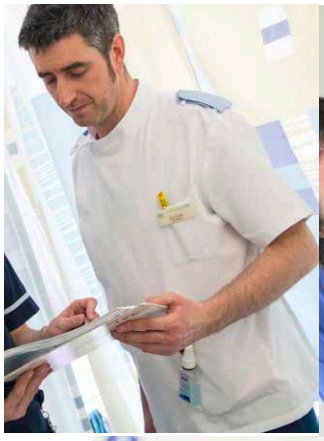
The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

ANNUAL REPORT & ACCOUNTS 2015/16



RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

The Royal Orthopaedic Hospital NHS Foundation Trust

Annual Report & Accounts 2015/16

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

CHAIRMAN AND CHIEF EXECUTIVE'S INTRODUCTION

This has been a challenging year for the majority of NHS organisations, the Royal Orthopaedic Hospital being no exception. The external context in which the Trust is operating has experienced tighter financial constraints and a real drive for delivering even greater efficiencies and safe care. Despite these changes, however, we remain proud to steer our organisation and continue to focus on the world class care that we deliver to our patients every day. During our time at the hospital, we take many opportunities to talk to our patients, staff and relatives to hear how our work is having an impact on them and actively encourage patient stories to be part of the routine agenda of the Trust Board.

The Trust remains ambitious in its intention to become the first choice for orthopaedic care and remains wedded to its Five Year Strategic Plan, with 2015/16 being the second year. Having now been established in post for some time, we have developed a clearer view of the leadership requirements needed to deliver the challenges faced by the organisation over the coming years within the context of the Strategic Plan.
A significant positive development during the year has been the selection of the ROH to be represented in one of the new Vanguard models of care. The Vanguards are designed to lead on the development of new models of care which will act as the blueprints for the NHS moving forward and as inspiration to the rest of the health and care system. We are proud that the ROH has been elected to provide the lead Chief Executive for the Vanguard in which we feature, known as the National Orthopaedic Alliance. This is a great opportunity for the ROH to strengthen collaboration, support improved outcomes and spread good practice. For patients it has the potential to help deliver higher quality care more consistently across the country.
Regionally, the development of the Sustainability and Transformation Plan footprint during 2015/16 has created a revised approach to system planning in Birmingham and Solihull, these models bringing together commissioners, provider organisations and local authorities to deliver sustainable transformation in patient experience and health outcomes over the longer term.

The Care Quality Commission, building on its initial visit in 2014, has revisited the Trust during the year and while there was recognition that there were significant improvements in services in the areas inspected, it was also clear that there was further work to do, which has been an area of real focus and commitment during the year and we thank all of those who are involved with delivering these improvements.

There have been some changes to the overall Board and Executive composition over the last year: Kathryn Sallah has joined the team, who as a qualified nurse and midwife, has increased the quotient of Non Executives on the Board who have a clinical background. Garry Marsh, was appointed substantively as the Director of Nursing & Clinical Governance during the year. Together they have made significant progress in strengthening the oversight of patient quality and safety by reinvigorating the operation of the Board's Quality & Safety Committee. Alongside this, and in response to the need for closer monitoring of financial performance and activity, an additional Board committee was created during the year, with responsibility for oversight of financial and operational performance. The focus of this committee has initially been on the plans to reverse a picture of deteriorating activity and finance. With the plan to fill the vacancy that has existed for some time in the Non-Executive cadre in 2016/17, it is the intention to refocus the committee on more routine oversight.

We are delighted with some of the accolades that the Trust has received during the year. We won two awards in the NHS Apprenticeship Recognition Awards: small apprenticeship employer of the year and apprentice employer champion of the year. On a national & international level, our success continued, with a number of prestigious awards for our ground breaking work in Oncology. We also attended the Health Service Journal and Nursing Times awards ceremony to celebrate the Trust being nominated as one of the Top 100 Places to work.

We have been recruiting talented new consultants to replace some of the great and pioneering consultants who are due to retire in 2016/17. We have recruited an additional three consultants in Oncology, and together with four new spinal consultants who are due to start with us over the next few months, this will strengthen our leadership of orthopaedic medicine. The past year has also seen the dedication of the Trust's lecture theatre to Professor Max Harrison, a former colleague surgeon and the launch of a series of lectures which will focus on orthopaedic medicine in its wider sense, appealing to the broader constituency of stakeholders.

It has been a year of transition for our governors, with a number of departures and the start of others to fulfil this incredibly important role. We say goodbye to Stella Noon and Yvonne Scott who, having served three terms as governors of the organisation, have been very much part of the fabric of the organisation. We have welcomed Petro Nicolaides and Carol Cullimore as public governors and Alex Gilder as a new staff governor. The work to foster proactive and positive relationships between the Board and the governors has continued during the year through new models of reporting by the Non Executives into the Council. Governors have stayed involved in the work of the Trust's key committees, now including the Quality & Safety Committee. The Annual General Meeting was held in October and was followed by the staff awards, an upbeat and positive celebration of achievement of our staff's excellent work.

We continue to be excited by our ambitions for the longer term: the ROH needs to build on its very solid foundations of good care and clinical practice but at the same time it also needs to undertake significant rapid strategic change to meet the increasing demands and pressures on NHS services generally. 2016/17 sees the bicentenary of the Trust, where we will celebrate 200 years of delivering groundbreaking care to many generations of patients. We want patients of the ROH to continue to benefit from world class outcomes and exceptional patient experience delivered by highly motivated staff who work with us to continually improve the quality of our services.

We would like to take this opportunity to thank all the incredibly dedicated people at the ROH who go about their work so devotedly and give their time freely to make the Trust the great place that it is.

Dame Yve Buckland, Chairman

Jo Chambers, Chief Executive

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1.0 OVERVIEW

1.1 OVERARCHING STATEMENT

2015/16 represents a successful year for the Royal Orthopaedic Hospital NHS Foundation Trust (ROH), albeit one in which the ongoing challenges facing the NHS as a whole continued to be felt.

The ROH continues to strive to deliver exceptional patient experience and world class outcomes in all that we do.

1.2 PURPOSE AND ACTIVITIES

The Royal Orthopaedic Hospital NHS Foundation Trust is a single specialty orthopaedic hospital offering routine elective and specialist treatment. It offers spinal services to the region and soft tissue and bone tumour services to the Midlands, the North of England and Wales.

1.3 BRIEF HISTORY AND STATUTORY BACKGROUND

The ROH was established as an NHS Trust in 1995 and founded under the National Health Services Act 2006 as the Royal Orthopaedic Hospital NHS Foundation Trust on the 1 February 2007. The main hospital location is five miles from Birmingham City Centre and two miles from the University of Birmingham. It is one of a number of acute trusts in Birmingham and primarily serves patients from the West Midlands. The Trust operates no branches outside the UK.

The accounts have been prepared under a direction issued by NHSI#1 under the National Health Service Act 2006.

1.4 PLANNING FOR THE FUTURE

The Trust's five year strategy is now two years into the five year cycle and the focus remains unchanged. However, the strategy is a living document, which requires a degree of flexing and review. The Trust Board has started a process of checks and balances to ensure that the plan remains contemporaneous and active.

Part of the process is to ensure that basic infrastructural issues such as the long term suitability of facilities, business operating models and workforce remain effective and suitable for our patient needs and the population we serve.

The overarching principles set out in 2014, when the current plan was developed, remain true and the plan is by and large fit for purpose. However, the NHS landscape has changed significantly and the performance and fiscal challenges are greater than ever before.

The Trust remains focused and committed to seven workstreams of:

- Creating a culture of excellence, innovation and service;
- Exceptional patient experience every step of the way;
- Safe and efficient processes;
- Fully engaged patients and staff;
- Information for excellence;
- Developing clinical services;
- ROH: The knowledge leader.

