be consulted on plans for future development of the hospital and its services and attend the Annual Members Day.

Level 3 Work with us. For further active membership involvement some members stand for election to the Council of Governors. There were also individual volunteer opportunities within the hospital.

Constituencies

There were three membership constituencies in the RNHRD NHS FT membership. The criteria were as follows:

Public constituency

Individuals were eligible to become members of the public constituency if:

- they lived in England or Wales
- they were not eligible to become a member of the staff constituency
- they were not a member of the patient constituency.

The minimum number of members of the public constituency was 400.

Staff constituency

Individuals were eligible to become members of the staff constituency if they:

- were employed under a contract of employment by the trust (provided that Non-Executive Directors of the trust shall not be regarded as employees for this purpose); or
- were employed or engaged through a designated trust provider and otherwise exercise functions on behalf of the trust.

Individuals were only eligible to become members of the staff constituency if:

- they were employed by the trust under a contract of employment which had no fixed term or a fixed term of at least 12 consecutive months; or
- they had been continuously employed by the trust for at least 12 months
- they had been employed by a designated trust provider or been exercising the trust's functions for a continuous period of 12 months.

The minimum number of members of the staff constituency was 100.

Patient constituency

Individuals were eligible to become members of the patient constituency if:

- they were a patient or carer
- they were not eligible to become a member of the staff constituency; and
- they were not a member of the public constituency.

Individuals who were eligible to join the patient constituency were allocated to the patient constituency unless they notified the membership office that they wished to be allocated to the public constituency. The minimum number of members of the patient constituency was 500.

Membership numbers

In February 2015, the RNHRD NHS FT had 4376 members, with 3113 patient and carer members, 910 public members and 353 staff members.

	Membership 2014/15 patients/public	**Membership 2014/15 Staff**
Age		
0-16	0	0
17-21	10	4
22+	4013	349
Ethnicity		
White	3840	313
Mixed	2	3
Asian & Asian British	45	19
Black or Black British	27	10
Other	109	4
Gender		
Male	1287	64
Female	2736	285
Trans-Gender	Data not available	0
Disability		
	Data not available	34

Further information on the diversity of the trust's membership can be obtained from the Membership Support Team.

Membership strategy

This strategy was written by the Council of Governors' Membership sub-group and:

- defined the membership community and how the trust would establish a more diverse and representative membership
- recognised that the process of building a meaningful membership involves effective communication between the trust and members

- set out the Council of Governors' accountability and responsibility and how the trust would work in partnership with the Council of Governors to achieve this
- set out how the members and membership would support the marketing and communication strategy and promote the trust and patient choice to the wider-public
- outlined how the trust would evaluate the success of membership.

Members could contact Governors or Directors and could do so through the Membership Support Service at the hospital.

Members were invited to attend an Annual Members Day in October 2014. The event was the tenth members' day and was held in combination with the Annual General Meeting. This was an opportunity to provide information on the work of the trust and its Accounts and gather feedback from members. The theme of the day was working together and presentations included:

- Working Together for Patient Benefit
- Working Towards the Future of our Clinical Services
- Introduction to Working with Partners
- Working Together with our Partners in Healthcare
- Working Together with our Members
- Working with Patients
- Working Together: Our Patients' Stories.

Members were also invited to:

- attend Council of Governors meetings
- apply for volunteer roles
- join the Friends of the Min.

The trust aimed to have a diverse and representative membership. It had a system which informed all new patients about membership opportunities. The Council of Governors produced an information pack for use in promoting the trust and membership to local groups. They also organised monthly coffee mornings at the hospital to communicate with and obtain feedback from members and patients.

The majority of patient involvement activities through the year were organised as part of membership activities. However, other activities included monthly Patient Literature Group meetings and a thriving volunteer programme.

Interim Quality Report to 31 January 2015

As a result of the acquisition of the RNHRD by the RUH Bath NHS FT on 1 February 2015 information for the formal Quality Account for the RNHRD will be included in the RUH Bath NHS FT 2014/15 Quality Account. An interim Quality Report is included below and has been prepared in accordance with the NHS Foundation Trust reporting manual 2014/15. This interim report outlines RNHRD progress against its priorities and national targets for the nine-month period ending 31 December 2014.

Part 1: Statement on Quality

The high quality of care that patients report is described through feedback on the quality of care they receive through: the Friends and Family Test, walk rounds by members of the RNHRD board, patient experience presentations to the board, the Patient-led Assessment of the Care Environment (PLACE), Patient Advice and Liaison Service (PALS) and complaints feedback, monthly surveys of our patients, governors' discussions with patients at their coffee mornings and reports on NHS Choices. The majority of this feedback was positive and any comments or concerns are immediately actioned by the operational staff.

The only elevated risk in the CQC Intelligent Monitoring Report dated December 2014 related to the Monitor Governance Risk Rating as a consequence of the financial risks as detailed in the strategic plan.

The RNHRD maintained compliance with the CQC standards of quality and safety throughout the period and the CQC did not carry out an inspection visit during this period.

The RNHRD met all the key quality performance indicators in Monitor's Risk Assessment Framework throughout 2014/15 with the exception of the maximum time of 18 weeks from point of referral to treatment in aggregate for non-admitted patients in August 2014 (target 95% actual was 94.29%).

The steps taken during 2014/15 to further improve quality included:

- implementing the Friends and Family Test for staff and publication of outcome measures on our website.
- introducing patient story presentations to the board.

Part 2: Priorities for improvement and statements of assurance

Priorities for improvement in 2014/15

The priorities were identified through:

1. Feedback from patients through the national 2013 CQC survey of adult inpatients results for RNHRD NHS FT, complaints and PALS
2. Feedback from the Council of Governors
3. Feedback from commissioning CCGs through the CQUINs
4. Feedback from staff through the national patient safety programme and review of the risk register and staff survey
5. Recommendations from root cause analyses.

The following quality improvements were agreed by the board, and outcomes up until Q3 2014/15 are noted in the table below:

Priorities for improvement 2014/15	**Monitoring**	**Measurement**	**Reporting/Outcome to Q3 2014/15**
Patient Safety			
To analyse the outcomes and raise awareness of analysis of outcome data of patients who fall with particular focus on pain management patients. [4]	To be reviewed by Falls group and reported in executive summary to Patient Safety and Quality Forum (PS&QF)	Incidents rated moderate and above Monthly audit of falls with analysis of trends and outcomes. Review of pain management patients for the strategies and patients' personal outcomes made to promote safety. Presentation of pain management falls and type of patients to the CCG.	Q1: A subgroup has addressed the specific issues around frequent fallers. All clinical staff at Bath Centre for Pain Services (BCPS) now send Datix incident forms involving patient falls to falls representative to enable consistency in analysing the falls data and communicating learning outcomes to the rest of the clinical team. Q2: A meeting (involving clinical staff on BCPS) took place on the 13/08/2014 to review the BCPS falls assessment from initial assessment through to discharge. Outcome: BCPS team to continue to use the multifactorial falls assessment on admission for all patients and individuals accompanying patients. In addition to this it was agreed that the BCPS team need to standardise the falls questions asked at the initial assessment. Q3: Findings of the falls data presented at the IG&QAC meeting, the CCG takes part in this meeting and receives

			the minutes. Outcome analysis and awareness raising completed.
To improve accuracy of the detection and diagnosis of urinary tract infections (UTI) by trialing an assessment sheet for the symptoms of UTI in the Outpatient department (OPD). This is aimed to increase accurate diagnosis and appropriate use of antibiotics. This will improve the early detection of infections, with appropriate testing and treatments[4]	To be reviewed by Continence group and reported in executive summary to PS&QF	Audit of health records to show accuracy in detection and treatment of UTI. Appropriate specimens to be tested, and clinical assessment on when to start treatment.	The Catheter Taskforce Meeting group (a local health community group). Q1: The assessment sheet was amended. The trial in the use of the sheet started in OPD for all patients that had an abnormal result from the diptix test on their urine specimen; this from March 2014 to 1 May 2014. To audit the assessment sheet the standard to measure was agreed. Q2: Audit completed, feedback from medical staff received. Minor changes to the assessment completed. Forms recommenced use in OPD on 26/08/14. Completed 26/08/14. Q3: Work associated with this priority for improvement has been completed.
Review the emergency transfer process and criteria, and implement formal post transfer review process[4]	To be reviewed by the PSQF and medical staffing meeting.	Root cause analysis of transfers undertaken in last two years. Followed by review of transfer criteria, and implementation of supporting recommendations.	Q1: Agreement to complete audit accomplished. Q2: Data for audit analysis identified, all relevant patient transfer notes available. Q3: Agreement of who will carry out the audit. Q4: to complete audit and provide results to the medical staff.
Clinical Effectiveness			
Establish personal treatment plans for osteoporosis patients[3]	To be reviewed the Bone group.	Full implementation of treatment plans.	Q1 Clinic letters review undertaken by registrars at the Bone meeting. Q2 Trial of adding a 'GP action' list to all the clinic letters in the patient clinic letters completed. Q3 Doctors' letters now contain GP action list, information about the patient, information for follow up, advice line telephone numbers
To implement a formal process for clinical supervision for nurses[4]	To be reviewed by the Head of Nursing	Full implementation of a formal documented process with learning outcomes.	Q1: Supervision structure designed, policy updated and nurse training identified. Q2: Nurses in the process of being trained at the RUH,

			using principles and RNHRD NHS FT policy. Feedback good. Q3: Protected time agreed by senior staff and integrated in the off-duty. All senior nurses trained and implementing the policy. Some junior nurses still to attend dates. Q4: Supervision audit to be completed on the nursing staff and the outcomes of supervision presented to the Safeguarding Committee at the next meeting.
To review admission criteria for day case assessment beds to ensure appropriate referral, admission avoidance and rapid access to treatment[3]	To be reviewed by Rheumatology Management Group and medical staffing.	Outcome of audit of the patients who access the service.	Q1: The actions from the audit have been completed e.g. results of audit distributed and discussed amongst medical staff, admissions referral form 'criteria' updated and new forms are to be placed in each of the clinic rooms. Q3: Next audit commenced in October. Q4: Data to be analysed.
Patient Experience			
Introduction of self-management course for patients with rheumatoid arthritis (RA), to survey patient reported outcomes following course in terms of self-management of condition[5]	Patient questionnaires post-course.	Analysis of patient questionnaires.	Q1: 2 clinician and 2 lay-tutors with RA completed training to enable delivery of RASMP courses. Completed. Q2: Plan and commence delivery of RASMP Course 1 by October 2014. Completed. Q3: Plan and commence delivery of RASMP Course 2 by January 2015. Course dates set for 20 January to 24 February 2015.
To reduce delayed follow ups in rheumatology	Activity data.	Number of patients with a delayed rheumatology follow-up	Q1: Plan devised. Q2: Medical capacity issues progressed. Initial audits of consultants reviewing notes, analysed and presented to IGQAC by consultant. Q3: Capacity issues remain, with plan in place to address. Each consultant planning to review 10 sets of patient notes to triage per week. Emergency clinics in place for urgent patients.
To improve the ladies ward bathroom facilities for privacy and dignity[1] and[2]	Progress to be monitored by Matron.	Completion of refurbishment of the ladies bathroom facilities.	Q3 refurbishment complete.

Statements of assurance

- Information on the review of services:

The RNHRD NHS FT commenced a new highly specialised service, the Breast Radiation Injury Rehabilitation Service (BRIR) in September 2012 which continued throughout the period of this report. The RNHRD leads the service, which was also delivered by Barts Health NHS Trust and the Christie NHS Foundation Trust under sub-contract for part of the nine-month reporting period. The trust's Complex Regional Pain Service transferred to specialist commissioning during 2013/14.

During 2014/15 the RNHRD NHS FT sub-contracted one relevant health service, the BRIR service.

The RNHRD NHS FT reviewed all the data available to it on the quality of care in all of these relevant health services. The volume of activity delivered by these partner organisations during 2014/15 was low, given the very small number of patients covered by the service.

The income generated by the relevant health services represented less than 1% of the total income generated from the provision of relevant health services by the RNHRD NHS FT for the period of this report.

- Information on participation in clinical audits and national confidential enquiries:

During the reporting period, two national clinical audits and no national confidential enquiries covered NHS services that the RNHRD NHS FT provided.

During the nine-month period the RNHRD NHS FT participated in 100% of the national clinical audits which it was eligible to participate in.

The national clinical audits that the RNHRD NHS FT was eligible to participate in were as follows:

Acute Care – National Cardiac Arrest Audit; and Long-Term Conditions – Rheumatoid and early inflammatory arthritis.

The national clinical audits that the RNHRD NHS FT participated in, and for which data collection was completed to end of Q3, are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

National Clinical Audit RNHRD NHS FT was eligible to participate in during 2013/14	Number of cases submitted to each audit as percentage of number of registered cases required by the terms of that audit
Acute Care – National Cardiac Arrest Audit	No cardiac arrests occurred during data collection period therefore no cases submitted.
Long-term Conditions – Rheumatoid and early inflammatory arthritis	100%

No reports from national clinical audits were reviewed as none were relevant to the services provided by the RNHRD NHS FT during the reporting period.

- Information on participation in clinical research:

The number of patients receiving relevant health services provided or subcontracted by the RNHRD NHS FT in the reporting period that were recruited during that period to participate in research approved by a research ethics committee was approximately 932 (includes both portfolio and non-portfolio recruitment).

- Information on the use of the CQUIN framework:

A proportion of RNHRD NHS FT income in the ten-month period was conditional upon achieving quality improvement and innovation goals agreed between the RNHRD NHS FT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2014/15 and for the following 12-month period are available online.

The monetary total for the amount of income at 31 January 2014/15 conditional upon achieving quality improvement and innovation goals was £403,000 which was received in full or part thereof.

The monetary total for the amount of income for 2013/14 conditional upon achieving quality improvement and innovation goals was £230k which was received in full.

The monetary total for the amount of income for 2012/13 conditional upon achieving quality improvements and innovation goals was £212k which was received in full.

- Information relating to registration with the CQC and periodic/special reviews:

The RNHRD NHS FT was required to register with the CQC and its registration status was that there were no conditions related to this trust's registration.
The CQC did not take enforcement action against the RNHRD NHS FT during the reporting period.

The RNHRD NHS FT did not participate in special reviews or investigations by the CQC during the period as no inspections took place.

- Information on the quality of data:

The RNHRD NHS FT submitted records during 2014/15 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data (to November 2014). The percentage of records in the published data which:

- included the patient's valid NHS number was: 99.9% for admitted patient care; 100% for outpatient care; and there was no percentage for accident and emergency care as there was no accident and emergency service provided by the trust.
- included the patient's valid General Practitioner Registration Code was: 99.8% for admitted patient care; 99.8% for outpatient care; and there was no percentage for accident and emergency care as no accident and emergency service is provided by the trust.

The RNHRD NHS FT was acquired by the RUH Bath NHS FT prior to the annual Information Governance Assessment.

The RNHRD NHS FT was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

RNHRD NHS FT actioned the following to improve data quality:

- improvement in the legibility or format of the off-duty rota in the event it should be required for further reference.

Performance against key national priorities and National Core Standards

Performance against the indicators relevant to the services provided by the RNHRD NHS FT are detailed in the table on the following page.

Core Indicator		
The percentage of patients aged • 0-15 and • 16 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period	National Average	The percentage of patients aged • 0-15 = 7.55% • 16 or over = 9.73% Acute specialist trust data 2011/12 from health and social care indicator portal
	Highest for Trusts	The percentage of patients aged • 0-15 = 8.36% • 16 or over = 14.09% Acute specialist trust data 2011/12 from health and social care indicator portal
	Lowest for Trusts	The percentage of patients aged • 0-15 = 3.75% • 16 or over = 0% Acute specialist trust data 2011/12 from health and social care indicator portal
	RNHRD NHS FT 2014/15	0-15 = 0 16 and over (n = 6) 1.9% As at 31.12.14
	RNHRD NHS FT 2013/14	0-15 = 0 16 and over (n = 3) 0.7% Note that the above is based on trust data as portal data is not currently available
	RNHRD NHS FT 2012/13	n = 1 (0.18%) Note that the above is based on trust data as portal data is not currently available
	RNHRD NHS FT 2011/12	n = 2 (0.2%) As reported by the trust in the 2012/13 Annual Report
The RNHRD NHS FT considers that this data is as described for the following reasons:	The number of readmissions is as reported due to admission, transfer and discharge policies and procedures in place.	
The RNHRD NHS FT intends to take/has taken the following actions to improve this percentage/proportion/score rate/number and so the quality of its services, by:	The RNHRD as of 1 February 2015 as part of the RUH Bath NHS FT will continue to review admission, transfer and discharge policies following new guidance or incidents.	
The trust's responsiveness to the personal needs of its patients	National average	68.1 Per data from the 2012 national

during the reporting period		inpatient survey
	Highest for Trusts	84.4 Per data from the 2012 national inpatient survey
	Lowest for Trusts	57.4 Per data from the 2012 national inpatient survey
	RNHRD NHS FT 2014/15	*2014 national inpatient survey data not yet available*
	RNHRD NHS FT 2013/14	77.0 Trust calculation from the 2013 national inpatient survey
	RNHRD NHS FT 2012/13	76.6
	RNHRD NHS FT 2011/12	69.9
The RNHRD NHS FT considers that this data is as described for the following reasons:		
The RNHRD NHS FT intends to take/has taken the following actions to improve this percentage/proportion/score rate/number and so the quality of its services, by:		
The percentage of staff employed by, or under contract to the trust during the reporting period who would recommend the trust as a provider of care to their family or friends	National average	Data not yet available from the 2014 national staff survey
	Highest for Trusts	93 Per data from the 2014 national staff survey
	Lowest for Trusts	36 Per data from the 2014 national staff survey
	RNHRD NHS FT 2014/15	91
	RNHRD NHS FT 2013/14	89
	RNHRD NHS FT 2012/13	80
	RNHRD NHS FT 2011/12	84
The RNHRD NHS FT considers that this data is as described for the following reasons:	The data is from the 2014 National Staff Survey, the score is higher than the national average for specialist acute trusts.	
The RNHRD NHS FT intends to take/has taken the following actions to improve this percentage/proportion/score rate/number and so the quality of	Any actions identified will be incorporated into the RUH Bath NHS FT plan going forward.	

its services, by:		
The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period	National average	96% Per February 2014 portal data
	Highest for Trusts	100% Per February 2014 portal data
	Lowest for Trusts	77% Per February 2014 portal data
	RNHRD NHS FT 2014/15	99.95% Per 31 January 2015 portal data
	RNHRD NHS FT 2013/14	100% The above is based on Trust data as portal data is not currently available.
	RNHRD NHS FT 2012/13	100%
	RNHRD NHS FT 2011/12	99.53% Per February 2014 portal data
The RNHRD NHS FT considers that this data is as described for the following reasons:	The national average is the percentage of adult patients admitted to NHS funded care as published by NHS England. The RNHRD NHS FT has policies and procedures in place for the risk assessment of venous thromboembolism and conducts clinical audits against these policies and procedures.	
The RNHRD NHS FT intends to take/has taken the following actions to improve this percentage/proportion/score rate/number and so the quality of its services, by:	The RNHRD as part of the RUH Bath NHS FT will continue to review any new national guidance and existing policies and procedures to maintain this score.	
The rate per 100,000 bed days of cases of *C. difficile* infection reported within the trust amongst patients aged 2 or over during the reporting period	National average	16.1 per 100,000 bed days Based on acute trust data as per the portal as at March 2013.
	Highest for Trusts	30.8 per 100,000 bed days Based on acute trust data as per the portal as at March 2013
	Lowest for Trusts	0 per 100,000 bed days Based on acute trust data as per the portal as at March 2013
	RNHRD NHS FT 2014/15	0 per 100,000 bed days as at 31.12.14
	RNHRD NHS FT 2013/14	n=0 The above is based on trust data as portal data is not available as at 21.5.14
	RNHRD NHS FT 2012/13	13.8 per 100,000 bed days Based on acute trust data as per the portal as at March 2013
	RNHRD NHS FT	25.6 cases per 100,000 bed

	2011/12	days Based on acute trust data as per the portal as at March 2013
The RNHRD NHS FT considers that this data is as described for the following reasons:	The RNHRD NHS FT had in place policies and procedures to reduce the risk of infection.	
The RNHRD NHS FT intends to take/has taken the following actions to improve this percentage/proportion/score rate/number and so the quality of its services, by:	The RNHRD has completed a root cause analysis and will implement the learning from the case. As part of the RUH, Bath NHS FT RNHRD will continue to review any new national guidance and existing policies and procedures to prevent and control infection.	
The number and, where available, rate of patient safety incidents reported within the trust during the reporting period.	National average	9.69 incidents reported per 100 admissions For acute specialist organisations 1 October 2013 – 31 March 2014 as reported by NRLS
	Highest for Trusts	32.88 incidents reported per 100 admissions For acute specialist organisations 1 October 2013 – 31 March 2014 as reported by NRLS
	Lowest for Trusts	4.72 incidents reported per 100 admissions For acute specialist organisations 1 October 2013 – 31 March 2014 as reported by NRLS
	RNHRD NHS FT 2014/15	7.66 (n= 119) incidents reported per 100 admissions and middle 50% of reporters for acute specialist organisations 1.10.13 – 31.3.14 as reported by NRLS
	RNHRD NHS FT 2013/14	5.86 (n = 91) incidents reported per 100 admissions and middle 50% of reporters for acute specialist organisations April – September 2013 as reported by NRLS
	RNHRD NHS FT 2012/13	5.63 (n = 99) incidents reported per 100 admissions April – September 2012 as reported by NRLS. 9.9 incidents reported per 100

		admissions October 2012 – March 2013 as reported by NRLS
	RNHRD NHS FT 2011/12	4.63 (n=88) incidents reported per 100 admissions April 2011 – September 2011 as reported by NRLS. 3.48 incidents reported per 100 admissions October 2011 – March 2012 as reported by NRLS.
The RNHRD NHS FT considers that this data is as described for the following reasons:	Staff continued to report incidents on the trust incident reporting system and the trust uploads these monthly to national system NRLS.	
The RNHRD NHS FT intends to take/has taken the following actions to improve this percentage/proportion/score rate/number and so the quality of its services, by:	The RNHRD as part of the Bath RUH FT will continue a culture of incident reporting through training in incident reporting at induction, access to incident reporting for all staff and review of incidents and feedback to staff.	
The number and percentage of such patient safety incidents that resulted in severe harm or death	National average	Less than1% of incidents – For acute specialist organisations 1 October 2013 – 31 March 2014 as reported by NRLS
	Highest for Trusts	3.8 (n=18) For acute specialist organisations 1 October 2013 – 31 March 2014 as reported by NRLS
	Lowest for Trusts	0 (n=0) – For acute specialist organisations 1 October 2013 – 31 March 2014 as reported by NRLS
	RNHRD NHS FT 2014/15	0% (n=0) Oct 2013 – March 2014 for all acute specialist organisations as reported by NRLS
	RNHRD NHS FT 2013/14	0% (n=0) April – September 2013 for all acute specialist organisations as reported by NRLS
	RNHRD NHS FT 2012/13	0% (n = 0) April 2012 – September 2012 as reported by NRLS 1.1% (n=2) October 2012 – March 2013 as reported by NRLS
	RNHRD NHS FT	0% (n=0) April 2011 –

	2011/12	September 2011 as reported by NRLS 0% (n=0) October 2012 – March 2013 as reported by NRLS
The RNHRD NHS FT considers that this data is as described for the following reasons:	Data published for acute specialist organisations 1.10.13 – 31.3.14 by NRLS. There were 0 incidents that were reported as resulting in severe harm or death for the RNHRD NHS FT.	
The RNHRD NHS FT intends to take/has taken the following actions to improve this percentage/proportion/score rate/number and so the quality of its services, by:	Any incidents which result in severe harm or death would be investigated by root cause analysis and resulting actions for improvement would be monitored by the Operational Governance Committee and reported through to the Board of Directors.	

For the reporting period the trust provided services in rheumatology, pain and fatigue management and endoscopy. The trust has not reported against the following indicators as the indicators were not relevant to the above services provided by the trust for the reporting period:

- The value and banding of the summary hospital-level mortality indicator and the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period
- The percentage of patients on Care Programme Approach
- The percentage of Category A telephone calls resulting in an emergency response
- The percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction
- The percentage of patients with suspected stroke assessed face to face
- The percentage of admission to acute wards for which Crisis Resolution Home Treatment Team acted as a gatekeeper
- The trust's patients reported outcome measures scores for groin hernia surgery, varicose vein surgery, hip replacement surgery, knee replacement surgery
- Patient experience of community mental health services.

Part 3. Other information

- An overview of the quality of care offered by the RNHRD NHS FT based on performance in 2014/15 against indicators selected by the board in consultation with stakeholders. The indicators were selected following feedback from national patient surveys, complaints, Governors and commissioners.

Quality overview

Indicator	Data Source	To End Q3 2014/15	2013/14	2012/13	2011/12	2010/11
Patient Safety						
MRSA bacteraemia	Data reported nationally and data governed by standard national definition	0	0	0	0	0
C.difficile	Data reported nationally and data governed by standard national definition	0	0	1	4	1
Meet essential /core standards regarding quality & safety	Data reported to CQC and reported through quality report to CCG/PCT	Met	Met	Met	Met during Q1, Q2 and Q4	Met

Indicator	Data Source	2014/15	2013/14	2012/13	2011/12	2010/11
Clinical Effectiveness						
The trust will continue to implement NICE guidelines relevant to the trust services	Data reported through Healthcare Commission special data collection and reported through quality report to CCG/PCT	Met	Met	Met	Met	Met
Improve availability of follow-up appointments	Number of written complaints regarding availability of follow-up appointments reported through quality report to CCG/PCT and Annual Report	0	0	1	5	2
Meet core standards regarding clinical effectiveness	Data reported through quarterly quality report to board and CCG/PCT	Met	Met	Met	Met	Met
Patient Experience						
Improve	National	Data not	8.1	7.8 (about the same as	7.5	74%

bathroom facilities and signage on wards	CQC Survey of Adult Inpatients in the NHS 2012 results for the RNHRD NHS FT question on mixed-sex bathroom or shower areas by percentage who answered no to the question: 'Whilst staying in hospital, did you ever share the same bathroom or shower area as patients of the opposite sex?'	available at end of Q3 2014/15	(about the same as other trusts & an improvement on the 2012 survey score)	other trusts and an improvement on the 2011 survey score)		
Improve telephone access for appointments	Number of complaints or PALS on this issue reported in Quality Report to CCG/PCT	0	25	49	85	10
All written complaints to continue to be managed effectively locally within policy timescales	Number of written complaints received and number managed locally within national complaints policy timescales	15 complaints received 13 of which were managed locally within the national complaints policy timescales. For 2 complaints the investigation took longer than	12 complaints received 11 of which were managed locally within the national complaints policy timescales.	17 out of 17	23 complaints received 20 of which were managed locally within the national complaints policy timescales.	11 complaints received 10 of which were managed locally within the national complaints policy timescales.

		anticipated and an interim letter was sent to the patient to explain the reason for the delay.	For one complaint the investigation took longer than anticipated and an interim letter was sent to the patient to explain the reason for the delay.			

The RNHRD NHS FT met all national quality performance targets during the period with the exception of the maximum time of 18 weeks from point of referral to treatment in aggregate for non-admitted patients in August 2014 (target 95% actual was 94.29%). Those that are set out in Monitor's Risk Assessment Framework and relevant to the Trust were:

C.difficile

- Patients aged 2 or more
- A positive laboratory test result for CDI recognised as a case according to the trust's diagnostic criteria
- Positive results on the same patient more than 28 days apart should be reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken
- The trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one)
- *Clostridium difficile* year-on-year reduction (to fit the trajectory for the year as agreed with CCG = 6 cases in 6 separate patients). The trust is on a trajectory to meet this target as there has been one case of *Clostridium difficile* in 2014/15 up to 31 January 2015, against a locally agreed trajectory of 6 for the year 2014/2015.
- Referral to treatment waiting times; non-admitted (95th percentile). The trust met this performance target throughout 2014/15 with the exception of August 2014 when 94.3% was achieved against a target of 95%
- Referral to treatment waiting times; admitted (95th percentile). The trust met this performance target throughout 2014/15
- Certification against compliance with requirements regarding access to healthcare for people with a learning disability

- The trust continued to monitor 28-day readmissions and provided commissioners with an exception report for any cases.

28 day readmissions

Numerator

The number of finished and unfinished continuous in-patient spells that are emergency admissions within 0 to 27 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies, but excluding the following: those with a main speciality upon re-admission coded under obstetric; and those where the re-admitting spell has a diagnosis of cancer (other than benign or *in situ*) or chemotherapy for cancer coded anywhere in the spell.

Denominator

The number of finished continuous in-patient spells within selected medical and surgical specialties, with a discharge date up to March 31 within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days prior to admission are excluded.

CQC registration and compliance with essential standards of quality and safety

- The board declared full compliance with the CQC Essential Standards of Quality and Safety to the end of Q3 2014/15.
- The CQC did not carry out an inspection visit at the RNHRD NHS FT during the nine-month reporting period.

Complaints

Information on complaints handling

The RNHRD had an established Patient Advice and Liaison Service (PALS) which, following acquisition, is now part of the Royal United Hospitals Bath NHS FT. This service is available to provide patients and their carers and families with confidential information, advice and support. PALS provides information about the hospital, the NHS, and organisations and support groups outside the NHS. It helps resolve concerns, including verbal and written complaints, when patients are using hospital services. PALS works with patients to improve hospital services, by listening to their experiences and ensuring that staff who deliver the services are aware of, and address, any issues raised.