During 2016/17, a refreshed five year strategy will be developed, consulting with our people, our partners and of course our patients.

1.5 KEY ISSUES AND RISKS

The Trust manages its internal risks through the Board Assurance Framework, which highlights major risks to the delivery of the Trust's strategic objectives and organisational goals. The key risks included in the Board Assurance Framework can be summarised as:

- Long-term viability as a Going Concern;
- Adequacy of business intelligence to manage the organisation on a day to day basis;
- Organisational leadership of culture change, both from a capability and a capacity perspective;
- Impact on patient experience and the financial position as a result of long waiting times in spinal deformity services;
- Impact of regulatory context on the ability of the organisation to retain a focus on its strategic direction;
- Failure to learn lessons from when things go wrong.

Of these, the most significant risks for the Trust as it moves into 2016/17 are as follows:

- **Risks to financial viability through the inability to manage internal costs, deliver key programmes or respond to tariff reductions** – these risks remain especially significant because of the very demanding financial settlement for 2016/2017 and internal challenges for example associated with controlling the use of temporary/agency staffing.
- **Adequacy of business intelligence** – this risk has become more pertinent this year as the Trust addressed a deteriorating financial and activity position. Robust and consistent business intelligence is needed to ensure that operational decisions and/or management of the business on a day to day basis is effective.
- **Long waiting times in spinal deformity** – there is a risk of poor patient experience and outcomes should patients needing spinal deformity procedures continue to wait excessively for treatment. There is the additional risk of financial adversity should fines for patients breaching the 52 week referral to treatment time access target continue to be applied by commissioners.

As well as the above risks, there are some wider uncertainties which impact on the Trust. Many of these, such as the changing external strategic context, continued challenge of growing NHS demand driven by demographic growth, patient expectations, technological advances and the economic environment of static or shrinking financial resources, are relevant to NHS providers as a whole.

1.6 GOING CONCERN STATEMENT

The financial statements, as provided in detail in later sections of the Annual Report, have been prepared on a Going Concern basis. The assumptions within the financial statements have been fully challenged through Audit Committee and Trust Board, and the Directors have a reasonable expectation that the ROH has adequate resources to continue in operational existence for the foreseeable future.

In reaching this conclusion, the Directors have taken into account the Trust's operational plan, the agreement of service delivery contracts with CCG and NHSE commissioners for 2016/17 and the strength of the Trust's liquidity position which will ensure that cash remains available to cover operating expenses over the current planning period.

Despite the difficult financial environment in which all public services exist, the Directors are confident that the Trust has robust plans in place to ensure its sustainability. For this reason, they continue to adopt the Going Concern basis in preparing the accounts.

Approved by the Board of Directors on 24th May 2016

Mrs Jo Chambers
Chief Executive
27th May 2016

2.0 PERFORMANCE ANALYSIS

2.1 PERFORMANCE FRAMEWORK

The Trust's performance framework operates at a variety of levels. The Trust Board reviews the key indicators for the Trust across eight categories (Safety, Effectiveness, Patient Experience, Treatment Targets, Activity, Efficiency, Workforce and Finance) via the Corporate Performance Report.

Further scrutiny of these key indicators takes place within two Board sub-committees; Quality & Safety Committee and Finance & Performance Committee. These committees undertake a more detailed review of performance in their specific areas, which may include deep-dives into specific areas of concern.

Local performance scrutiny takes place at Divisional performance meetings, which have been reintroduced following the development of the new divisional structure in 2015/16.

Work is ongoing to further develop the corporate reporting structure, with a greater emphasis on forward projections and external benchmarking. The Trust is also considering how the 'Carter Model Hospital' approach can be utilised within a revised performance framework. This reporting will be underpinned by a suite of local business intelligence reports as part of a major transformation project to revamp business intelligence services at the ROH.

2.2 PATIENT CARE PERFORMANCE

The Care Quality Commission undertook a re-inspection in July 2015, specifically to review the position in the Outpatients and the Trust's Critical Care departments, both having been previously rated as 'Inadequate' for being responsive and safe respectively. The CQC report was published on 4 December 2015 and reported that, while services had improved in those areas, further improvements were still needed. The Trust's overall rating remains as 'Requires Improvement'. The CQC rated both Critical Care and Outpatients as being 'Good' for being caring. The Trust has welcomed the findings of the CQC inspection and this has proved to be a further catalyst for change following the initial inspection in 2014. The Trust has taken a number of actions to address the areas where we fell short of good practice and delivery of these and the associated outcomes are monitored by the Board and its committees on a regular basis.
During the year we have also made good progress in a number of our key quality priorities for 2015/16:

- Over 95% of patients are assessed for the risk of VTE (venous thromboembolism) upon admission to hospital;
- Improved standards of incident investigation;
- Ensuring our patients get enough help to eat their meals;
- To reduce the length of time patients are starved before surgery;
- To be compliant with National Joint Registry standards of consent and reporting.

The Trust has worked hard to improve the experience of our patients, with key successes including:

- Significant improvement to the complaints' management process has been delivered during the year, following the identification of some shortfalls previously. Whilst this has not yet resulted in a reduction in the number of complaints received by the Trust, which rose slightly in 2015/16 to 113 from a total of 105 in 2014/15, it has seen a significant improvement in response times to patients from a position where no complaints were responded to within agreed timescales in August 2015 to one where 95% of complaints are responded to within timescale by end March 2016.
- The processes for ensuring that the Trust is compliant with the Duty of Candour regulations have been strengthened, thereby ensuring that when a patient experiences moderate or severe harm while in the care of the Trust, that we rapidly acknowledge our shortcomings and involve the patient fully in discussions about what went wrong.
- The Trust has put a lot of focus on improving our appointments process in order to offer a reliable and effective service to all of our patients and address feedback from patients that has suggested we need to eliminate some of the inefficiencies in our current system. This year, this work has been supported by the introduction of the 'In Touch' system to better manage outpatient appointments.
- Much work has continued to eliminate any cases of avoidable pressure ulcers, with considerable effort having been given to improving training and documentation. This is a key area for improvement in 2016/17 as identified in the Quality Account.

The Trust consistently now records 100% against use of the World Health Organisation (WHO) checklist and has achieved

the local target for compliance for 10 out of 12 months during 2015/16, a marked improvement against the position in 2014/15, where the local target compliance was reached in just 2 out of 12 months.

2.3 OPERATIONAL PERFORMANCE

During 2015/16, the strategic and operational performance of the Trust was delivered through our revised divisional structure, comprising two clinical divisions (Patient Services and Patient Support Services) and two supporting divisions (Patient Access and Estates & Facilities). These divisions were responsible for the delivery of safe and effective patient centred care, high quality outcomes and compliance with national and local finance and performance targets.

The Trust treated 14,954 admitted patients and 69,253 outpatients in 2015/16, a decrease of 2% and 6% respectively as compared to the previous financial year.

	PERFORMANCE AGAINST PLAN			PERFORMANCE AGAINST 2014/15 ACTUAL	
	ACTUAL TREATED 2015/16	PLAN TO TREAT 2015/16	VARIANCE	ACTUAL TREATED 2014/15	VARIANCE
Inpatients	7,100	7,385	(285)	7,114	(14)
Day Cases	7,854	8,231	(377)	8,186	(332)
Total Admitted Patient Care	14,954	15,615	(661)	15,300	(346)
First Appointment	19,544	20,767	(1,213)	19,416	138
Follow Up Appointment	44,689	47,542	(2,853)	47,059	(2,370)
Outpatient Procedures*	5,020	7,232	(2,212)	7,494	(2,474)
Total Outpatients	69,253	75,540	(6,287)	73,969	(4,716)

*Note – Some outpatient procedures were recoded as First/Follow ups from 15/16 onwards due to national coding changes in the final grouper released

Overall activity decreased in 2015/16, largely linked to key operational challenges related to unplanned surgical vacancies and sickness. Recruitment challenges in specialist service areas meant that the time taken to appoint to specialist surgical posts was greater than anticipated, however this additional time has enabled a number of high calibre consultant appointments to be made, with four spinal surgeons and three oncology surgeons starting with the Trust in 2016/17.