Written complaints

The trust received 15 written complaints from April 2014 to December 2014. Twelve of the responses were provided within the timeframes set out in the trust's complaints policy. For three complaints the investigation took longer than anticipated and an interim letter was sent to the patient to explain the reason for the delay.

No complaints received from April 2014 to December 2014 were referred to the Health Service Commissioner to consider.

The subject matter of complaints that the responsible body received:

Appointments delay/cancellation (outpatients)	2
Attitude of staff	3
All aspects of clinical treatment/care	4
Communication verbal/written	4
Appointments delay (outpatients)	1
Failure to follow agreed procedures	1
Total	15

Issues arising out of those complaints, or the way in which the complaints were handled and action taken are detailed in the table below.

Issues arising out of complaints	**Action taken as a result of written complaints**
Incorrect information provided regarding process for claiming patient's travel expenses to and from hospital appointment.	Review and update of hospital Travel Costs Scheme leaflet by the hospital's Patient Literature Group to make it easier to read.
Patient concern regarding their experience during a programme.	Information packs about the service were reviewed and improved. Review of accommodation external to the hospital to manage the resource and support patients effectively.
Patient concern regarding their experience during two outpatient appointments.	Medical Director met with consultant to reflect on appointments and review learning. Consultant wrote directly to patient with apology.
GP expressed concerns regarding a delay in access to a service for one of his patients.	Review and improved administration resource and support to improve communication and reduce errors and omissions.
Concern regarding a patient's experience during an outpatient appointment and the decision not to admit patient at that time.	Clinical Lead and Head of Operations met with the patient to address concerns and identify a future treatment plan.
Patient reported an incident with an employee that occurred during a therapy appointment.	Complaint passed on to the RUH for investigation and action as employee was RUH employee seconded to RNHRD NHS FT. Serious Incident Investigation and HR investigation completed by RUH. Safeguarding alert instigated. Support provided to patient from RNHRD PALS, RNHRD NHS FT Service Lead and RUH Head of Therapies.
Patient concern regarding communication from an administration team.	Review and improved administration resource and support to improve communication and reduce errors and omissions. Quality control processes identified and implemented.
Delay in outpatient appointment.	No recommendations for improvement.
Concerns regarding the practice of a consultant.	Medical Director reviewed and found that usual practice had been followed and the situation was assessed with reference to the DH Maintaining High Professional Standards in the Modern NHS.
Concerns regarding an outreach	Consultant visited the outreach clinic and met with family and

clinic.	staff. Actions taken by Clinical Lead reviewed by consultant and Medical Director. Communication and supervision procedures reviewed and strengthened.
Highlighted two clinical governance issues regarding clinic letters and communication of change in practice for referral requests for imaging.	Apologised for human errors identified. Reviewed records of all RUH radiology paper referrals made since March 2014 found that every patient has had their appointment.
Patient concern regarding attitude of a doctor.	Medical Director reviewed recruitment and employment of locum doctors and reported findings to the Board of Directors. Medical Director reported complaint to agency employing doctor.
Patient concern regarding verbal and written communication by locum doctor.	Medical Director met with consultant to reflect on appointments and review learning. Consultant wrote directly to patient with apology.
Patient concern regarding verbal and written communication by locum doctor.	Medical Director met with consultant to reflect on appointments and review learning. Consultant wrote directly to patient with apology.
Waiting time for new patient appointment did not meet a patient's expectation	No recommendations for improvement.

Improvements in patient/carer information

The Patient Experience and Membership Manager was the Chair of the trust's Patient Literature Group. This group's membership represented patients from all of the hospital's specialties. Since it began in November 2005 the group has reviewed approximately 300 leaflets and pieces of information produced for patients and carers by staff in the trust. All literature was reviewed to ensure information was accessible to and appropriate for patients, and produced to trust standard. The group also developed a policy to assist staff when producing patient information and literature, and a monitoring system to ensure the literature was meeting the trust's standards.

Equality delivery system

During April to December 2014 the trust used the Equality Delivery System (EDS) to review its equality performance and to identify future priorities and actions. The EDS is designed to support NHS organisations to deliver better outcomes for patients and communities and better working environments for staff. It is a tool to help organisations start the analysis that is required by section 149 of the Equality Act 2010 – the public sector equality duty.

The EDS is made up of 18 outcomes grouped around four goals. Every year the trust reviewed performance against each outcome and agreed actions for improvement. The resulting prioritised quality objectives and associated actions were incorporated into the trust plans.

Feedback from patients identified a need for a review of communication access for patients who have hearing impairments. From the review the trust found that it:

- offered an individualised approach dependent on needs

- recorded communication requirements for individual patients on its appointment computer system (Webtrack)
- provided email access to the appointment office
- offered PALS email address as a central contact point for the trust
- ensured equality impact assessments were conducted during all policy reviews and service changes.

As a result of the review the trust purchased two portable hearing loops for the outpatient department and therapy outpatient departments.

A governor with an interest in this field advised on communication access for patients who have hearing impairments during the trust's implementation of the 15 Steps Challenge and regarding the trust's standard text for the website and patient leaflets.

Equality & Diversity was reported to the senior management group (SMG). A summary of workforce equality statistics are detailed below:

	Employees 2014/15*	Employees 2013/14	Employees 2012/13	Employees 2011/12	Employees 2010/11	Employees 2009/10	Membership 2014/15
Age							
0-16	0	0	0	0	0	0	0
17-21	4	4	9	9	9	12	10
22+	341	336	466	451	451	455	4013
Ethnicity							
White	305	294	388	400	399	399	3840
Mixed	3	4	14	9	8	9	2
Asian & Asian British	19	21	40	23	23	26	45
Black or Black British	10	11	16	18	14	21	27
Other	4	10	13	10	9	12	109
Gender							
Male	63	78	97	79	78	81	1287
Female	278	262	378	381	380	386	2736
Gender Reassignment	0	0	0	0	0	0	Data not available
Disability							
Declared a disability	34	25	10	7	7	7	Data not available

*figures to 31st January 2015 correct as of 30/04/2015

Clinical Effectiveness

Clinical effectiveness is a quality improvement process that seeks to improve patient care and outcomes through a systematic review of care against explicit criteria and the implementation of change. The trust had a commitment to clinical effectiveness and audit, to evidence-based medicine, monitoring practice and continuously improving local and national standards.

Structures were in place to ensure that audit against any national guidelines relevant to the Trust were undertaken.

National CQC Survey of Adult Inpatients in the NHS 2014 results for the RNHRD NHS FT

To improve the quality of services that a trust delivers, it is important to understand what patients think about their care and treatment. One way of doing this is by asking patients who have recently used the trust's services to tell it about their experiences.

The trust participated in the national CQC survey of adult inpatients; the results are not available at the end of Q3 2014/15.

Regulatory ratings

As described in the 2013/14 Annual Report on 1 October 2013 Monitor replaced the longstanding Compliance Framework with a new Risk Assessment Framework which changed the approach to the assessment of the regulatory ratings for each Foundation Trust.

From this date the Financial Risk Rating was replaced by the Continuity of Services Rating while the elements which determined the Governance Risk Rating were revised.

Continuity of Services Rating

The Continuity of Services Risk Rating incorporates two common measures of financial robustness, liquidity and capital servicing capacity. Using these two metrics Monitor determines on a scale of 1 to 4 the risk that the trust will fail to carry on as a going concern. A rating of 1 indicates the most serious risk and a rating of 4 the least risk.

Governance Risk Rating

The elements used to assess the Governance Risk Rating are:

- Performance against national access and outcomes requirements
- CQC judgments
- Third-party information
- Quality governance indicators
- Continuity of services and aspects of financial governance.

Monitor will use the information gathered under these headings to assess the strength of governance at each NHS Foundation Trust. A green rating means there are no evident concerns, where there are concerns the rating will be described as 'under review', while a red rating means that regulatory action has been taken.

Factors affecting the Trust's Regulatory Ratings for 2014/15

For some time significant and long-standing financial challenges compromised the ability of the trust to comply with the duty specified within its licence to operate efficiently, economically and effectively.

On 23 April 2013 Monitor issued the trust with enforcement undertakings. These were based on the trust delivering a financial risk rating of 1 throughout the 2012/13 financial year, forecasting a deficit of £0.6m for 2012/13 (after recognizing £2.1m of additional funding support received during the financial year), and a likely shortfall of £3.6m in 2013/14 without cash injections from the Department of Health to fund the deficit and meet essential capital expenditure.

For 2014/15 the trust continued to be subject to formal enforcement pursuant to Section 106 of the Health and Social Care Act 2012 to address the financial issues leading to non-compliance with its licence conditions. Details of Monitor's actions and supporting documentation are available to view on the Monitor website.

These factors influenced Monitor's view of both the continuity of services rating and governance risk rating (automatically red when enforcement undertakings have been issued) for 2014/15 and which are set out in the following table together with the actual performance against plan.

Table of analysis

2014/15	Annual Plan	Q1	Q2	Q3
Continuity of service rating	2	2	3	3
Governance rating	Red	Red	Red	Red

2013/14	Annual Plan	Q1	Q2	Q3	Q4
Under the Compliance Framework					
Financial risk rating	1	1	1		
Governance risk rating	Red	Red	Red		
Under the Risk Assessment Framework					
Continuity of service rating				1	1
Governance rating				Red	Red

The improved continuity of service rating in Q2 resulted from the receipt of a pre-agreed cash drawdown of public dividend capital to meet routine expenditure, but which also improved the trust's liquidity position at the end of the quarter. This was sufficient to move the rating from a 2 to a 3.

As detailed elsewhere in the report the trust entered into a Monitor approved transaction with the Royal United Hospitals Bath NHS Foundation Trust on 1 February 2015 and thereafter ceased to exist as a separate entity.

Public interest disclosures

Income disclosure

Income from the provision of goods and services for the purposes of health service in England is greater than income from the provision of goods and services for any other purpose for the RNHRD. The RNHRD NHS FT received income from other services including private patients and catering. The income generated from these additional activities serves to enhance patient care and further knowledge and understanding of the conditions treated at the RNHRD.

Communication and consultation

To fulfil the trust's obligations under the Transfer of Undertakings (Protection of Employment) Act (TUPE), a TUPE with measures consultation took place with all employees during December 2014 and January 2015. Both management and staff side, which includes trade union representatives, were involved with this consultation on the transfer of the employment of RNHRD NHS FT employees to the employment of the RUH NHS FT in line with the planned acquisition.

Communication and engagement around the proposal to transfer the RNHRD NHS FT endoscopy service to the RUH site and integrate with the RUH endoscopy service took place over 2014/15. This included engagement with commissioners, B&NES Wellbeing Policy Development and Scrutiny Panel, GPs and patients. Feedback on the proposal was taken into consideration and informed approval of the service transfer. The endoscopy service transferred to the RUH on 1 February 2015.

Patient and public involvement activities

Patient and public involvement activities during 2014/15 included:

- Patient involvement in the 15-steps challenge, a tool to assist patients and staff to work together to identify both good practice and areas for improvements that will enhance the patient experience. During 2014/15 patients were involved in assessing the trust's outpatient department, therapy outpatient department and the inpatient wards
- Patient Literature Group monthly meetings to review information produced by the trust to ensure it is accessible to and appropriate for patients
- Patient and public volunteers complemented and supported the services delivered and helped to build bridges with the local community
- Patients were involved in the plans for the refurbishment of the trust's outpatient department.

Health & wellbeing

The trust had no health and safety enforcement notices during the reporting period.

An Occupational Health service including an Employee Assistance scheme providing confidential counselling services for employees and their families was available via a contract with the Royal United Hospitals NHS Foundation Trust Occupational Health providers.

The action plan generated as a result of the NHS Employers health and wellbeing survey in June 2013 continued to be monitored during 2014-2015. This was included as a standard agenda item of the monthly meeting with staff side. During 2014-2015 the trust continued to invest in the resilience of its managers and employees and health and well-being of staff.

Sickness absence data

Due to an improved health management and sickness absence policy and procedure, sickness absence figures fell dramatically over the calendar year and at year-end (January - December) reported a figure of 3.48%. The breakdown of sickness absence over the calendar year is set out below:

Period	% FTE Total sickness absence
January	3.26
February	2.58
March	2.25
April	2.63
May	3.83
June	4.20
July	4.21
August	3.62
September	2.58
October	3.36
November	2.98
December	6.08
Year	**3.48**

Correct as of 30/03/2015

Better payment practice code

The Better Payment Practice Code requires NHS organisations to aim to pay all valid non-NHS invoices within 30 days of receipt or the due date whichever is later.

Cost allocation and charges

The RNHRD NHS FT complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Policies and procedures with respect to countering fraud and corruption

The trust had policies and procedures in place with respect to countering fraud and corruption. It took a proactive approach to raising awareness of the potential for fraud

amongst its staff and worked closely with the local counter fraud service to ensure preventative measures were in place.

Charitable funds

The Royal National Hospital for Rheumatic Diseases Charitable Fund was the main fundraising charity for research, building and equipment projects across the trust and will continue as a separate fund linked to the RUH charitable fund. The RNHRD is grateful to all those patients, friends and relatives who have contributed to the charity over the past year.

In accordance with IAS 27 (revised), the financial statements of the RNHRD NHS FT have been consolidated to incorporate the Accounts of the Royal National Hospital for Rheumatic Diseases Charitable Fund.

Financial Accounts for the ten months ended 31 January 2015

Presented to Parliament pursuant to Schedule 7, paragraph 25(4)(a) of the National Health Service Act 2006

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Statement of the Chief Executive's responsibilities as the Accounting Officer of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RNHRD NHS FT). The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper Accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

On 1 February 2015, the RNHRD NHS FT was acquired by the Royal United Hospitals Bath NHS Foundation Trust. The Chief Executive of the Royal United Hospitals Bath NHS Foundation Trust has assumed the role of Accounting Officer for the Annual Report and Accounts for the 10 months to 31 January 2015.

Under the NHS Act 2006, Monitor has directed the RNHRD NHS FT to prepare for each financial year a Statement of Accounts in the form and on the basis set out in the Accounts Direction. The Accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the RNHRD NHS FT and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

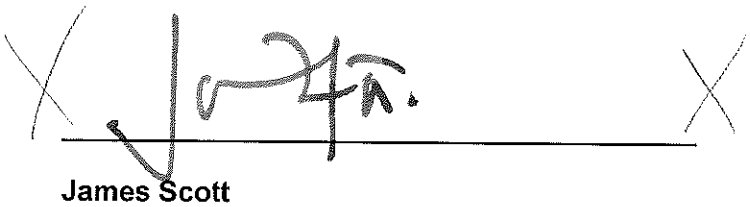
In preparing the Accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgments and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the Accounts;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the Accounts on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the RNHRD NHS

FT and to enable him to ensure that the Accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the RNHRD NHS FT and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.



James Scott

Chief Executive,
Royal United Hospitals Bath NHS Foundation Trust

29 April 2015

Annual Governance Statement to 31 January 2015

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the RNHRD NHS FT, to 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 in the RNHRD NHS FT until the date of acquisition 31 January 2015 and was in place to approve of the Quarter 3 Quality Report and M8 Accounts.