The 'Transformation into Action' programme was introduced in December 2015 to ensure that any issues that were affecting the smooth transition of patients throughout the hospital were addressed in a timely fashion to ensure that both patient experience and the Trust's overall efficiency were improved. This programme has led to some major improvements already, including a significant reduction in the number of long-stay patients and a reduction in the number of patients who have operations cancelled for hospital reasons.

The management of our highly specialised paediatric spinal deformity patients within national waiting time targets continues to be a major challenge. For a cohort of medically complex children, the Trust is reliant upon a whole health system approach to identify and ring-fence appropriate capacity in terms of specialist staffing and facilities to enable

timely treatment of these patients. Where the health system is unable to provide this capacity, the ability of the Trust to deliver treatment within a satisfactory timescale is significantly limited. With support from NHS England, the ROH was able to treat 30 additional spinal deformity patients in 2015/16 at the Cromwell Hospital in London, ensuring that this key group of patients were able to receive surgical treatment that was unavailable locally due to capacity constraints. Despite this work, the Trust continued to see waiting times rise for this complex group of patients. As at 31st March 2016, 38 patients had been waiting over 52 weeks for treatment.

The Trust continues to work with NHS England's specialist commissioning team, and other provider partners to find both short-term and strategic solutions to this ongoing issue. Additional capacity has been funded in 2016/17 to support the reduction of waiting times in this service, with further capacity promised from 2017/18.

All other annual Monitor performance targets were achieved in 2015/16, as shown in the table below:

Target	Target performance	Actual performance %			
		Q1	Q2	Q3	Q4
18 weeks RTT – Incomplete	92%	94.1	93.1	92.1	92.0
Cancer – 2 week wait to be first seen following urgent GP referral	93%	99.1	99.3	100	100
Cancer – 31 day wait from diagnosis to first treatment	96%	100	97.4	100	100
Cancer – 31 day wait for second or subsequent treatment- surgery	94%	100	100	100	100
Cancer – 62 day wait for first treatment (from urgent GP referral)	85%	77.8	100	86.4	93.3

Whilst the 62 day cancer target was achieved across the year as a whole, the Trust did fail to achieve the target in Quarter 1. This related to a single patient breach, however the small number of relevant patients for this target (one breach out of 4.5 accountable patients – half a patient relates to shared care between two organisations) resulted in the Trust failing to meet the 85% target.

2.4 FINANCIAL PERFORMANCE

2015/16 has proved a financially challenged year for the NHS as a whole, and the ROH has not been immune to these pressures. The Trust's final accounts show a deficit of £6,305,000, however this includes material non-operating adjustments linked to asset impairments, consolidation of the Trust's charitable funds accounts and a capital to revenue transfer. The table below shows the overall deficit excluding these items:

Final accounts deficit	(£6,588,000)
Consolidation of charitable funds	(£1,112,000)
Final accounts deficit – Trust only	(£7,700,000)
Capital to revenue adjustment	(£2,300,000)
Impairment to asset valuation	£3,237,000
Underlying deficit	**(£6,763,000)**

This position shows a significant underperformance against the planned 2015/16 deficit of £2,000,000. The biggest single driver for this underperformance was an under-delivery of activity targets, with 661 fewer admitted patient care spells being undertaken against planned levels. This accounted for circa £3.2m of the outturn underperformance. In addition to this, the Trust incurred a high level of fines relating to breaches of the 52 week waiting times target in spinal

deformity services. These fines, linked to the capacity pressures outlined within the operational performance section earlier, totalled £1,120,000 for the full year.

Expenditure on temporary staffing continued to create financial pressures in 2015/16, with recruitment challenges within junior doctors, theatres, HDU and ward nursing, leading to a reliance on temporary resources to maintain safe staffing levels. The Trust spent £5,525,000 on agency and contract staffing in 2015/16, up from £4,637,000 in the previous year. Through a combination of national interventions, such as the introduction of capped pay rates for agency staff and local interventions linked to revised staffing models and recruitment routes, the Trust has started to make inroads into agency expenditure in the final quarter of 2015/2016, and is expecting further savings in 2016/17.

The final deficit figure also includes a material adjustment highlighted at year end relating to a discrepancy on stock valuation. This has been treated as an under issuing of stock into the expenditure position and consequently an adjustment of £1,325m was actioned. This had the impact of worsening the Trust's overall deficit.

The NHS is constantly under pressure to ensure that services are provided in the most efficient way, and the Trust has taken this challenge seriously, delivering £2,535,000 of efficiency and cost savings in 2015/16. This includes major schemes linked to reducing length of stay (thereby reducing the number of community rehabilitation beds that the Trust needs to commission), administrative savings linked to the introduction of digital dictation and reductions in the pay rates for junior doctor locums following changes in the procurement process.

Despite the in-year financial challenges, the Trust remains in a strong financial position, with £10.6m of cash supporting our overall financial resilience. The Trust continues to receive the highest rating for liquidity from our regulators.

In 2015/16, Monitor introduced the Financial Sustainability Risk Rating (FSRR) as a replacement for the Continuity of Services Risk Rating. The FSRR places a greater emphasis on I&E performance, and the link between planned and actual in year performance. The financial challenges faced by the Trust in 2015/16, as evidenced by the year end deficit, are clearly shown in the metrics measured as part of the FSRR, leading to the Trust delivering an FSRR of 2 for the final three quarters of 2015/16. For further details please see Accountability Report, Section 6.

2.5 R&DS CONTRIBUTION TO CORPORATE STRATEGY (2014-2019)

The last twelve months has seen the research portfolio of the Trust expand with support from the research and development team. The numbers of patients recruited into research did reduce slightly in comparison to previous years, however, the number of studies being conducted at the Trust continues to increase with more sub-specialties getting involved in research. We have continued to expand our relationships with partner organisations to improve the care we deliver to our patients through ground breaking research.

Research and innovation are key drivers to support the Trust's vision to become 'The First Choice for Orthopaedic Care'. Particularly, strategic initiative 7: ROH The Knowledge Leader, which is the core work stream within the strategy which seeks to expand our research, innovation, audit, education and teaching capabilities.

Our corporate strategy embeds the foundations to develop an organisational culture which integrates research, innovation, clinical audit and effectiveness (outcomes) into a new department, the 'ROH Knowledge Management Team'. The aim of the new Knowledge Hub is to develop an expert team to provide specialist support to colleagues across the Trust to deliver high quality research, innovation and audit projects. The new team are now twelve months into the integration with education and teaching teams and are housed in modern redeveloped offices within the new Knowledge Hub.

2.6 R&D PERFORMANCE

The Trust has continued to grow and expand its research portfolio and capabilities with an average of 34 new clinical research projects registered per annum with the R&D Department.

Arthroplasty, Arthroscopy, Physiotherapy, Oncology are our most research active areas. The Anaesthetic and Spinal Directorates have seen a notable rise in the number of research projects registered and this is due to new consultants being appointed with a particular interest in clinical research.

Radiology, hand and foot, spinal and anaesthetics departments still have huge potential to increase the amount of research that is undertaken within their specialist areas.

	2011-12	2012-13	2013-14	2014-15	2015-16	Total
Arthroplasty	4	3	12	4	13	36
Oncology	8	9	1	8	5	31
Other	3	7	6	7	6	29
Arthroscopy	9	4	6	5	4	28
Physio	1	2	6	1	3	13
Histopathology	4	1	3	1	1	10
Spinal	2	2	1	1	3	9
Anaesthetics		1	3	3	1	8
Hand and Foot		1	2		1	4
Trust Wide			1		2	3
N/A	1				0	1
Radiology			1		0	1
Total	32	30	42	30	39	173

Number of new projects registered (x) sub-specialty

Although our participant recruitment into clinical research studies reduced during 2015/16, we currently have 32 pending studies (in set-up), with six being large recruiting studies, which should see our recruitment figures increase for 2016/17.

	2011-12	2012-13	2013-14	2014-15	2015-16	Total
NIHR	125	837	1038	860	407	3267
Commercial	69	7	11	21	45	153
Other	19	23	20	282	141	485
Total	213	867	1069	1163	593	3905

Participant recruitment into research

Our contribution to National Institute for Health Research (NIHR) adopted studies continues the highest type of studies that our patients are being recruited into and this can be attributed to increased collaborative projects being developed with our academic partners in addition increased funding from the National Institute for Health Research Clinical Research Network: West Midlands.

The number of patients recruited into commercial studies doubled in 2015/16 compared to the previous year which is due to our increased partnerships with industry (pharmaceutical and medical device companies).

The table below, shows recruitment by local investigator. From reviewing this data, it is clear that the majority of research undertaken within the Trust is led by a small proportion of our clinical staff, which is unfortunate, but shows that the ROH still has a lot of potential to increase the number of clinicians becoming actively involved in undertaking clinical research projects.

	2011-12	2012-13	2013-14	2014-15	2015-16	Total
Davis, ET	66	445	187	417	71	1186
Grimer, R	31	157	147	473	191	999
Moore, F	29	209				209
Snow, M	35	34	37	50	20	176
Bache, E	6		67	29	34	136
Jeys, L		1	25	24	39	89
Siddaiah, N				55		55
O'Hara, J					53	53
Thomas , A					48	48
Carter, S			5	14	23	42

Top ten recruiting onsite researchers

2.7 RESEARCH INCOME

The Trust has continued to increase external R&D income to fund the infrastructure costs associated with supporting the delivery of clinical research project. 78% of the research income is received from the NIHR via the regional Clinical Research Network (CRN:WM) through activity based funding, research capability funding and bids for strategic funding. The rest of the research income is received from the life sciences industries from conducting commercial contract research, and other non-commercial income, such as charitable funding from research grants (Table below).

Funding sources (2015/16)	£
NIHR funding	395,167
Other non-commerical income	20,000
Commercial Income	93,973
Total	**509,140**

Research income for 2015/16

2.8 R&D NETWORKING: CRN WEST MIDLANDS

The Trust is an active member of the NIHR Clinical Research Network West Midlands (CRN: WM). Although it is difficult to compare a specialist orthopaedic hospital with the large acute Trusts across the region, it should be noted that the ROH has grown to become the highest recruiting specialist orthopaedic hospital in the UK in relation to NIHR recruitment for 2015/16. The R&D Department works closely with CRN: WM in relation to study set-up, study delivery, networking with other member organisations and supports the provision of training and development of clinical research staff within the wider health research community.

The R&D Director has been appointed as the regional clinical speciality lead for orthopaedics, which links together

orthopaedic specialists within the West Midlands region to design and deliver high quality collaborative musculoskeletal and orthopaedic studies, providing increased opportunities for the ROH.

2.9 NETWORKING: WEST MIDLANDS ACADEMIC HEALTH SCIENCE NETWORK (WMAHSN)

Representatives from our Trust meet regularly with the leadership team of the WMAHSN. Additionally, Trust staff have attended and participated in a number of regional AHSN events and meetings, particularly in relation to healthcare innovation.

Throughout 2015/16, the CEO of the ROH was the Chair of the WMAHSN Central Spoke Council and a member of the WMAHSN Board. The purpose of the Spoke Council is to help establish and maintain an inclusive partnership of key stakeholders to oversee programmes of work across the Central Spoke of the AHSN in fulfilment of pan-regional objectives. The meetings were hosted by the ROH, attracting senior academic, healthcare and industry representatives from across the West Midlands region.

2.10 TRAINING AND DEVELOPMENT

The R&D department continues to provide research training to ROH staff including Good Clinical Practice (GCP) training, which is mandatory for all researchers. A total of 78 members of staff received GCP training during 2015/16. Additional specialist training and courses have been provided through the NIHR Clinical Research Network and the Birmingham Research Training Collaborative which are available for all staff employed within the Trust.

In an attempt to improve awareness of the Research Nurse role, and to attract nurses to explore the possibility of a career in Research, the R&D department continues to be part of the orthopaedic pathway for the first year nursing students. The students spend a day in the department attending clinics with the research nurses, learning about the role of a research nurse and the portfolio of studies at the ROH. This gives them the opportunity to see research being conducted in the Trust.

Additionally, the R&D department continues to support the student nurse teaching programme. This session aims to give the participants an understanding of research and why this is important. It identifies how the Trust is committed to supporting Research & Innovation, an exploration of our research portfolio and highlights what support is available from the R&D Department.

2.11 ROH R&D INVESTMENTS

The Trust's R&D department has invested in staff, systems and infrastructure during 2015/16 to improve and develop its internal resources and capabilities. Investments include funding a grant writer and a senior clinical research fellow in oncology to lead and support our research into bone and soft tissue sarcomas. Equipment, training and investing into our support departments are examples of other R&D investments into the Trust.

Full investment details that have been made during 2015/16 can be found in the table below:

Investment detail	£
Grant writer	31,463
Senior Clinical Fellow	22,388
Pathology Lab equipment	11,075
Staff Training and Development	3,623
Support staff (Pathology, Phelbotomy, Finance)	23,618
Total	**92,167**

2.12 ALLIED HEALTH PROFESSIONAL (AHP) AND NURSE LED RESEARCH

The R&D department continues to embed the Research Link Nurse Role across the Trust and hold bi-monthly meetings. In addition, research updates are given at the Nurse Leaders Forum. AHP and Nurse led Research is an area that has great potential for the future and is something that the R&D Department is very keen to develop. An important first step

to achieve this goal is to raise the profile; understanding and knowledge of research and the support available from the department to nurses across the Trust.

The AHP Team have continued to develop home grown studies over the last year in four key areas: sciatica treatment, functional restoration in the treatment of low back pain, bone tumour symptoms and total knee replacements. One of our research physiotherapists was successfully awarded our first AHP research, to conduct a piece of research looking at whether patient reported outcome measures (PROMs) can predict outcomes at one year following knee surgery.

The R&D Team has recently completed a piece of work, refreshing the R&D section of the Trust's corporate strategy, outlining its internal priorities and strategic objectives for the next three years. The future provides many realistic opportunities in relation to research and innovation for our staff, patients and other stakeholders; underpinning our journey to become the first choice for orthopaedic care.

2.13 THE IMPACT OF THE BUSINESS ON THE ENVIRONMENT

The Trust embraces sustainability working through its staff to reduce its carbon footprint and help with controlling its environmental impact. With our 'Green Champions' the Trust promotes carbon reduction through good housekeeping; this we consider will make a contribution in driving down the energy usage at the ROH. Engagement and encouragement at work fosters a culture of carbon efficiency which will lead to carbon reductions at work and in people's personal lives.

Through modification we have recently installed magnetic rings to our incoming gas mains on two of our buildings. The initial feasibility study suggests a 10% saving in gas consumption. We continue to invest in electrical energy saving investments such as LED lamps and better controls for our building management systems. Where appropriate, we apply meters and energy saving devices to control electrical usage.

The Trust continues to invest in energy saving initiatives such as super insulating buildings and installing energy efficient double glazed windows and doors to external locations.