Capacity to handle risk

Leadership is given to the risk management process through:

- the Audit Committee and board developing and agreeing the Assurance Framework
- the board sub-committees' structures which are now well embedded to strengthen risk management. The Finance and Activity Committee meets monthly and the Integrated Governance and Quality Assurance Committee (IGQAC) meets quarterly as a minimum, both committees report to the Audit Committee and board
- the Finance and Activity Committee considers financial risks associated with finance and activity plans
- IGQAC considers risks associated with clinical quality and governance
- the Audit Committee reviews all risks on the risk register rated moderate and above and ensures that appropriate controls are in place to minimise risks
- the Clinical Risk Committee reviews all clinical risks rated moderate and above and receives reports on complaints & claims and reviews reports from the following committees: health and safety, infection prevention and control, medical

devices, drugs and therapeutics, safeguarding and reports from the National Patient Safety Agency and reports to IGQAC

- staff are trained or equipped to manage risk in a way appropriate to their authority and duties
- all staff receive training at induction on risk management policy and process and staff responsibilities and duties
- all staff have access to electronic incident reporting which is encouraged and supported by line managers. Line managers aim to complete their approval of incident reports within two weeks and the trust reports patient safety incidents to the National Reporting and Learning Service and patient safety incidents are reviewed at the Clinical Risk Committee
- the trust seeks to learn from good practice through: membership of local safeguarding committees and the implementation of a range of patient safety initiatives
- regular briefings for the senior managers.

The risk and control framework

The objective of the Risk Management Strategy is to ensure that the trust will conduct its business to the best possible standard and provide the highest quality of care in a safe environment, through identifying, prioritising and managing all aspects of risk.

The trust's Risk Management Strategy aims to achieve the key objective above and ensure:

- management processes are in place to minimise risks
- high patient safety standards are maintained
- the cost of risk is reduced
- safe practices exist
- safe systems exist
- safe premises
- awareness of dangers and liabilities.

The strategy harnesses the knowledge and expertise of individuals within the organisation and translates it, with their help, into positive action, to help the trust to achieve its objectives.

Risk management is embedded in the activity of the organisation through risk management policies and monitoring against these at various committees. All staff receive training at induction on the management of risk and reporting of incidents.

Risks to data security are managed and controlled through implementation of the Code of Conduct in Respect of Confidentiality and Data Security policy and procedures and staff training at induction on information governance and through national information governance training.

Risk (or change in risk) is identified, evaluated and controlled through reporting of risks on a trust risk register, risks are then reviewed at the relevant sub-committee level to ensure all risks have been identified, evaluated and controlled.

Quality assurance is obtained through reporting to the IGQAC committee on a range of quality governance areas including patient safety, clinical risk, clinical effectiveness, patient experience and any external visits, information governance, human resources and a six-monthly review of compliance against the NHS Constitution. Assurance is obtained routinely on CQC registration requirements through a review of the evidence to support compliance at IGQAC and review of the CQC Quality and Risk Profiles at the IGQAC meeting and the board.

Financial assurance is obtained through reporting to the monthly Finance and Activity Committee.

Risk appetites are determined by the review of all risks on the risk register, rated moderate and above, at each Audit Committee meeting which then reports to the board. The Audit Committee and board also review the Assurance Framework on a six-monthly basis.

These governance structures ensure that detailed information is analysed prior to presentation to the board and consequently the IGQAC and Finance and Activity Committees provide assurance. The committees review the content of the governance declarations prior to presentation to the board to ensure they are consistent with a range of information presented.

The trust is able to assure itself of the validity of its Corporate Governance Statement, required under NHS Foundation Trust condition 4(8) 9b) through the above board and board sub-committee governance structures and

- in 2014/15 the board sub–committees reviewed the content of the governance declarations prior to presentation to the board to ensure they are consistent with a range of information presented
- the governance declarations are presented to the board for approval and signature prior to submitting to Monitor.

Major risks - In year:

Item	Principal risks and uncertainties	Mitigating actions	Risk rating & level at 31.12.14
1	Loss of key personnel – business continuity risk	Regular review of staffing to meet strategic objectives	
2	Delay in Rheumatology follow-ups	Increase in Rheumatology medical staff capacity, weekly audit of follow-up list	
3	Failure to meet provider licence conditions due to risks detailed in 4, 6 & 7 below	This risk will be mitigated on acquisition by the RUH NHS FT	Moderate
4	Risk to occurrence of the potential acquisition by the RUH	This risk will be mitigated through the RUH and RNHRD NHS FT transaction process and structures	Low
5	Risk to RNHRD NHS FT brand on acquisition by RUH	Dedicated transaction work stream established with regular meetings schedule in place	Moderate
6	Failure to meet cash targets and/or obtain funding required to meet the cash shortfalls forecast	The risk has been mitigated for the period from 1 April 2014 to 31 January 2015 by securing Public Dividend Capital facility against which a drawdown of £1m has been made in the period. With effect from 1 February 2015, the assets and liabilities of the trust will be acquired by RUH, and the DH has provided funding to the RUH to meet any outstanding obligations	Moderate
7	Failure to achieve activity and cost levels underpinning the plan in 2014/15	Monitoring of performance against plan with corrective action at earliest opportunity to minimise adverse variances	Moderate
8	Single consultant specialty	This risk will be mitigated on 1.2.15 as the endoscopy service will transfer to the RUH NHS FT and will no longer be a single consultant specialty	Moderate

The elevated risk noted by the board in the CQC Intelligent Monitoring Dec 2014 report was:

One red elevated risk which relates to the Monitor Governance Risk Rating as a consequence of the financial risks.

Future risks:

The RNHRD NHS FT was informed by Monitor, in a letter dated 23 May 2012, that it had been placed in significant breach of one term of its Authorisation, namely Condition 2: the general duty to exercise its functions effectively, efficiently and economically. As a Foundation Trust, the RNHRD NHS FT was issued a Provider Licence by Monitor on 1 April 2013. The circumstances in which the NHS Foundation Trust was in significant breach of its authorisation also gave rise to the NHS Foundation Trust being in breach of its Provider Licence and consequently Monitor issued enforcement undertakings.

The trust submitted a strategic plan in line with these enforcement undertakings in October 2013. As reported in the 2013/14 Annual Report, the strategic plan was to be acquired by another NHS organisation and this strategic plan will be completed through the acquisition by the Royal United Hospitals NHS FT on 1 February 2015.

Equality impact assessments are integrated into core trust businesses through completion of standard equality impact assessment forms in trust policies and procedures and review by the appropriate ratifying committee.

Public stakeholders are involved in managing risks which impact on them through:

- Governor representatives' attendance at board meetings and Audit Committee meetings and through discussion with Executive Directors at Council of Governor meetings; and board meetings monthly in public
- Attendance at the B&NES Wellbeing Policy and Development Scrutiny Panel to provide updates and discussion around the future of the RNHRD NHS FT services at meetings held in public.

The Foundation Trust is fully compliant with the registration requirements of the CQC.

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. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency

requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaption reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The trust has had an underlying deficit through the three preceding financial years (2013/14 £1,125k, 2012/13 £2,605k [before restructuring costs and additional funding] and 2011/12 £1,006k), and the budget for 2014/15 reflected an expectation of further deterioration in the position. There was a recognition that with such a small revenue base, and little scope for further reduction in fixed and semi-fixed overheads, further cost improvements would be challenging. Further, tariff deflation and pay inflation compounded the issues faced when determining the plan for the year ahead. The budget for 2014/15 was approved by the trust's board as a deficit of £2,205k.

The Finance & Activity board sub-committee has actively scrutinised the financial performance of the trust against the 2014/15 plan on a monthly basis and provided reports to the trust's board and Audit Committee accordingly. The external auditors have been kept appraised of the situation throughout.

Information Governance

There have been no serious incidents relating to information governance including data loss or confidentiality breach and no incidents classified as Level 2 in the Information Governance Incident Reporting Tool during 2014/15.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

The steps which have been put in place to assure the board that the quality reports present a balanced view and that there are appropriate controls in place to ensure the accuracy of the data:

- Governance and leadership
- The role of policies and plans in ensuring quality of care provided
- Systems and processes
- People and skills; and
- Data use and reporting (comments on the systems in place to review and report the quality metrics, focusing on both data collection and reporting).

Governance and leadership

- Up to the end of December 2014/15 the RNHRD NHS FT board approved the overall strategy for quality which included trust-wide quality goals covering safety,

clinical effectiveness and patient experience which incorporated national and local priorities. The local priorities were identified by our patients, members, governors and local Healthwatch representatives, CCGs and staff

- Up to the end of December 2014/15 the board held open board meetings every month, quality is the first board key standing agenda item
- The board reviewed performance against national quality goals every month and the local quality goals each quarter
- The board quality governance structure has an established board sub-committee, the IGQAC chaired by a non-executive director with further non-executive director and executive director membership. The IGQAC committee receives reports on a range of quality issues and provides assurance to the board on quality performance throughout the trust including: compliance with CQC essential standards of quality and safety, clinical risks and incidents, patient safety, patient experience, complaints, PALS, CQC Intelligent Monitoring reports for the RNHRD NHS FT, clinical effectiveness including national guidance such as National Institute for Health and Care Excellence (NICE), and training reports
- The board is advised of any risks to clinical quality through an up-to-date risk register report which covers all trust services and is presented to each meeting of the Audit Committee; each risk has a designated lead director
- There is a process in place for capturing front-line staff concerns, including a whistle blowing policy; the Audit Committee receives a report at each meeting on whistleblowing
- The trust has in place a bespoke audit system, Vital Aspects of Clinical Care (VACC), which provides early warning indicators for patient safety. The board received a report on the VACC outcomes each month up to January 2015
- To ensure the quality report presents a balanced view a draft version was approved by the IGQAC committee prior to presentation to the board.

<u>The role of policies and plans in ensuring quality of care provided</u>

- The organisation structure in place up to 31 January 2015 ensures clear responsibilities for delivering quality performance
- The trust has policies in place to ensure quality of care provided and updates to policies are ratified by the sub-committees
- There are clear rules within trust policies to cover escalation of serious untoward incidents and complaints
- A statement regarding occurrences of any serious untoward incidents and complaints is included in the monthly quality performance report to the board
- Action plans to address quality performance issues are reviewed at IGQAC to ensure that actions are completed and lessons are learned
- There is a continuous rolling programme of clinical (national and local) and internal audit in relation to quality governance, which includes action plans competed from the audit and a programme of re-audits are undertaken to assess improvement. This process is reviewed at IGQAC and the Audit Committee.

Systems and processes

- Quality outcomes are made public through board meetings in public, through presentations and feedback at Council of Governors meetings, Annual Members Day and posting information on the trust's website
- Patient feedback is reviewed by the board through the monthly patient walk rounds, patient stories and the quarterly quality reports which include feedback through complaints, PALS, feedback to Governors, and the CQC Intelligent Monitoring Reports for RNHRD NHS FT. The trust participated in the CQC National Inpatient Survey during 2014/15; the results will be published in April 2015
- The board actively engages other stakeholders on quality through:
    - quarterly quality reports reporting at the IQGAC meeting attended by a representative of the host commissioner
    - meeting and sharing quality reports with the host commissioner, and
- Governors are in attendance at all board and Audit Committee meetings.

People and skills

- Quality governance is subject to rigorous challenge, including full non-executive director engagement and review through participation in Audit Committee and IGQAC
- The capabilities required in relation to delivering good quality governance are reflected in the make-up of the board
- The Audit Committee has conducted self-assessments during the year against the Code of Governance
- The board members have taken a proactive approach to improving quality through monthly walk rounds to identify areas for improvement, the outcome of the walk rounds are reported to the board; the resulting action plans are presented to the board
- During 2014/15 up to January 2015 a patient story was included on the agenda at the start of each board meeting
- The board received training including on quality issues prior to each board meeting
- Staff throughout the trust are involved in national patient safety initiatives
- The Chief Executive briefing sessions for all staff include items on quality.

Data use and reporting

- The trust's Information Governance Strategy, Policy and Annual Plan include data quality requirements of accuracy, validity, reliability, timeliness, relevance and completeness
- The board received a monthly dashboard on national priority indicators and regulatory requirements and local performance measures, including Monitor's risk ratings and adverse event reporting. These include performance against targets in conjunction with a Red/Amber/Green (R/A/G) rating and historic own performance and benchmarking where available

- Granular reports are reviewed by IGQAC and the Finance and Activity Committee
- The reports cover all the trust's services and are challenged at the individual service level
- There were no compliance or improvement actions following the outcome of the CQC unannounced inspection visit during 2013/14 and there was no inspection visit by the CQC during 2014/15 up to 31 December 2015 and the trust remains fully compliant with the registration requirements of the CQC
- There are no major concerns with coding accuracy performance
- There were no high risks identified through the internal audit of data quality.

Data and confidentiality

There were no serious incidents involving data loss or confidentiality breach during 2014/15.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report and other performance information available to me. My review is also informed by comments made by the external auditors in their reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and the IGQAC and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The board received reports from:

- The Audit Committee on systems of internal control
- Monthly finance reports
- The Finance and Activity Committee which considers the potential impact of finance and activity risks
- The IGQAC which includes clinical risks rated as moderate or above and the information governance toolkit annual assessment results and action plan
- Assurance framework.

The Audit Committee completed a review of the assurance framework and received reports from the Finance and Activity Committee, Charitable Fund and IGQAC. All organisational risks rated as moderate or above and all audit recommendations rated as high priority are considered by the Audit Committee, and the committee monitors and enforces implementation of those recommendations.

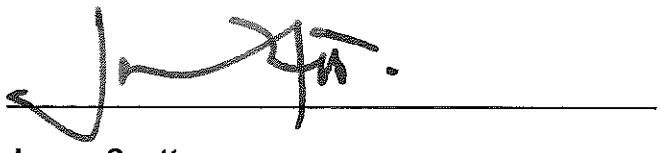
Taking account of the issues identified, the Head of Internal Audit opinion was that based on the work undertaken in the period 1 April 2014 to 31 January 2015, significant assurance can be given that there is a sound system of internal control which is designed to meet the organisation's objectives, and that controls are being consistently applied in all the areas reviewed.

Conclusion

Having regard to the processes in place and matters raised in committee reports and reports from internal and external auditors I am able to conclude that no significant internal control issues have been identified.

Further, on the basis that the board has resolved that the patient services of the trust should be transferred as noted within this Annual Report, the requirement of paragraph 3.20 of the Monitor NHS Foundation Trust Annual Reporting Manual 2014/15 has been met and accordingly the Accounts have been prepared on a going concern basis.