The Trust monitors its incoming water supplies through intelligent meters. Our waste streams are monitored and the Trust is looking to further develop its recyclable waste stream.

The Trust is the proud owner of a 'Green Apple Award' as a result of our effort to maintain and develop the semi-wooded environment on our Woodlands site. This continues the tradition maintained by the Cadbury family of keeping tree planting as a vibrant part of our community.

2.14 SOCIAL, COMMUNITY AND HUMAN RIGHTS RESPONSIBILITIES

Building on the Trust's historic adoption of the FREDA principles - Fairness, Respect, Equality, Dignity and Autonomy, during the year the Trust has completed a self assessment against the Equality Delivery System which seeks to assist NHS organisations to assess how they are addressing equalities outcomes, including ensuring better health outcomes for all of our communities and considering human rights issues. The Trust has self-assessed as achieving one from the four goals and developing practices in relation to the remaining three. Details of the self-assessment can be found on our website.

2.15 POST YEAR-END EVENTS

There have been no important events since the end of the financial year affecting the Foundation Trust that influence the information within this annual report

2.16 OVERSEAS OPERATIONS

There were no branches operated by the ROH outside the UK during the year.

ACCOUNTABILITY REPORT

SECTION 1:

DIRECTORS' REPORT

1.0 DIRECTORS HOLDING OFFICE DURING 2015/16

The following Directors held office throughout the period of this report:

Dame Yve Buckland – Chairman
Term of Appointment: From 1 May 2014 to 31 March 2017

Chair Person, Dame Yve Buckland was awarded a DBE in 2003 for services to Public Health.
Yve was the first national Chair of the Water Consumer Council. She is former national Chair of the NHS Institute for Innovation and Improvement.

Yve is also an Honorary Member of the Warwick Business School's Faculty of Public Health and Medicine and a fellow of their Institute of Governance and Public Management.

Mrs Jo Chambers - Chief Executive Officer

Jo Chambers, CEO, has over 30 years NHS experience in acute, community and primary care services as Chief Executive and previously as Director of Finance and Performance, with a track record of service improvement and developing teams.

Her previous experience also includes system-wide leadership as a commissioning Chief Executive.

Jo is currently the Lead Chief Executive for the Specialist Orthopaedic Alliance and is leading the development of new models of care through the National Orthopaedic Alliance Vanguard.

Jo is the Deputy Chair of the HEE West Midlands Leadership Transformation Theme, leading on Chief Executive development for the region and until recently was a member of the West Midlands Academic Health Science Network Board.

Jo is the health provider representative on the West Midlands Combined Authority Public Service Board.

Mr Timothy Pile - Vice Chairman, Senior Independent Director - Non Executive Director
Term of Appointment: 1st term of office expired 31 December 2015 and was extended until 31 December 2018

Executive Chair of Cogent Elliott. Past President of the Birmingham Chamber of Commerce. Previously Chief Executive of Sainsbury's Bank and Non-Executive Director of Cancer Research UK. Various management positions held at Alliance & Leicester and Lloyds. Other roles include Trustee of the Library of Birmingham, and Board member of Marshalls PLC. Governor of Bromsgrove School.

Mr Rod Anthony - Non Executive Director and Chairman of the Audit Committee
Term of Appointment until 31st May 2017 (1st term of office)

A Chartered Accountant and experienced Chief Finance Officer and Managing Director. Currently chairman of Social and Local CIC (a strategic marketing agency providing support to the public and third sectors) and a director of The Innovations in Healthcare Gateway Limited (supporting the promotion and exchange of good practice ideas for health and care provision around the world).
Rod also provides consultancy and board advisory support to a number of commercial and social enterprise businesses, primarily operating within the field of healthcare innovation and improvement. Formally CFO and Interim Managing Director at the NHS Institute for Innovation and Improvement, CFO at the Forensic Science Service Ltd and executive at GlaxoWellcome Plc (now GlaxoSmithKline Plc). Previously Rod was also vice chair of Birmingham and Solihull NHS PCT cluster and Deputy Chair at Solihull Care Trust.

HH Frances Kirkham - Non Executive Director
Term of Appointment until 10 February 2017 (2nd term of office)

Senior Circuit Judge, Technology and Construction Court, Birmingham. Founder Committee Member and First Secretary, UK Association of Women Judges. Trustee for A-CET (African Children's Education Trust) Previous appointments have included partner roles for various solicitor firms; information officer for British Non-Ferrous Metals Federation; Publication Writer for Bank of London and South America, Lloyd's Bank. Various Governor roles include Chair of Governors for Heathfield School for Girls, Board member of Centre for Advanced Litigation at Nottingham Law School, Council member for Chartered Institute of Arbitrators.

Professor Tauny Southwood – Non Executive Director
Term of Appointment until 31 January 2017 (2nd term of office)

Consultant in Paediatrics at Birmingham Children's Hospital Head of the Department of Paediatrics at the University of Birmingham and Head of e-learning at the College of Medical & Dental Sciences Previous roles have included Chair at EULAR Standing Committee on Paediatric Rheumatology; Head of Division of Reproductive & Child Health and Member of Medical School Board; Clinical Director and Director of Research & Development and Member of Executive Board.

Mrs Kathryn Sallah – Non Executive Director
Term of Appointment until 31 March 2018 (1st term of office)

Kathryn Sallah has been working as an independent management consultant since January 2007. Her portfolio consists of health service reviews and redesign, advice to and development of NHS Boards, policy development and providing professional coaching. Previous clients include the Department of Health, the Welsh Office, Primary Care Trust's, community provider services and Acute Trusts in England. Kathryn, a qualified nurse and midwife, has over 35 years experience in healthcare in the UK and abroad. Kathryn's main focus has been on women's health issues and improvement in maternity services and due to this has also been the Midwifery Advisor to the Department of Health over several years. Kathryn has developed a keen interest in public health issues, which resulted in her successfully completing a Masters in Public Health at Birmingham University. She has held three Directors of Nursing posts: Walsall Manor Hospital, Birmingham Women's Hospital and Birmingham Strategic Health Authority. Her responsibilities at the SHA included lead Director for the reduction of perinatal mortality. This considerable experience at Board level has given Kathryn great understanding of corporate governance and accountability from both an Executive and Non Executive Director perspective. Kathryn is currently a Trustee of two Charitable Trusts, which have honed further her non executive skills. Kathryn chaired the national "Birthplace" research steering committees and was the Project Director for the Mid Staffordshire independent case note review. In 2007 Kathryn was awarded a MBE for services to Health Care in the Queen's Birthday Honors list.

Mr Paul Athey – Director of Finance

Paul was appointed in May 2013 after spending four years as the Trust's Deputy Director of Finance. he is a member of the National Payment by Results Technical Working Group and Foundation Trust Technical Issues Group. Paul has 14 years of NHS experience in a variety of roles in both provider and commissioning organisations. he is a former National Financial Management Trainee.

Mr Jonathan Lofthouse – Director of Operations

Appointed in 2014, Jonathan oversees all operational aspects of the Trust, leading three divisions which include all clinical services. Jonathan has a been working in the NHS for 23 years, holding a variety of posts at director level, with significant experience in a variety of acute trusts and ambulance trusts.

Mr Andrew Pearson - Medical Director

Mr Pearson is a Consultant Orthopaedic Surgeon and Medical Director for the Royal Orthopaedic Hospital. He qualified at Charing Cross and Westminster Medical School in London and underwent his higher surgical training in orthopaedic surgery in the West Midlands. On completion of this training he undertook a fellowship in advanced hip surgery at The Nuffield Orthopaedic Centre in Oxford.

He has published papers and chapters in medical literature, taught other surgeons on courses and has presented work nationally and internationally. His research work centres on improving the success of hip replacement surgery for his patients. Mr Pearson has particular interest in the development of new and improved bearing surfaces for hip replacement surgery and in improving patient outcomes in revision hip replacement surgery for infection.

His orthopaedic practice encompasses primary and revision hip replacement surgery as well as hip resurfacing surgery. He receives tertiary referrals from other orthopaedic surgeons both regionally and nationally.

Mr Garry Marsh – Director of Nursing & Clinical Governance

Garry Marsh brings with him a wealth of nursing and operational experience, having been in the NHS for more than 20 years in a variety of roles. Most recently he has been Deputy Chief Nurse at United Lincolnshire Hospitals NHS Trust, where he carried out this role for four years. He is well qualified, with a BSc (Hons) in Health Studies and an MSc in Health Policy and Management.

The following are non-voting members of the Board

Prof Phil Begg - Director of Strategy & Transformation

Phil provides executive leadership at Board level on strategy. His role is to lead on the implementation of the five year strategy and push forward the organisation's transformation agenda. Phil holds research positions at the University of Birmingham and the University of Kentucky, and was formerly the Head of Academic Research/Education at University Hospitals Birmingham. He has a history of management positions, which sit alongside a successful clinical career.

Ms Anne Cholmondeley - Director of Workforce and Organisational Development

Anne was appointed to the Trust in September 2009. She was previously Head of HR with 18 years of experience in HR in the private and public sectors. Anne has 3 years' experience as Head of HR and Acting HR Director in Foundation Trusts prior to appointment. She has an MA in HR Development and Fellow of the Chartered Institute of Personnel and Development.

The Board is supported by:

Mr Simon Grainger-Lloyd - Associate Director of Governance & Company Secretary

Simon was appointed in August 2015, following a number of years as Trust Secretary of a large acute provider trust previously and Board Secretary of the Forensic Science Service

1.1 DIRECTORS' INTERESTS AND INDEPENDENCE

The Trust maintains a register of Directors' interests which is open to the public: access is available by writing to:

Associate Director of Governance & Company Secretary
The Royal Orthopaedic Hospital NHS Foundation Trust
Bristol Road South
Northfield
Birmingham, B31 2AP

The Board considers that all Non-Executive Directors are independent in character and judgment and there are no relationships or circumstances which are likely to affect, or appear to affect, their judgment.

1.2 BALANCE, COMPLETENESS AND APPROPRIATENESS OF THE BOARD OF DIRECTORS

The Board of Directors comprises both Non-Executive and Executive Directors. The Executive Directors comprise the Chief Executive, Director of Finance, Medical Director, Director of Operations and Director of Nursing & Clinical Governance. During the year the quotient of Non Executives on the Board with a clinical background increased to two, with the recruitment of Kathryn Sallah, a qualified midwife and nurse. In addition two Non Executives have financial expertise: one of whom is a qualified Accountant, and a judge. The Chairman has a wide range of experience as a Non Executive and Board Chairman, both in the NHS and in the regulated water industry and was awarded DBE in 2003 for services to Public Health. Taking the wide range of experience of the Board of Directors as a whole, the balance and completeness of the Board is felt to be appropriate.

1.3 BOARD OF DIRECTORS' DISCHARGE OF OBLIGATIONS

The Directors are obliged under law to prepare financial statements for each financial year and present them annually to the Trust's Council of Governors and members at the Annual General Meeting. The Directors are also responsible for the adoption of suitable accounting policies and their consistent use in the financial statements, supported where necessary by reasonable and prudent judgments.

The Directors confirm that the above requirements have been complied with in the financial statements.
In addition, the Directors are responsible for maintaining adequate accounting records and sufficient internal controls to safeguard the assets of the Trust and to prevent and detect fraud or any other irregularities, as described further in the Statement of Accounting Officer's Responsibilities. The Directors also confirm that the Board has conducted a review of the effectiveness of its system of internal controls which are set out more comprehensively in the Annual Governance Statement.

The Directors 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.

1.4 MEETINGS OF THE NON-EXECUTIVE DIRECTORS

In accordance with the Foundation Trust Code of Governance, the Chair and Non-Executive Directors have met outside of normal Board meetings during 2015/16, with the Chief Executive in attendance as requested. The Chairman holds meetings with NEDs without executives being present on a regular basis, often prior to a formal Board meeting. The CEO attends these meetings by invitation.

1.5 SIGNIFICANT COMMITMENTS OF THE TRUST CHAIRMAN

Dame Yve Buckland, Trust Chairman, has no other significant commitments other than to the Foundation Trust.

1.6 APPOINTMENT AND REMOVAL OF NON-EXECUTIVE DIRECTORS

In accordance with the Trust's Constitution, the Council of Governors has the power to appoint and remove the Chair and Non-Executive Directors of the Trust. Although authority for the final decision cannot be delegated, much of the business of appointment or removal is carried out by the Council of Governors' Nominations and Remuneration Committee.
In accordance with the Foundation Trust Code of Governance, the Chair and Non-Executive Directors are offered the opportunity to stand for two 3-year terms provided their performance is good, following which positions are subject to open recruitment.

1.7 PROCESS FOR APPOINTING OR REMOVING NON-EXECUTIVE DIRECTORS

The appointment of the Chairman and Non-Executive Directors typically follows the following process:

- The Trust Board reviews the skills, composition and balance of the Board and advises the Council of Governors.
- The Nominations and Remuneration Committee of the Council of Governors discusses the skill-set required and the time commitment of the role and recommends the process of appointment to the full Council. A search consultant is usually appointed.

- Selection of a candidate to be nominated to the Council of Governors takes place. Background checks including those required to meet the Fit and Proper Person's test take place.
- The Council of Governors meet to consider and appoint candidate.
- Removal of the Chair or another Non-Executive Director requires the approval of three-quarters of the members of the Council of Governors.

1.8 COMPANY SECRETARY

Simon Grainger-Lloyd was appointed as Associate Director of Governance and Company Secretary in August 2015. Simon is an experienced Board Secretary, having previously served as Secretary to a large acute provider trust for several years and prior to that, within a private sector environment.

1.9 STATEMENT OF OPERATION OF THE BOARD OF DIRECTORS AND COUNCIL OF GOVERNORS

The primary role of the Board of Directors is to lead the Trust within the context of its strategy, whilst ensuring successful financial stewardship of the organisation. In order to achieve this, the Board receives regular reports on all aspects of its business to enable appropriate decisions to be taken. In addition the Board has a schedule of reserved decisions, which lists out those decisions which only the Board can make and a scheme of delegation which details those areas of responsibility delegated to committees and individual Directors/Manager.

One of the key roles of the Council of Governors is to oversee the work of the Board and the Board and Council have agreed a statement that defines how each will operate and how any disagreements will be resolved.

The Council of Governors holds the Non-Executive Directors (NEDs) to account for performance in their roles as leaders of the organisation and seeks to represent the views of the general public. Governors appoint and remove the Chair and NEDs and set their terms of office. Trust auditors are appointed by Governors; Governors and the Board must, by majority, agree changes to the constitution.

The Board is collectively responsible for the performance of the Trust. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the Trust as a whole and for the public.

The Board of Directors:

- provides entrepreneurial leadership of the Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed;
- is responsible for ensuring compliance by the Trust with its licence, its constitution, mandatory guidance issued by NHSI, relevant statutory requirements and contractual obligations;
- sets the Trust's strategic aims, at least annually, taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place for the NHS foundation trust to meet its priorities and objectives and, then, periodically reviewing progress and management performance;
- as a whole is responsible for ensuring the quality and safety of health care services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health (DH), NHS England, the Care Quality Commission (CQC) and other relevant NHS bodies;
- ensures that the Trust functions effectively, efficiently and economically;
- sets the Trust's vision, values and standards of conduct and ensures that its obligations to its members are understood, clearly communicated and met.