Signed



James Scott

Chief Executive,
Royal United Hospitals Bath NHS Foundation Trust

29 April 2015

Independent auditors' report to the Council of Governors of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

Report on the financial statements

Our opinion

In our opinion, the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust's (the "Trust's") group financial statements and parent Trust's financial statements (the "financial statements"):

- give a true and fair view of the state of the group's and of the parent Trust's affairs as at 31 January 2015 and of the group's and parent Trust's income and expenditure and the group's and parent Trust's cash flows for the 10 month period then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

What we have audited

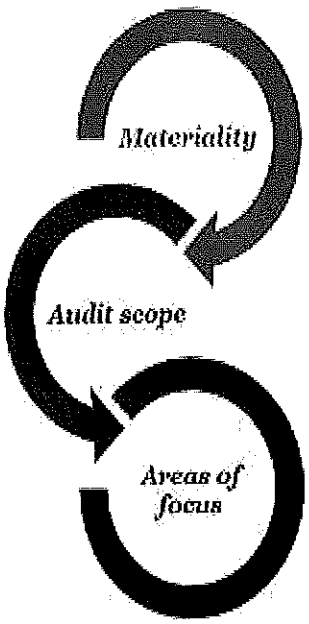
The Trust's financial statements comprise:

- the consolidated and parent Trust's statement of financial position as at 31 January 2015;
- the consolidated and parent Trust's statement of comprehensive income for the 10 month period then ended;
- the consolidated and parent Trust's statement of cash flows for the 10 month period then ended;
- the consolidated and parent Trust's statement of changes in taxpayers' equity for the 10 month period then ended; and
- the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

The financial reporting framework that has been applied in the preparation of the financial statements is the NHS Foundation Trust Annual Reporting Manual 2014/15 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our audit approach

Overview



- Overall group materiality: £362,000 which represents 2% of expenditure.

- We conducted all audit work at the Trust's site in Bath for the Trust and the Royal National Hospital for Rheumatic Diseases Charitable Fund (together the "group").
- We performed substantial audit work prior to the period end to mitigate the risk of a lack of staff continuity.

- Risks arising from the acquisition of the Trust's services by another NHS Foundation Trust.
- Risk of fraud in the recognition of revenue from commissioners and the recognition of liabilities.
- Valuation of property.

The scope of our audit and our areas of focus

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)").
We designed our audit by determining materiality and assessing the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain. As in all of our audits, we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.
The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are identified as "areas of focus" in the table below. We have also set out how we tailored our audit to address these specific areas in order to provide an opinion on the financial statements as a whole, and any comments we make on the results of our procedures should be read in this context. This is not a complete list of all risks identified by our audit.

Area of focus	*How our audit addressed the area of focus*
Transfer of the Trust's activities to another NHS Foundation Trust *Refer to page 7 (Chair's Closing Statement), page 113 (Significant Accounting Policies) and pages 113-136 (notes to the financial statements).* The financial statements have been prepared using the going concern basis of accounting because, although the Trust ceased to exist as a separate legal entity on 1 February 2015 (the "transfer date"), the services provided by the Trust were transferred to Royal United Hospitals Bath (RUH) as a going concern and continue to be provided following the transfer. The transfer was approved by the boards of the Trust and the RUH, as well by as the NHS regulator, Monitor. Under the requirements of the NHS Foundation Trust Annual Reporting Manual, where there are arrangements in place for continuation of services, the financial statements should be prepared on a going concern basis. Even in the context of the going concern basis, the transfer of the Trust's assets, liabilities and obligations after the period-end had the potential to affect a number of elements of the financial statements: • Restructuring costs – the transfer has given rise to redundancy costs, payments in lieu of notice and other restructuring costs totalling £698,000, with a risk that these may not be included in the correct period or appropriately disclosed. • Impairments/provisions – any plans that RUH may have to dispose of the Trust's assets or to change their use (after the transfer date) may result in reductions in their recoverable amount, which would need to be recognised in the financial statements. Similarly, any plans that RUH may have to terminate property leases after the transfer date may lead to the Trust needing to make provision for early termination costs. • NHS debtors and creditors balances – with a period end of 31 January 2015, the normal process for agreeing NHS balances cannot be used by the Trust so there is a heightened risk	We liaised with the Trust at an early stage to consider and understand its plans for transferring its services to RUH. We performed the following testing: • We read the plans, which were approved by the Board and Monitor and which have been announced publicly, for the provision of services being transferred in 2015/16 and subsequent years, over the course of the transitional plan and discussed these with management of the RUH to determine whether services were expected to continue and to understand the assets and staffing levels that will be used to deliver them. The plans support the continuance of the services provided by the RNHRD and, hence, the going concern basis of preparation of the accounts, along with the carrying values of assets. • We inspected severance agreements of staff who had been advised of redundancy prior to the period end, re-performed calculations of amounts awarded to individuals and compared the treatment adopted in the financial statements to NHS guidelines in this area. Redundancy costs primarily relate to costs in respect of the directors and senior management. We did not identify any exceptions. • In the absence of the intra-NHS confirmations procedure, we requested confirmations of outstanding debtor balances from targeted NHS bodies with whom the Trust had significant balances outstanding at 31 January 2015. 75% of the bodies targeted responded, providing confirmation of 59% of the balance targeted by value. Where no confirmation was received, we tested the unconfirmed amounts to subsequent cash receipts. We agreed a sample of creditor balances to other supporting documentation, such as invoice or subsequent payment. • Compared the disclosures made by the Trust in relation to the transfer to the requirements in the Foundation Trust Reporting Manual without finding any errors and checked them to the

Area of focus	*How our audit addressed the area of focus*
of error and/or disputed balances occurring. • Disclosures – additional financial statements disclosures are required in relation to the transfer. • Remuneration report – information as at 31 January 2015 is needed from the Pensions Agency to enable the Trust to complete the remuneration report. If this information is not available then the report may not meet the requirements of the FT ARM and we would need to consider the implications for our audit report.	evidence we had obtained in the course of our audit, finding them to be consistent with it. • Confirmed that the Trust had obtained the required information from the Pensions Agency and agreed the disclosures in the Remuneration Report to it.
Risk of fraud in the recognition of revenue from commissioners and the recognition of liabilities The Trust has delivered an operating deficit for a number of years and continued under close scrutiny by Monitor until the transfer date. Income from commissioners is earned from patient activity under a contract with the CCGs. In addition to this contract income for patient activity, other income from commissioning bodies is also recognised. Because Commissioners are often under pressure to spend the resources available to them in any financial year, a risk was identified that, the Trust may take advantage of this pressure and, in order to reduce the deficit for the year and potentially fraudulently, bill amounts to the commissioning bodies (and recognise this as income) in respect of activity that either does not exist or has been delivered after the date of transfer. Given the operating position of the Trust, there is a further risk that the directors may defer recognition of liabilities (by under-accruing for expenses that have been incurred during the period but which were not paid until after the date of transfer) in order to improve the financial results.	We tested patient activity income from commissioners by agreeing the amounts recognised in the income statements to contracts and to the Trust's patient activity systems to ensure that amounts were contractually due and reflect actual activity. We then tested a sample of entries in the Trust's activity system and agreed these to patient records, which confirmed the accuracy of the activity system. We independently confirmed a sample of balances due from commissioners with the relevant counterparty, as noted above. We tested a sample of other income from commissioners by tracing the transaction to invoices or other correspondence with the commissioners and using our knowledge and experience in the industry to determine whether the revenue was recognised in the correct period. Similarly, we selected a number of payments made and invoices received after the year end and used the invoice to determine whether the expenditure was recognised in the correct period. Recognising that the costs connected with the transfer of the Trust's operations to RUH were equally susceptible to being recognised in the wrong accounting period, we contemplated this risk as part of our testing of those expenses outlined above. We did not identify any transactions that were indicative of fraud in the recognition of income or expenditure.
Revaluation of property *See note 1.7 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates and note 12 for further information.* Property, plant and equipment (PPE) represents the largest asset balance in the Trust's statement of financial position. The Trust reassesses the value of its freehold land and buildings each year, which involves applying a range of assumptions and the use of external expertise. We focused on this area because the value of the	We confirmed that the valuer engaged by the Trust to perform the valuations had professional qualifications and was a member of the Royal Institute of Chartered Surveyors (RICS). Using our own valuations expertise, we determined that the methodology and assumptions applied by the valuer was consistent with market practice in the valuation of hospital buildings. The value of the Trust's properties in the financial statements is based upon the Modern Equivalent Asset being located in Bath city centre and the land is, therefore, valued accordingly. The

Area of focus	*How our audit addressed the area of focus*
properties and the related movements in their fair values recognised in the financial statements are material. Additionally, the value of properties included within the financial statements is dependent on the reliability of the valuations obtained by the Trust, which are themselves dependent on: • the accuracy of the underlying data provided to the valuer by the Directors and used in the valuation; • assumptions made by the Directors, including the likely location of a "modern equivalent asset"; and • the selection and application of the valuation methodology applied by the valuer, including assumptions relating to build costs and the estimated useful life of the buildings.	Trust could, however, have chosen to base the valuation on a location outside of the city centre, which would have impacted the land value. We considered these assumptions made by the Trust and consider the approach taken to be an acceptable basis for valuation. We tested the data provided by the Trust to the external valuer, a key element of which is the gross internal area, by agreeing it to floor plans for the properties valued. We agreed that the values provided to the Trust by the valuer had been correctly included in the accounts and that the valuation movements were accounted for correctly.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Group, the accounting processes and controls, and the environment in which the Group operates.

The Trust comprises one single entity with books and records all retained at the head office in Bath. The group comprises the Trust and the Royal National Hospital for Rheumatic Diseases Charitable Fund. We focused our audit work on the areas of focus described above. Because of the risk of lack of continuity of staff within the finance function after the transfer, we performed as much testing as we could in advance of the period end. At the year-end there was sufficient continuity of staff to reduce this risk.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.
Based on our professional judgement, consistent with last year, we determined materiality for the financial statements as a whole as follows:

Overall group materiality	£362,000 (2013: £390,000).
How we determined it	2% of expenditure
Rationale for benchmark applied	We have applied this benchmark, which is a generally accepted measure when auditing not for profit organisations, because we believe this to the most appropriate financial measure of the performance of a Foundation Trust.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £17,500 (2013: £19,500) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Other required reporting in accordance with the Audit Code for NHS foundation trusts

Opinions on other matters prescribed by the Audit Code for NHS foundation trusts

In our opinion:

- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

Consistency of other information

Under the Audit Code for NHS foundation trusts we are required to report to you if, in our opinion:

• information in the Annual report is: - materially inconsistent with the information in the audited financial statements; or - apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or - otherwise misleading.	We have no exceptions to report arising from this responsibility.
• the statement given by the directors on page 27, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable and provides the information necessary for members to assess the Group's and Parent Trust's performance, business model and strategy is materially inconsistent with our knowledge of the Group's and Parent Trust acquired in the course of performing our audit.	We have no exceptions to report arising from this responsibility.
• the section of the Annual Report on pages 55-56, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.	We have no exceptions to report arising from this responsibility.
• the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.	We have no exceptions to report arising from this responsibility.

Report on arrangements for securing economy, efficiency and effectiveness in the use of resources

The Audit Code for NHS Foundation Trusts requires us to report where we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We draw your attention to the Trust's Annual Governance Statement on pages 91 –100.

On 1 April 2013, the Trust was issued a Provider Licence by the regulator Monitor. The Trust requires a Provider Licence in order to provide NHS services, in accordance with the Health and Social Care Act 2012. At this time, Monitor stated that they had reasonable grounds to suspect that the Licence has provided and is providing health care services for the purposes of the NHS in breach of the following

We have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of

conditions of its Licence: CoS3(1) and FT4(5)(a).

These breaches by the Licensee demonstrate a failure of financial governance arrangements and financial management standards, in particular but not limited to a failure by the Licensee to establish and effectively implement systems and/or processes to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively.

resources for the financial period, and our certificate is qualified in this respect.

Responsibilities for the financial statements and the audit

Our responsibilities and those of the directors

As explained more fully in the Directors' Responsibilities Statement, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of Royal National Hospital for Rheumatic Diseases NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, 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.

What an audit of financial statements involves

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Group's and Parent Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

We primarily focus our work in these areas by assessing the directors' judgements against available evidence, forming our own judgements, and evaluating the disclosures in the financial statements.

We test and examine information, using sampling and other auditing techniques, to the extent we consider necessary to provide a reasonable basis for us to draw conclusions. We obtain audit evidence through testing the effectiveness of controls, substantive procedures or a combination of both.

In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Qualified Certificate

As reported above we are not able to conclude that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the financial period.

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Heather Ancient

Heather Ancient (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Bristol
30 April 2015

(a) The maintenance and integrity of the Royal National Hospital for Rheumatic Disease NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Foreword to the Accounts

These Accounts for the ten months ended 31st January 2015 have been prepared by the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust under Schedule 7 paragraphs 24 and 25 of the National Health Service Act 2006 in the form which Monitor has, with the approval of the Treasury, directed.

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust Report and Accounts for the ten months ended 31st January 2015 are presented to Parliament pursuant to Schedule 7, paragraph 25(4)(a) of the National Health Service Act 2006.

James Scott

Chief Executive,
Royal United Hospitals Bath NHS Foundation Trust

29 April 2015

ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FOUNDATION TRUST

ACCOUNTS 2014/15

STATEMENT OF COMPREHENSIVE INCOME FOR THE TEN MONTHS ENDED 31ST JANUARY 2015

	Note	Group 2014/15 Total	Group 2013/14 Total	Foundation Trust 2014/15 Total	Foundation Trust 2013/14 Total
		£000	£000	£000	£000
Income					
Income from activities	3	**14,826**	16,670	**14,826**	16,670
Other operating income	4	**1,724**	1,783	**1,786**	1,775
Operating income		**16,550**	18,453	**16,612**	18,445
Operating expenses	5,6	**(17,447)**	(19,630)	**(17,285)**	(19,535)
Restructuring costs	5,6	**(698)**	113	**(698)**	113
Operating deficit		**(1,595)**	(1,064)	**(1,371)**	(977)
Finance income and expenditure					
Finance income	7	**13**	17	**4**	7
PDC dividends payable	8	**(138)**	(155)	**(138)**	(155)
Deficit for the year		**(1,720)**	(1,202)	**(1,505)**	(1,125)
Revaluation gains property, plant and equipment		**250**	**416**	**250**	**416**
Net gains on revaluation of financial assets		**16**	**6**	**0**	**0**
Total comprehensive expenditure for the year		**(1,454)**	**(780)**	**(1,255)**	**(709)**

ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FOUNDATION TRUST

ACCOUNTS 2014/15

STATEMENT OF FINANCIAL POSITION AS AT 31ST JANUARY 2015

	Note	Group		Foundation Trust	
		31st January 2015 £000	31st March 2014 £000	31st January 2015 £000	31st March 2014 £000
Non-current assets					
Intangible assets	10	25	58	25	58
Investments	11	268	252	0	0
Property, plant and equipment	12	6,782	6,627	6,782	6,627
Total non-current assets		7,075	6,937	6,807	6,685
Current assets					
Inventories	13	54	41	53	38
Trade and other receivables	14	1,787	867	1,898	896
Cash and cash equivalents	18	1,032	1,960	852	1,652
Total Current assets		2,873	2,868	2,803	2,586
Total assets		9,948	9,805	9,610	9,271
Current liabilities					
Trade and other payables	15	(2,214)	(1,580)	(2,206)	(1,575)
Deferred income	17	(608)	(715)	(608)	(715)
Total current liabilities		(2,822)	(2,295)	(2,814)	(2,290)
Non-current liabilities					
Trade and other payables		(32)	0	(32)	0
Provisions	16	(60)	0	(60)	0
Deferred income	17	0	(22)	0	(22)
Total non-current liabilities		(92)	(22)	(92)	(22)
Total liabilities		(2,914)	(2,317)	(2,906)	(2,312)
Total assets employed		7,034	7,488	6,704	6,959
Financed by taxpayers' equity					
Public dividend capital		7,515	6,515	7,515	6,515
Revaluation reserve		1,146	896	1,146	896
Income and expenditure reserve		(1,957)	(452)	(1,957)	(452)
Charitable Reserves		330	529	0	0
Total taxpayers' equity		7,034	7,488	6,704	6,959

The notes on pages 113 to 136 form part of these accounts.