Informal and frequent communication between the Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

The Senior Independent Director and Chairman encourage informal communication on behalf of the Board of Directors including: discussions between Governors and the Chairman, the Chief Executive or a Director, through the office of the Chief Executive or any other person appointed to perform the duties of the Chief Executive to the Board.

Formal communications are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively.

Communications initiated by the Council of Governors, and intended for the Board of Directors, will be conducted as follows:

- Specific requests by the Council of Governors will be made through the Chairman, to the Board of Directors;
- Any governor has the right to raise specific issues at a duly constituted meeting of the Council of Governors through the Chairman. In the event of disagreement, two thirds of the governors present must approve the request. The Chairman will raise the matter with the Board of Directors and provide the response to the Council of Governors;
- Joint informal meetings will take place between the Council of Governors and the Board of Directors as and when necessary.

1.10 WORKING WITH GOVERNORS AND MEMBERS

The ROH is a Foundation Trust which is a membership organisation with two constituencies of public membership (open to patients and others). Staff are also members and these groups elect representatives to serve on the Council of Governors alongside a small number of stakeholder-appointed members.

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 through a number of means including:

- Attendance at Council of Governors meetings by Directors - the NEDs, CEO and executive team colleagues, where appropriate, brief Governors about the Trust's strategy and current developments, and answer questions to ascertain their views. At meetings of the Council a NED is asked to give a detailed outline regarding their role on the Board and Committee responsibilities and a question and answer session is held. NEDs also account to the Govenors for key Board decisions.
- The Governors are invited to attend public Board meetings and the Chairman encourages them to ask questions and to communicate their views and the views of members. Governors also attend some of the key committees and working groups of the Trust as observers and report back to the Council as a result.
- The Members and Governors communication strategy is being revised to raise the profile of the Trust and the role of the Governors among members and encourage members to share their views.

1.11 EVALUATION OF BOARD

Each Board committee prepares an annual work plan and evaluates its performance against this, formally reporting to the Board on an annual basis. Additionally, an item is included on the agenda of each Committee to prompt discussion of meeting effectiveness, a process which has driven some improvement and refinement in the operation of the Board committees during 2015/16.

The Board has not undertaken a formal evaluation of its performance during the year, however as part of an Audit Committee workshop held in October 2015, there were productive discussions on how assurance is best provided to the Board and how the Board environment might operate more effectively. The Trust is planning for its Well Led Framework review which is to conclude in the early part of 2017.

Executive Directors are set objectives which are evaluated by the CEO; the CEO's own performance is evaluated by the Chairman of the Trust. NEDs' objectives are set by the Chairman; their evaluation is carried out by the Chairman and the results are shared with the Council of Governors. The Chairman's appraisal is carried out by the Senior Independent Director, facilitated by the Associate Director of Governance & Company Secretary, with input from the Lead Governor. The results are shared with the Council of Governors.

The Board keeps the balance of its skills and competencies under review to ensure completeness and appropriateness for the requirements of the Trust. Both the Board and the Council of Governors considered that there was a need to strengthen clinical knowledge within the NED cadre and therefore a further NED with a clinical background commenced in April 2015.

1.12 BOARD AND COMMITTEE MEMBERSHIP

Trust Board

The Chair of the Board is the Trust Chairman. Board meetings should be held at least 10 times per year and members must attend at least 70% of all meetings but should aim to attend all scheduled meetings.#1

The Board is responsible for setting and delivering strategy and for ensuring that the Trust meets its statutory duties and effectively manages risks through the Trust's Assurance Framework and Risk Register. The Board develops and delivers

the organisational strategy ensuring delivery of a high quality service and all performance targets. The Board exercises all the powers of the Trust. Some powers may be delegated to a committee of Directors or to an Executive Director. The Board comprises seven Non-Executive Directors #2; seven Directors, including two advisory Directors (non voting), and the Associate Director of Governance & Company Secretary.

#1 In addition to full Board meetings, Board Workshops were held on 3.6.15, 7.10.15 and 13.1.16
#2 There is a vacancy for one Non Executive Director

DIRECTOR	DATE							TOTAL
	1/4/15	6/5/15	1/7/15	2/9/15	4/11/15	2/12/15	3/2/16	
Yve Buckland (Ch)	✔	✔	✔	✔	✔	✔	✔	7/7
Tim Pile	A	✔	✔	✔	✔	✔	A	5/7
Rod Anthony	A	✔	✔	✔	✔	✔	A	5/7
Elizabeth Chignell #3	✔							1/7
Kathryn Sallah	✔	✔	✔	✔	✔	✔	✔	7/7
Frances Kirkham	✔	✔	✔	✔	A	✔	✔	6/7
Tauny Southwood	✔	✔	✔	A	✔	✔	✔	6/7
Jo Chambers	✔	✔	✔	✔	✔	✔	✔	7/7
Paul Athey	✔	A	✔	✔	✔	✔	✔	6/7
Jonathan Lofthouse	A	✔	✔	✔	✔	✔	✔	6/7
Andy Pearson	✔	A	✔	A	✔	A	✔	4/7
Garry Marsh #4	✔	✔	✔	A	✔	✔	✔	6/7
The non voting Directors attended as follows:								
Phil Begg	✔	✔	✔	A	✔	✔	A	5/7
Anne Cholmondeley	A	✔	✔	✔	✔	✔	✔	6/7

KEY:

✔	Attended
A	Apologies tendered
	Not in post or not required to attend
#3	Resigned from the Trust in April 2015
#4	Interim Director of Nursing and Governance until 7/15

Board Committees
During the year the Trust reviewed its Board committee structure to ensure risk is appropriately discussed and managed within the organisation and includes fully all disciplines. During 2015/16 the Board had the following committees:

Audit Committee
The Audit Committee is chaired by a Non-Executive of the Trust and meets at least five times a year. The Director of

Finance is the lead executive for the Committee. The Committee ensures the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance. It maintains an oversight of the foundation trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements. It reviews the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks. The Chief Executive, Chairman and Directors attend where additional assurance is considered necessary.

DIRECTOR	DATE					TOTAL
	21/4/15	26/5/15	17/9/15	24/11/15	26/2/16	
Rod Anthony (Ch)	✔	✔	✔	✔	✔	5/5
Tim Pile	✔	✔	✔	✔	✔	5/5
Kathryn Sallah	A	✔	✔	✔	✔	4/5
Although not formal members the following Non-Executive Directors and Directors attended as follows:						
Yve Buckland		✔			✔	7/7
Paul Athey	✔	✔	✔	✔	✔	6/7
Jo Chambers		✔			✔	6/7
Garry Marsh					✔	7/7

KEY:

✔	Attended	A	Apologies tendered

During 2015/16 Audit Committee sought assurances and reviewed performance across a range of areas, primarily:

- Reviewing evidence of the effective operation of internal controls and risk management processes;
- Ensuring an effective internal audit function that provides appropriate independent assurance to the Audit Committee, Chief Executive and Board;
- Receiving reports on counter-fraud work within the Trust;
- Considering the nature and scope of the external audit, reviewing all external audit reports and ensuring co-ordination, as appropriate, with other external audit functions in the local health economy;
- Reviewing audit and management reports, and monitoring progress with the implementation of improvement actions across the Trust;
- Reviewing the standing orders, standing financial instructions and standards of business conduct for the organisation;
- Receiving reports from executive managers across the Trust on areas of assurance and risk management of interest to the Committee.

In addition, the Committee:

- Considers and makes recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the Trust's External Auditor and oversees the relationship with the External Auditor;
- Monitors the integrity of the financial statements of the Trust, reviewing significant financial reporting issues and judgments which they contain.