The Accounts on pages 109 to 112 were approved by the board of directors on 29th April 2015 and signed on its behalf by

James Scott

Chief Executive,
Royal United Hospitals Bath NHS Foundation Trust

29 April 2015

ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FOUNDATION TRUST

ACCOUNTS 2014/15

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE TEN MONTHS ENDED 31ST JANUARY 2015

	Note	Public Dividend Capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total Foundation Trust £000	Charitable reserves £000	Total Group £000
Taxpayers' equity at 1st April 2014		6,515	896	(452)	**6,959**	529	**7,488**
Deficit for the year		0	0	(1,505)	**(1,505)**	(215)	**(1,720)**
New PDC received		2,000	0	0	**2,000**	0	**2,000**
PDC repaid		(1,000)	0	0	**(1,000)**	0	**(1,000)**
Revaluation gains on property, plant and equipment	12	0	250	0	**250**	0	**250**
Realised and unrealised gains on investment assets		0	0	0	**0**	16	**16**
Taxpayers' equity at 31st January 2015		7,515	1,146	(1,957)	**6,704**	330	**7,034**
Taxpayers' equity at 1st April 2013		6,015	480	673	**7,168**	600	**7,768**
Deficit for the year		0	0	(1,125)	**(1,125)**	(77)	**(1,202)**
New PDC received		500	0	0	**500**	0	**500**
Revaluation gains on property, plant and equipment	12	0	416	0	**416**	0	**416**
Realised and unrealised gains on investment assets		0	0	0	**0**	6	**6**
Taxpayers' equity at 31st March 2014		6,515	896	(452)	**6,959**	529	**7,488**

Public Dividend Capital represents capital provided by the Department of Health to fund the initial net assets employed when the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust was created plus additional Public Dividend provided in 2013/14 and 2014/15. (See Note 1.15)

The revaluation reserve contains revaluations of non-current assets relating principally to the Royal National Hospital for Rheumatic Disease NHS Foundation Trust's land and property.

The income and expenditure reserve is the aggregate of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust's previous years' operating surpluses or deficits.

The charitable reserves are the aggregate of previous years' excesses of income over expenditure in the Royal National Hospital for Rheumatic Diseases Charitable Fund.

ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FOUNDATION TRUST

ACCOUNTS 2014/15

STATEMENT OF CASH FLOWS FOR THE TEN MONTHS ENDED 31ST JANUARY 2015

	Note	Group 2014/15 £000	Group 2013/14 £000	Foundation Trust 2014/15 £000	Foundation Trust 2013/14 £000
Cash flows from operating activities					
Operating (deficit) of continuing operations		(1,595)	(1,064)	(1,371)	(977)
Operating (deficit)		(1,595)	(1,064)	(1,371)	(977)
Non-cash income and expenses					
Depreciation and amortization	10,12	385	471	385	471
(Increase)/decrease in trade and other receivables	14	(924)	1,669	(1,006)	1,662
(Increase)/decrease in Inventories	13	(13)	40	(15)	43
Increase/(decrease) in trade and other payables	15	574	(2,285)	571	(2,263)
(Decrease)/increase in other liabilities	17	(97)	299	(97)	299
Increase/(decrease) in provisions	16	60	(10)	60	(10)
Net cash used in operations		(1,610)	(880)	(1,473)	(775)
Cash flows from investing activities					
Interest and investment income received	7	13	17	4	7
Purchase of intangible assets	10	(12)	(9)	(12)	(9)
Purchase of property, plant and equipment	12	(245)	(49)	(245)	(49)
Net Cash used in investing activities		(244)	(41)	(253)	(51)
Cash flows from financing activities					
PDC received		1,000	500	1,000	500
PDC dividend paid		(74)	(152)	(74)	(152)
Net cash generated from financing activities		926	348	926	348
(Decrease) in cash and cash equivalents		(928)	(573)	(800)	(478)
Cash and cash equivalents at 1st April		1,960	2,533	1,652	2,130
Cash and cash equivalents at 31st January / 31st March		1,032	1,960	852	1,652

1.ACCOUNTING POLICIES

Monitor has directed that the accounts of Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trusts Annual Reporting Manual (FT ARM) which has been agreed with HM Treasury. Consequently, the following accounts have been prepared in accordance with the FT ARM 2014/15 issued by Monitor. The accounting policies contained in the manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to Foundation Trusts. The accounting policies have been applied consistently unless otherwise stated in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of land, buildings and financial assets.

1.2 Going Concern

International Accounting Standards (IAS1) requires management to assess, as part of the accounts preparation process, the Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trust Annual Reporting Manual paragraph 3.20, the financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the Foundation Trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust was acquired by the Royal United Hospitals Bath NHS Foundation Trust on 1st February 2015. All services provided by the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust are planned to continue to be provided, therefore the accounts for the 10 months to 31st January 2015 have been prepared on a going concern basis.

1.3 Consolidation

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust is the corporate trustee to the Royal National Hospital for Rheumatic Diseases Charitable Fund (the Charitable Fund). The Foundation Trust has assessed its relationship to the Charitable Fund and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The Charitable Fund's statutory accounts are prepared in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- Recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- Eliminate intra-group transactions, balances, gains and losses.

1.4 Income Recognition

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Financial support was received from the Department of Health in the form of additional Public Dividend Capital during 2013/14 and in 2014/15; this was not recognised as income.

1.5 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the scheme can be found at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.6 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, plant and equipment

Recognition

Property, Plant and Equipment is capitalised where

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably and;
- has an individual cost of at least £5,000; or
- the items form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.
- where a component is separable from its host asset and is considered significant it is capitalised separately.

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Property assets are measured subsequently at fair value.

Property

The fair value of land and buildings are determined by valuations carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out primarily on the basis of modern equivalent cost for specialised operational property and existing use value for

1.7 Property, plant and equipment (continued)

Property (continued)

non-specialised operational property. For non-operational properties, including surplus land, the valuations are carried out at open market value. For property assets the frequency of revaluations will be at least every five years, in line with Monitor's view, but more frequently in volatile times in the property market.

Assets under construction are valued at cost and are subsequently revalued by professional valuers when brought into use or when factors indicate that the value of the asset differs materially from its carrying value.

Other assets

Other assets include plant, machinery and equipment and the depreciated historical cost basis has been adopted as a proxy fair value in respect of these assets which have short lives or low values.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant or equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component pf an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaces is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust depreciates its non-current assets on a straight-line basis over the expected life of the asset after allowing for the residual value. Useful lives are determined on a case by case basis. The typical lives for the following assets are:

Asset category	Useful life (years)
Freehold property – buildings	10 - 29
Plant & machinery	5 – 15
Equipment - transport	7 – 10
Equipment - information technology	5
Equipment - furniture and fittings	5 – 10

Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognized in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of "other comprehensive income".

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or services potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

1.7 Property, plant and equipment (continued)

Impairments(continued)

An impairment that arises form clear consumption economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer

was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of "other impairments" are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as "Held for Sale" once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as "Held for Sale"; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their "fair value less costs to sell". Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as "Held for Sale" and instead is retained as an operational asset and the asset's economic life adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their **fair value** on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward in future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the NHS Foundation Trust's business or which arise from contractual or other legal rights. Subject to a £5,000 threshold, they are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

1.8 Intangible assets (continued)

Software licences

Software which is integral to the operation of hardware, e.g., an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. All intangible assets are currently amortised over a 5 year life.

1.9 Revenue government and other grants

Government grants are grants from Government bodies other than income from NHS bodies for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.10 Inventories

Inventories are stated at the lower of cost and net realisable value on a first in first out basis. High turnover items such as drugs are held in the financial statements at cost.

1.11 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

All other financial assets and financial liabilities are recognised when the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the NHS Foundation Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as 'Loans and receivables' (trade debtors and cash) or as 'Available-for-sale financial assets' (investments held by the Charitable Fund). Financial liabilities are classified as 'other financial liabilities' (trade creditors) Financial assets and financial liabilities at 'fair value through income and expenditure'

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

1.11 Financial instruments and financial liabilities (continued)

Loans and receivables (continued)

Loans and receivables are recognised initially at fair value, net of tions costs, and are subsequently measured at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets (Charitable Fund only)

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Charitable Fund intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognized initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognized in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognized are transferred from reserves and recognized in "Finance Costs" in the Statement of Comprehensive Income.

Financial liabilities at amortised cost

Financial liabilities at amortised cost are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current liabilities.

Determination of fair value

For financial assets carried at fair value, the carrying amounts are determined from quoted mid - market prices of the underlying investments held by the COIF.

Impairment of financial assets

At the date of the Statement of Financial Position, the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision that is determined specifically on individual assets.

1.12 Leases

Operating leases

Leases not classified as finance leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.13 Provisions

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust recognizes a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published by HM Treasury.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Foundation Trust is disclosed at note 17 but is not recognised in the Foundation Trust's accounts.

Non-clinical risk pooling

The Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation Trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when the liability arises.

1.14 Contingencies

Contingent liabilities are not recognised, but are disclosed in Note 23, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as (1) possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Foundation Trust's control or (2) present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability. Advice from the senior executive team is taken when reporting contingencies. However, the nature of contingencies is such that uncertainty is inherent.

1.15 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust, the Royal National Hospital for Rheumatic Diseases NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS32.

A charge, reflecting the cost of capital utilised by the Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Foundation Trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) **average daily** net cash balances held with the Government Banking Services (GBS) excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the financial statements. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.16 Value Added Tax

Most of the activities of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Corporation Tax

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust does not foresee that it will have any material commercial activities on which corporation tax liability will arise under the guidance issued by HM Revenue and Customs.

1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Foundation Trusts not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.20 Accounting standards and amendments issued but not yet adopted in the ARM

The following accounting standards have been issued but have not yet been adopted. NHS bodies cannot adopt new standards unless they have been adopted in the HM Treasury FReM, which generally does not adopt an international standard until it has been endorsed by the European Union for use by listed companies.

Change published	Financial year for which the change first applies
IFRS 9 Financial Instruments	Not yet EU adopted. Expected to be effective from 2018/19.
IFRS 13 Fair Value Measurement	Adoption delayed by HM Treasury. To be adopted from 2015/16.
IFRS 15 Revenue from contracts with customers	Not yet EU adopted. Expected to be effective from 2017/18.
IAS 36 (Amendment) – recoverable amount disclosures	To be adopted from 2015/16 (aligned to IFRS 13 adoption)
Annual Improvements 2012	Effective from 2015/16 but not yet EU adopted
Annual Improvements 2013	Effective from 2015/16 but not yet EU adopted
IAS 19 (amendment) – employer contributions to defined benefit pension schemes	Effective from 2015/16 but not yet EU adopted
IFRI 21 Levies	EU adopted in June 2014 but not yet adopted by HM Treasury

– * This reflects the EU-adopted effective date rather than the effective date in the standard.

1.21 Critical accounting judgements and key sources of estimation uncertainty

Critical accounting judgements

In the application of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.21 Critical accounting judgements and key sources of estimation uncertainty (continued)
Critical accounting judgements (continued)

In terms of the valuation of non current assets, where a formal revaluation is undertaken, all values correspond to existing use value (EUV) or modern equivalent asset (MEA). EUV is used for non-specialised owner occupied operational property and is based on estimates of the amount for which an asset should exchange on a valuation date between a willing buyer and a willing seller in an arm's length transaction. MEA is the cost to create a modern equivalent of the existing asset, taking into account modern material and building techniques. The valuation takes into account both the current and intended future use of the asset.

Key sources of estimation uncertainty

Only key sources of estimation uncertainty that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are disclosed.

The calculation of the provision for impaired receivables is based on management's estimation of the possible level of irrecoverable debt by reference to a detailed review of outstanding balances at the end of the financial year.

NHS receivables include accruals for services provided but not invoiced at the end of the financial year. These were calculated by reference to activity data and were subsequently invoiced.

1.22 Subsidiaries

Subsidiary entities are those over which the Foundation Trust is exposed to, or has the rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power to direct the relevant activities of the entity. The income, expenses, assets, liabilities, equity and reserves are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Foundation Trust.

The Foundation Trust consolidates the results of Royal National Hospital for Rheumatic Diseases Charitable Fund, over which it considers it has the power to exercise control in accordance with IFRS10 requirements.

2 SEGMENTAL ANALYSIS

2.1 Segmental analysis – explanation of the services provided by specialties (Foundation Trust only)
Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision maker. The chief operating decision maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust's Board of Directors. The individual segments are consistent with the organizational structure of the Foundation Trust which is based on clinical specialties.

The Operating income for each segment is mainly derived from Clinical Commissioning Groups as a result of delivery of patient care in these specialties. In addition, income is sourced from NHS England to fund education and training costs in line with national policy.

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust's income and activities are for the provision of health and health related services within the UK. The services provided by the Foundation Trust are designated between specialties. Details of the services provided within each of the NHS Foundation Trust's main clinical specialties are included below. The Information is a summary of activity by specialty level.

Service Area	Examples of services provided
Rheumatology	Outpatients, inpatients and day cases including clinical measurement services, such as bone scans.
Pain Management	Inpatient and outpatient services for patients with chronic pain.
Chronic Fatigue Syndrome	Care provided in an outpatient setting in clinics with therapies, for example physiotherapy.

2 SEGMENTAL ANALYSIS – FOUNDATION TRUST (continued)

2.1 Segmental analysis – explanation of the services provided by specialties (continued)

Service Area	Examples of services provided
PbR excluded drugs income	Income for drugs provided to patients, directly recharged to partner NHS organisations.
Neuro Rehabilitation	Care was provided principally in an inpatient but also an outpatient setting for patients requiring intensive neuro rehabilitation. These services ceased on 31st March 2013, a provision relating to expenditure on this service unwound in the accounts to 31st March 2014.

2.2 Segmental analysis by service area (Foundation Trust only)

2014/15	Rheumatology £'000	Pain Management £'000	CFS £'000	High cost Drugs £'000	Other £'000	Neuro Rehabilitation £'000	Total £'000
Income	5,892	1,347	757	5,780	2,836	0	16,612
Expenditure	3,635	712	485	5,780	7,371	0	17,983
Contribution to operating result	2,257	635	272	0	(4,535)	0	(1,371)
Finance income	0	0	0	0	4	0	4
PDC dividends payable	n/a	n/a	n/a	n/a	(138)	n/a	(138)
Operating result/(deficit)	2,257	635	272	0	(4,669)	0	(1,505)
Revaluation	n/a	n/a	n/a	n/a	250	n/a	250
Total comprehensive income/ (expenditure)	2,257	635	272	0	(4,419)	0	(1,255)

2013/14	Rheumatology £'000	Pain Management £'000	CFS £'000	High cost Drugs £'000	Other £'000	Neuro Rehabilitation £'000	Total £'000
Income	7,785	1,445	965	6,235	2,015	0	18,445
Expenditure	5,409	693	609	6,235	6,589	(113)	19,422
Contribution to operating result	2,376	752	356	0	(4,574)	113	(977)
Finance income	0	0	0	0	7	0	7
PDC dividends payable	n/a	n/a	n/a	n/a	(155)	n/a	(155)
Operating result/(deficit)	2,376	752	356	0	(4,722)	113	(1,125)
Revaluation	n/a	n/a	n/a	n/a	416	n/a	416
Total comprehensive income/ (expenditure)	2,376	752	356	0	(4,306)	113	(709)

2. SEGMENTAL ANALYSIS (continued)

2.2 Segmental analysis by service area (continued)

Rheumatology includes Clinical Measurement Services, Diagnostics and Complex Regional Pain Services
(1) CFS – Chronic Fatigue Syndrome – services for adults and children
(2) Other includes Research and Development and Breast Radiation Injury Rehabilitation Service
The above analysis is consistent with reports presented to the Main Board

2.3 Charitable Fund

The group financial statements include amounts in respect of the RNHRD Charitable Fund that do not form part of the segments reported above.

The income and expenditure included in the group financial statements in respect of the charity are as follows:

	2014/15 £000	2013/14 £000
Operating income	225	78
Operating expenditure	449	165
Finance income	9	10

3. PATIENT RELATED ACTIVITY – GROUP AND FOUNDATION TRUST

3.1 **Income from activities**	**Total 2014/15 £000**	Total 2013/14 £000
Elective income	**1,944**	2,013
Non-elective income	**1,568**	2,265
Outpatient income	**5,081**	5,746
Private patient income	**161**	219
Other clinical income from mandatory services	**6,072**	6,427
	14,826	16,670
Commissioner requested services	**14,665**	16,451
Non-Commissioner requested services	**161**	219
	14,826	16,670

3.2 **Income from activities by source**		
NHS Foundation Trusts	**10**	0
NHS Trusts	**10**	31
NHS England and Clinical Commissioning Groups	**14,342**	15,985
Department of Health – other	**0**	6
NHS other	**153**	233
Non-NHS: private patients	**161**	219
NHS injury scheme	**14**	62
Non-NHS: other	**136**	134
Total Patient Related Income	**14,826**	16,670

3.3 **Income from activities by type**		
NHS patient activity	**8,735**	10,024
Other clinical income	**150**	192
PbR excluded drugs income	**5,780**	6,235
Private patient income	**161**	219
Total patient related income	**14,826**	16,670

4. OTHER OPERATING INCOME

	Group		Foundation Trust	
	2014/15 Total £000	2013/14 Total £000	**2014/15 Total £000**	2013/14 Total £000
Research and development	**787**	972	**787**	972
Education and training	**211**	323	**211**	323
Charitable and other contributions to expenditure	**87**	0	**374**	70
Other income	**414**	410	**414**	410
Voluntary charitable income	**225**	78	**0**	0
	1,724	**1,783**	**1,786**	**1,775**

5. OPERATING EXPENSES

5.1 Expenses by type

	2014/15 Total £000	2013/14 Total £000	**2014/15 Total £000**	2013/14 Total £000
Services from NHS Foundation Trusts	**252**	207	**252**	207
Services from NHS Trusts	**402**	752	**402**	752
Purchase of Healthcare from non-NHS bodies	**93**	90	**93**	90
Executive directors' costs	**436**	569	**436**	569
Non-executive directors' costs	**62**	85	**62**	85
Staff costs	**7,554**	8,570	**7,528**	8,537
Drug costs	**5,793**	6,541	**5,793**	6,541
Clinical supplies and services (excluding drug costs)	**412**	240	**412**	240
Supplies and services – general	**209**	117	**209**	117
Establishment	**306**	348	**306**	348
Transport	**16**	23	**16**	23
Premises	**1,252**	986	**1,252**	986
(Decrease)/increase in bad debt provision	**(75)**	15	**(75)**	15
Depreciation and amortisation	**384**	471	**384**	471
External audit fees	**57**	68	**57**	63
Internal audit fees	**46**	46	**46**	46
External auditor's other remuneration	**18**	17	**18**	22
Restructuring costs	**698**	(113)	**698**	(113)
Other	**230**	485	**94**	423
Total operating expenses	**18,145**	**19,517**	**17,983**	**19,422**

Restructuring costs in 2014/15 in both the Group and the NHS Foundation Trust relate to the acquisition of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust by Royal United Hospitals Bath NHS Foundation Trust, which took place on 1st February 2015. The credit to restructuring costs in 2013/14 all relates to discontinued operations in both the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust and the Group.

Depreciation includes accelerated depreciation as detailed in note 13.1

5.2.1 External auditor's other remuneration

	Group		Foundation Trust	
	2014/15 £000	2013/14 £000	**2014/15 £000**	2013/14 £000
Audit of Royal National Hospital for Rheumatic Diseases Charitable Fund	**0**	0	**0**	5
Agreed upon procedures on management information	**18**	0	**18**	0
Quality Report	**0**	17	**0**	17
	18	17	**18**	22

5. OPERATING EXPENSES (continued)

5.2.2 Auditors' liability cap

The Board of Governors appointed PricewaterhouseCoopers LLP as external auditors for the ten months ending 31st January 2015. The engagement letter signed on 15 January 2015, states that the liability of PricewaterhouseCoopers LLP, its members, partners and staff (including but not limited to negligence) shall in no circumstances exceed £1 million in the aggregate in respect of all services (2013/14 - £1 million).

5.3.1 Operating leases

The Foundation Trust's obligations under operating leases mainly relate to a lease for the hiring of apartments used for accommodating patients attending training courses. This lease will expire in October 2016. Other payments relate to minor items of equipment. There are no contingent rents or sublease arrangements.

	Group		Foundation trust	
	2014/15 £000	2013/14 £000	**2014/15 £000**	2013/14 £000
Operating lease rentals	**75**	88	75	88
	75	88	75	88

5.3.2 Total future minimum lease payments are:

Not later than one year	**104**	44	104	44
Later than one year and not later than five years	**72**	0	72	0
Later than five years	**0**	0	0	0
	176	44	176	44

5.4 Directors' remuneration

Details of payments made to Directors are included in the Annual Report on pages 32 to 38. Total remuneration to Directors in the 10 months to 31st January 2015 was £414,000 (£536,000 in 2013/14)

Employers' contributions to the pension scheme in respect of directors was £45,000 in the ten months to 31st January 2015 (£61,000 in 2013/14). Benefits are accruing to 5 directors (5 directors 2013/14) under the defined benefit scheme. 1 director retired during the year ended 31st March 2014 so benefits are no longer accruing on his behalf.

6. STAFF COSTS AND NUMBERS

6.1 Staff Costs

	Group		Foundation Trust	
	2014/15 £000	2013/14 £000	**2014/15** £000	2013/14 £000
Salaries and wages	**6,723**	7,658	6,702	7,631
Social Security costs	**473**	556	471	554
Employer contributions to NHSPA	**794**	925	791	921
	7,990	9,139	**7,964**	9,106

Pension costs (text as provided for Annual Report and Accounts to 31st March 2014)

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP 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.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

6. STAFF COSTS AND NUMBERS (continued)

a) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31st March 2014, is based on valuation data as 31st March 2013, updated to 31st March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31st March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31st March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1st April 2015.

c) Scheme provisions
The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1st April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From

2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

6. STAFF COSTS AND NUMBERS (continued)

6.2 Monthly average number of persons employed (Group)

	2014/15 Total Number	2014/15 Permanently Employed	2014/15 Other	2013/14 Total Number
Medical and dental	**22**	**22**	**0**	17
Administration and estates	**81**	**81**	**0**	80
Nursing, midwifery & health visiting staff	**69**	**69**	**0**	68
Scientific, therapeutic and technical staff	**56**	**56**	**0**	47
Bank and agency staff	**4**	**0**	**4**	19
Total	**232**	**228**	**4**	231

The Charitable Fund employs one full time member of staff as an administrator. The monthly average number of persons employed by the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust were as above minus one administrator. The average number of persons employed includes directors on a service contract. The numbers above refer to whole time equivalents, rather than the number of staff employed.

6.3 Retirements due to ill-health

There were no retirements at any additional cost to the Pension Scheme. (2013/14: None costing £Nil)

6.4 Staff exit packages

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)
Less than £10,000	0	1	1	0
£10,001 - £25,000	0	2	2	0
£25,001 - £50,000	0	0	0	0
£50,001 - £100,000	2	0	2	0
£100,001 - £150,000	1	0	1	0
£150,001 - £200,000	1	0	1	0
Total number of exit packages by type (total cost)	**4 (£439,315)**	**3 (£34,965)**	**7 (£474,280)**	**0**

There were no staff exit packages in 2013/14.

7. FINANCE INCOME

	Group		Foundation Trust	
	2014/15 £000	2013/14 £000	**2014/15** £000	2013/14 £000
Finance income	**13**	17	4	7

Finance income relates to interest received on bank account balances and dividend income from investments (Group).

8. PDC DIVIDENDS PAYABLE

	Group		Foundation Trust	
	2014/15 £000	2013/14 £000	**2014/15 £000**	2013/14 £000
Public dividend capital (PDC) dividend paid	**78**	159	78	159
Actual public dividend capital dividend charge incurred during the period	**138**	155	138	155
(Outstanding) / Overpaid recoverable	**(60)**	4	(60)	4

9. THE LATE PAYMENT OF COMMERCIAL DEBTS (INTEREST) ACT 1998

There was no interest payable arising from claims made by businesses under this legislation (2013/14 £Nil).

NOTES TO THE ACCOUNTS 2014-15 (continued)

10. INTANGIBLE ASSETS – ALL FOUNDATION TRUST

Software licences	**2014/15 £000**	2013/14 £000
Cost at 1st April	**294**	316
Additions	**12**	9
Reclassifications	**0**	0
Disposals	**(134)**	(31)
Cost at 31st January 2015 / 31st March 2014	**172**	294
Accumulated amortisation at 1st April	**236**	238
Provided during the year	**45**	31
Reclassifications	**0**	(2)
Disposals	**(134)**	(31)
Accumulated amortisation at 31st January 2015 / 31st March 2014	**147**	236
Net book value		
-Purchased assets at 1st April	**10**	74
-Donated assets at 1st April	**48**	4
-Total net book value of intangible assets at 1st April	**58**	78
-Purchased assets at 31st January 2015 / 31st March 2014	**17**	10
-Donated assets at 31st January 2015 / 31st March 2014	**8**	48
-Total net book value of intangible assets at 31st January 2015 / 31st March 2014	**25**	58

Amortisation provided in the year of £45,000 includes accelerated depreciation of £25,000 relating to systems development whose remaining useful life was revised during the year. (2013/14 £0)

11. INVESTMENTS – ALL CHARITABLE FUND

	2014/15 £000	2013/14 £000
Valuation at 1st April	**252**	246
Revaluation gain	**16**	6
Valuation at 31st January 2015 / 31st March 2014	**268**	252

The investments are held under the powers conferred on the Charitable Fund by clause D (10) of the Charity deed. Investments are valued at market value, which is calculated as being the mid-point value excluding dividends on the day of valuation.
£262,000 (£246,000 at 31st March 2014) of the investment is held in a Charity Investment Fund managed by CCLA Investment Management Limited consisting of a holding of 21,341 units. Asset allocation of the fund at 31st December 2014 / (2014 31st March) comprised of:

	2014/15	2013/14
• Fixed interest	3.2%	2.3%
• U.K. equities	47.0%	45.5%
• Overseas equities	34.9%	36.6%
• Cash	2.5%	3.7%
• Property / infrastructure	12.4%	11.9%

12. PROPERTY, PLANT AND EQUIPMENT – ALL FOUNDATION TRUST

12.1 Property, Plant and Equipment at the statement of financial position date comprise the following elements:

	Freehold Land £000	Freehold buildings excluding dwellings £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000	Assets under construction £000	Total £000
Cost or valuation at 1st April 2014	**2,082**	**4,104**	**945**	**34**	**486**	**78**	**0**	**7,729**
Additions - purchased	0	81	95	0	30	9	30	245
Revaluations	0	23	0	0	0	0	0	23
Disposals	0	0	(1)	0	(27)	(29)	0	(57)
At 31st January 2015	**2,082**	**4,208**	**1,039**	**34**	**489**	**58**	**30**	**7,940**
Accumulated depreciation at 1st April 2014	**0**	**0**	**678**	**34**	**346**	**44**	**0**	**1,102**
Provided during the year	0	227	48	0	42	23	0	340
Revaluations	0	(227)	0	0	0	0	0	(227)
Disposals	0	0	(1)	0	(27)	(29)	0	(57)
Accumulated depreciation at 31st January 2015	**0**	**0**	**725**	**34**	**361**	**38**	**0**	**1,158**
Net book value								
- Purchased at 31st January 2015	2,082	3,937	236	0	128	10	30	6,423
- Donated at 31st January 2015	0	271	78	0	0	10	0	359
Total at 31st January 2015	**2,082**	**4,208**	**314**	**0**	**128**	**20**	**30**	**6,782**

The NHS Foundation Trust Annual Reporting Manual requires all foundation trusts to prepare their financial statements in accordance with IFRS and the HM Treasury FReM, except in cases of specific divergence. This guidance does not specify any departure from Royal Institute of Chartered Surveyors (RICS) standards, for which valuation on the modern equivalent asset (MEA) basis is the accepted norm for specialized operational property and existing use value (EUV) for non-specialised operational property. The effective date of the last full formal revaluation of land and buildings was 31st January 2015 and was undertaken by external valuer Boshier and Company Chartered Surveyors. The modern equivalent asset basis values assets by estimating the costs to create a modern equivalent of the existing asset, taking into account modern materials and building techniques. The existing use method values at the estimated amount for which an asset should exchange on the valuation date between a willing seller and a willing buyer in an arm's length transaction.

Depreciation charged in the year of £340,000 includes accelerated depreciation of £15,000 relating to Furniture and Fittings whose remaining useful life was revised during the year. (2013/14 depreciation charge of £440,000 included accelerated depreciation of £75,000 relating to plant and machinery)

12. PROPERTY, PLANT AND EQUIPMENT CONTINUED

12.2 Property, Plant and Equipment at the prior Year's statement of financial position date comprise the following elements:

	Freehold Land £000	Freehold buildings excluding dwellings £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000	Assets under construction £000	Total £000
Cost or valuation at 1st April 2013	2,082	3,911	1,182	34	792	94	0	8,095
Additions - purchased	0	18	9	0	22	0	0	49
Revaluations	0	175	0	0	0	0	0	175
Disposals	0	0	(246)	0	(328)	(16)	0	(590)
At 31st March 2014	**2,082**	**4,104**	**945**	**34**	**486**	**78**	**0**	**7,729**
Accumulated depreciation at 1st April 2013	0	0	787	34	625	45	0	1,491
Provided during the year	0	241	135	0	49	15	0	440
Reclassifications	0	0	2	0	0	0	0	2
Revaluations	0	(241)	0	0	0	0	0	(241)
Disposals	0	0	(246)	0	(328)	(16)	0	(590)
Accumulated depreciation at 31st March 2014	**0**	**0**	**678**	**34**	**346**	**44**	**0**	**1,102**
Net book value								
- Purchased at 31st March 2014	2,082	3,841	231	0	138	10	0	6,302
- Donated at 31st March 2014	0	263	36	0	2	24	0	325
Total at 31st March 2014	**2,082**	**4,104**	**267**	**0**	**140**	**34**	**0**	**6,627**

13. INVENTORIES

	Group		Foundation Trust	
	31st January 2015 £000	31st March 2014 £000	31st January 2015 £000	31st March 2014 £000
Raw materials and consumables	**54**	41	**53**	38

The movement in inventories is recognised in operating expenses.

14. TRADE AND OTHER RECEIVABLES

	Group		Foundation Trust	
	31st January 2015 £000	31st March 2014 £000	31st January 2015 £000	31st March 2014 £000
Current:				
NHS and other related parties receivables	**1,378**	686	**1,378**	686
Provision for impaired receivables	**(82)**	(187)	**(82)**	(187)
Prepayments	**107**	133	**107**	133
Accrued income	**197**	38	**197**	38
PDC overpaid, recoverable	**0**	4	**0**	4
Other receivables	**187**	193	**298**	222
Total current trade and other receivables	**1,787**	867	**1,898**	896
Provision for impairment of receivables				
At 1st April	**187**	235	**187**	235
(Decrease) / increase in provision	**(75)**	136	**(75)**	136
Amounts utilised	**(30)**	(63)	**(30)**	(63)
Unused amounts reversed	**0**	(121)	**0**	(121)
At 31st January 2015 / 31st March 2014	**82**	187	**82**	187

14.1 Analysis of Impaired receivables

Ageing of impaired receivables				
0 – 30 days	**0**	0	**0**	0
30 - 60 days	**0**	0	**0**	0
60 – 90 days	**0**	0	**0**	0
90 – 180 days	**46**	79	**46**	79
Over 180 days	**36**	108	**36**	108
	82	187	**82**	187

14.2 Ageing of non-impaired receivables past their due date

0 – 30 days	**72**	315	183	345
30 - 60 days	**95**	86	95	86
60 – 90 days	**72**	22	72	22
90 – 180 days	**0**	15	0	15
Over 180 days	**3**	0	3	0
Overdue	**242**	438	353	468
Not yet due	**1,580**	429	1,580	429
	1,822	867	1,933	897

15. TRADE AND OTHER PAYABLES

	Group		Foundation Trust	
	31st January 2015 £000	31st March 2014 £000	31st January 2015 £000	31st March 2014 £000
Current trade and other payables:				
NHS and other related parties payables	**36**	329	**36**	329
Other trade payables	**440**	397	**440**	397
Other payables	**154**	169	**152**	169
Accruals	**1,524**	685	**1,518**	680
PDC dividend payable	**60**	0	**60**	0
Total current	**2,214**	1,580	**2,206**	1,575

15. TRADE AND OTHER PAYABLES (continued)

Accruals in the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust and the Group as at 31st January 2015 include an amount of £508,000 in relation to redundancy costs (31st March 2014 £NIL)
In accordance with IFRS and HM Treasury's FReM The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust has made an accrual of £22,000 for cost of untaken leave at 31st January 2015. This is a decrease of £4,000 from the accrual of £26,000 at 31st March 2014.

16. PROVISIONS

	Group		Foundation Trust	
	31st January 2015 £000	31st March 2014 £000	**31st January 2015 £000**	31st March 2014 £000
At 1st April	**0**	10	**0**	10
Arising during the year	**60**	10	**60**	10
Utilised during the year – cash	**0**	(20)	**0**	(20)
At 31 January 2015 / 31 March 2014	**60**	0	**60**	0

The NHS Litigation Authority (NHSLA) has advised disclosure of a provision of £30,000 at 31st January 2015, in respect of LTPS (Liabilities to Third Parties Scheme) as part of non-clinical risk pooling (31st March 2014 £Nil). It is probable that the liability will be cleared between one and five years. There is no provision required in respect of clinical negligence - the NHSLA is carrying a provision of £27,450 at 31st January 2015 in respect of Clinical Negligence (31st March 2014 £397,920).
An amount of £30,000 has been provided for potential future dilapidations arising on the termination of an accommodation operating lease in October 2016.

17. DEFERRED INCOME – FOUNDATION TRUST

	31st January 2015 £000	31st March 2014 £000
Current liabilities		
Deferred income	**608**	715
Non-current liabilities		
Deferred income	**0**	22
	608	737

All deferred income relates to the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust.

18. CASH AND CASH EQUIVALENTS

	Group		Foundation Trust	
	31st January 2015 £000	31st March 2014 £000	**31st January 2015 £000**	31st March 2014 £000
At 1st April	**1,960**	2,533	**1,652**	2,130
Net change in year	**(928)**	(573)	**(800)**	(478)
At 31st January 2015 / 31st March 2014	**1,032**	1,960	**852**	1,652

	31st January 2015 £000	31st March 2014 £000	**31st January 2015 £000**	31st March 2014 £000
Made up of:				
Cash at commercial banks and in hand	**77**	55	**24**	45
Cash with the Government Banking Service	**955**	1,889	**828**	1,607
Other current investments	**0**	16	**0**	0
	1,032	1,960	**852**	1,652

19. ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES CHARITABLE FUND

Summary Statement of Financial Position

	31st January 2015 £'000	31st March 2014 £'000
Restricted Funds	**41**	66
Unrestricted Funds	**289**	463
Total Charitable Fund Reserves	**330**	529

Where there is a legal restriction on the purpose to which a fund may be spent, the fund is classified in the accounts as a restricted fund. Other funds are classified as unrestricted funds.

20. CAPITAL COMMITMENTS

The Group and the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust had no capital commitments as at 31st January 2015 (£Nil at 31st March 2014).

21. EVENTS AFTER THE REPORTING PERIOD

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust was acquired by the Royal United Hospitals Bath NHS Foundation Trust on 1st February 2015 and all balances included in the accounts of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust were transferred to the Royal United Hospitals Bath NHS Foundation Trust as at that date. The assets and liabilities of the Royal National Hospital for Rheumatic Diseases Charitable Fund were transferred to the Charitable Fund of the Royal United Hospitals Bath NHS Foundation Trust, within which the funds of the Royal National Hospital for Rheumatic Diseases Charitable Fund are classified as restricted or designated funds.

22. CONTINGENT LIABILITIES

There were no contingent liabilities as at 31st January 2015 (2014: £Nil). At 31st March 2014, a constructive obligation had not arisen in respect of a transfer of services, with regard to the strategic intent to transfer services to another provider, and therefore no provision was made at that date for any restructuring or redundancy costs.

23. RELATED PARTY TRANSACTIONS

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust has received revenue payments from the Charitable Fund, of which it is the corporate trustee. The annual report and accounts for the Royal United Hospitals Bath Charitable Funds will include the Royal National Hospital for Rheumatic Diseases Charitable Funds and copies are available on request from the Royal United Hospitals Bath NHS Foundation Trust.

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust received income totalling £287,000 from the Charitable Fund in 2014/15 (£70,000 2013/14). The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust processed payments totalling £118,000, in 2014/15 (£161,000 2013/14) on behalf of the Charitable Fund.
The Charitable Fund owed the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust £112,000, as at 31st January 2015 (£30,000 at 31st March 2014) in respect of payments by the Foundation Trust on its behalf.

There are no commitments by the Charitable Fund to pay for capital expenditure as at 31st March 2015 (2013/14 £Nil)

All government bodies which fall within the Whole of Government accounts boundary are regarded as related parties because they are all under the common control of HM Government and Parliament. This includes for example all NHS bodies, all local authorities and central Government bodies.

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust had transactions in excess of £500,000 with the following NHS and other Whole of Government Accounting organisations during the ten months to 31st January 2015 / year to 31st March 2014:

23. RELATED PARTY TRANSACTIONS (CONTINUED)

	2014/15 Income £000	**2014/15 Expenditure £000**	2013/14 Income £000	2013/14 Expenditure £000
Bath and North East Somerset CCG	**3,281**	**0**	3,732	0
NHS England	**2,974**	**0**	3,015	0
Somerset CCG	**1,918**	**0**	2,244	0
South Gloucestershire CCG	**534**	**0**	652	0
Royal United Hospitals Bath NHS FT (was Royal United Hospital NHS Trust to 31 October 2014)	**10**	**163**	63	1,725
Royal United Hospital NHS Trust (became Royal United Hospitals Bath NHS FT on 1st November 2014)	**9**	**345**	0	0
Wiltshire CCG	**3,731**	**0**	4,145	0
NHS Pension Scheme	**0**	**791**	0	966
National Insurance Fund	**0**	**471**	0	556

Significant balances outstanding between the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust and other NHS and Whole of Government Accounting Organisations at the balance sheet date were as follows:

	31st January 2015 Receivable	**31st January 2015 Payable**	31st March 2014 Receivable	31st March 2014 Payable
	£000	**£000**	£000	£000
Bath and North East Somerset CCG	**169**	**0**	126	0
NHS England	**468**	**0**	(291)	0
North, East, West Devon CCG	**60**	**0**	59	0
Somerset CCG	**34**	**0**	51	0
South Gloucestershire CCG	**10**	**0**	169	0
Royal United Hospitals Bath NHS FT	**22**	**124**	33	66
Wiltshire CCG	**159**	**0**	88	0
NHS Pension Scheme	**0**	**0**	0	125
HM Revenue and Customs	**0**	**0**	24	0

Income is in respect of services provided by the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust to patients referred by the entities above and other non patient related income. Expenditure with other NHS bodies is in respect of goods and services provided by the entities to the Foundation Trust.

The Royal United Hospitals Bath NHS Foundation Trust expenditure and payable figures and the Royal United Hospital NHS Trust expenditure figure exclude High Cost Drugs.

In addition, the Foundation Trust pays tax and national insurance to HM Revenue and Customs on behalf of employees which totalled £1,223,000 (£1,542,000 in 2013/14). The Foundation Trust also pays the NHS Pension Scheme on behalf of employees, such contributions totalled £517,000 (£570,000 in 2013/14)

The only payments to key management personnel are as detailed in Note 5.4 and in the Remuneration report on pages 32 to 38 of the Annual Report and Accounts.

24. ANALYSIS OF BALANCES TRANSFERRED TO SUCCESSOR ORGANISATION (Foundation Trust)

All balances were transferred to Royal United Hospitals Bath NHS Foundation Trust

Summarised final statement of financial position	£'000
Non-current assets	6,807
Current assets	2,803
Current liabilities	(2,814)
Non-current liabilities	(92)
Net assets	6,704

25. FINANCIAL INSTRUMENTS

25.1 Financial risks

Liquidity risk

The Trust's net operating costs are incurred under contracts with commissioners, which are financed from resources voted annually by Parliament. The Trust largely finances its capital expenditure from internal cash resources, generated through the depreciation charge. Cash is invested in accordance with approved procedures. Cash flows are monitored and monthly forecasts are produced, to ensure that commitments are met. During the 10 months to 31 January 2015, the Trust's costs exceeded the income generated from activities which presented a liquidity risk. This was mitigated in the ten months to 31st January 2015 through the availability of additional public dividend capital.

Market risk

Market risk arises when the Trust is exposed to the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises of currency risk and interest rate risk. Currently there is limited exposure to all components of market risk due to the restricted cash availability in this area.

Credit risk

The majority of the Trust's income is from NHS Trusts, in particular Clinical Commissioning Groups. The Trust therefore has very little credit risk from these organisations. Non-NHS income only represents a very small percentage of the Trust's income; procedures are in place to manage the credit risk. The provision for impairment of receivables is less than 1% of overall income.

25.2 Financial assets by category

	Group		Foundation Trust	
	31st January 2015 £000	31st March 2014 £000	**31st January 2015 £000**	31st March 2014 £000
Assets as per SoFP				
Loans and receivables				
Trade and other receivables excluding non-financial assets	**1,680**	734	**1,791**	764
Cash and cash equivalents at bank and in hand	**1,032**	1,960	**852**	1,652
Available for sale				
Other investments	**268**	252	**0**	0
Total	**2,980**	2,946	**2,643**	2,416

25. FINANCIAL INSTRUMENTS (continued)

25.3 Financial liabilities by category

	Group		Foundation Trust	
	31st January 2015 £000	31st March 2014 £000	31st January 2015 £000	31st March 2014 £000
Liabilities as per SoFP				
Trade and other payables excluding non-financial liabilities	**2,306**	1,580	**2,298**	1,575
Total	**2,306**	1,580	**2,298**	1,575

25.4 Maturity of financial liabilities

	Group		Foundation Trust	
	31st January 2015 £000	31st March 2014 £000	31st January 2015 £000	31st March 2014 £000
In one year or less	**2,214**	1,580	**2,206**	1,575
In more than one year but less than two years	**92**	0	**92**	0
Total	**2,306**	1,580	**2,298**	1,575

26. THIRD PARTY ASSETS

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust held £260 cash at bank and in hand at 31st January 2015 relating to money held on behalf of patients (31st March 2014 £260). The Charitable fund does not hold assets on behalf of third parties.

27. LOSSES AND SPECIAL PAYMENTS

These are costs that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared to the generality of payments.

	2014/15 Number	2014/15 £000	2013/14 Number	2013/14 £000
Losses				
Bad debts and claims abandoned	44	33	25	27
Total losses	44	33	25	27
Special payments				
Ex-gratia payments loss of personal effects	0	0	1	0
Ex-gratia payments of personal injury	3	30	1	10
Ex-gratia payments of Other	2	14	1	2
Total Special Payments	5	44	3	12
Total Losses and Special Payments	49	77	28	39

Amounts are reported on an accruals basis but exclude provisions for future losses.

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