The Audit Committee provides an annual report of its work to the Trust Board and a note of each meeting's proceedings is prepared by the Chairman of the Audit Committee and is subsequently presented at the following Trust Board meeting. The Committee has an annual workplan that ensures it embraces the necessary range of activities, including relating to internal and external audit activities. Where work is undertaken by auditors that is not of an audit nature, this is separately commissioned against a clear brief and is undertaken by someone who is not engaged in independently auditing the Trust. Where possible, this is scheduled into the workplan and is included in the information presented

to the Council of Governors. This workplan is made available to the Council of Governors and the Chairman of Audit is available to update the Council on any matters of interest.

Discharge of Responsibilities

During 2015/16 the Audit Committee reported assurance to the Trust Board, focusing on the following key areas:

- Ensuring that the financial statements for the year ended 31st March 2016 reflect a true and fair position and that there were no significant issues within the external auditors' report to those charged with governance that need to be reported to the Trust Board;
- Ensuring that the Annual Governance Statement reflected the Committee's knowledge of the Trust and that no further disclosures were required. In doing so the Committee considered in detail the Head of Internal Audit Opinion on the 2015/16 financial year as well as other sources of assurance;
- A significant amount of work continued during the year to further develop the Board Assurance Framework and the way in which risks are reported to the appropriate assurance committees. Good progress was made during the year with risk management and reporting processes and, when the refreshed and more comprehensive Board Assurance Framework was reviewed by the Committee, it was considered to provide greater assurance surrounding the risks to the delivery of the Trust's strategic objectives and organisational goals;
- In line with the approved internal audit plan, during 2015/16, the Trust commissioned a number of internal audit reviews. Good progress was made with the delivery of the internal audit plan and the Committee closely reviewed progress made by internal audit in delivering the plan and reviewed the reports arising from these audits. The Committee tracked the progress management made in implementing agreed improvement actions and there was an emphasis on ensuring that improvement actions were implemented in a timely manner. When required, the relevant action owner attended Audit Committee to provide positive assurance that adequate controls were in place;
- As a follow-up to audit work completed in 2014/15, the Committee received regular reports from executive managers;
- During the year the Committee continued to give priority to developing a closer and more supportive working relationship with the Quality & Safety Committee (QSC) formerly the Clinical Governance Committee (CGC). The Chair of QSC is a member of the Audit Committee which has strengthened the link between Audit Committee and the work of the QSC and its sub-committees;
- The Audit Committee reviews 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;
- The Committee monitored closely matters of compliance with specific clinical policies and procedures, as noted in the Annual Governance Statement and has worked with the QSC to strengthen controls and compliance in this area;
- The term of office for the external auditors was not due to conclude during this financial year as their appointment had been approved by the Council of Governors in 2014/15;
- The Trust's internal audit function is provided by RSM. The Trust works closely with a Partner and Senior Manager from RSM to ensure it receives an independent, objective assurance on our systems of internal controls and evaluation of improvements on the effectiveness of our risk management, control and governance processes. The Audit Committee agrees an annual internal audit plan that is developed in line with the Trust's key strategic risks and objectives and monitors delivery against this plan at each Audit Committee meeting;
- An Audit Committee Workshop was held to raise the level of understanding and engagement in board assurance process and the Audit Committee's role in providing independent oversight and scrutiny on behalf of the Board. The Workshop also considered the Trust's existing Board assurance processes to provide a steer on where the Trust should focus efforts on improving the wider systems of assurance and consideration of how to improve the oversight and scrutiny role of Audit Committee.

Quality & Safety Committee

During the year the Clinical Governance Committee was renamed Quality & Safety Committee to better reflect the full remit of clinical quality, patient safety, clinical governance and effectiveness considered as part of its workplan. This Committee has designated responsibility for the oversight of clinical risk management and is chaired by a Non-Executive Director of the Trust. The Director of Nursing and Clinical Governance is the lead executive. The Trust's lead Clinical Commissioning Group has a standing invitation to attend meetings. The Quality & Safety Committee meets monthly and regularly reviews clinical risks through consideration of the Corporate Risk Register, which also includes risks of a clinical nature of sufficient severity and/or impact as to warrant inclusion on the Board Assurance Framework. The Committee's cycle of routine business also requires a set of subcommittees and groups with a clinical focus to report to the Committee on their work and to highlight any risks within their remit which may not otherwise be included on the formal risk registers. This process includes the evaluation of mitigating actions that have taken place to understand

and assess the outcomes of these actions. The Chair of the Committee is a Non-Executive Director holding a clinical background. The Committee membership comprises no fewer than three Non-Executive Directors, Medical Director, Chief Executive, Director of Nursing and Clinical Governance and Director of Operations.

DIRECTOR	DATE											TOTAL
	15/4/15	13/5/15	10/6/15	8/7/15	11/9/15	14/10/15	13/11/15	9/12/15	27/1/16	24/2/15	30/3/15	
Kathryn Sallah (Ch) #2 #4	A	✔	✔	✔	✔	✔	✔	✔	✔	✔	A	9/11
Frances Kirkham (Ch)#1	✔	✔	A	✔	✔	A	✔	✔	✔	A	A	8/11
Tauny Southwood#3 #7	✔	A	✔	✔	A	A	A	✔	✔	✔	✔	7/11
Elizabeth Chignell#5	A											1/11
Jo Chambers	✔	A	✔	✔	A	✔	A	✔	A	✔	✔	7/11
Andy Pearson	✔	✔	✔	✔	✔	✔	✔	A	✔	A	✔	10/11
Garry Marsh#6	A	✔	✔	✔	A	✔	✔	✔	A	✔	✔	8/11
Jonathan Lofthouse				A	A	A	A	✔	A	A	✔	2/8
Although not formal members the following Non-Executive Directors and Directors attended as follows:												
Yve Buckland	✔		✔	✔		✔		✔				
Rod Anthony		✔	✔	✔	✔				✔			
Tim Pile				✔		✔	✔					

KEY:

✔	Attended	#3	Meeting Chair June 2015
A	Apologies tendered	#4	Assumed Chair of Committee from July 2015
	Not in post or not required to attend	#5	Resigned 23/4/15
#1	Meeting Chair April 2015	#6	Interim Director of Nursing and Governance until 7/15
#2	Meeting Chair May 2015	#7	Meeting Chair March 2016

Transformation Committee

The Transformation Committee was created during 2014/2015 to provide assurance to the Board with regards to progress on the delivery of the Trust's Transformation programme aand delivery of strategy. The Committee is chaired by a Non-Executive of the Trust and meets around six times a year. The Director of Strategy and Transformation is the lead executive for the Committee. It regularly reviews and tracks the progress of key deliverables within the Trust's Strategic Plan via routine monitoring reports from seven work streams. The Committee reviews the impact of delays and underperformance in individual initiatives on the wider programme to ensure that risks are mitigated, interdependencies are managed and help identify solutions where appropriate. The Committee meets at least 6 meetings per annum#1. The Committee comprises no fewer than two Non Executive Directors, one of which is the Chair, CEO, Director of Strategy & Transformation, Director of Workforce and Organisation Development.

#1 During 2015/16 5 formal Transformation Committee meetings were held, in addition Workshops were held on 18/5/15, 14/7/15, 3/11/15

DIRECTOR	DATE					TOTAL
	28/4/15	22/9/15	17/12/15	19/1/16	15/3/16	
Tim Pile (Ch)	✔	✔	✔	✔	✔	5/5
Rod Anthony	✔	✔	✔	✔	✔	5/5
Yve Buckland	A	✔	✔	✔	✔	4/5
Jo Chambers	✔	A	A	✔	✔	3/5
Paul Athey	✔	✔	A	✔	✔	4/5
Garry Marsh	✔	✔	✔	✔	✔	5/5
Jonathan Lofthouse	✔	✔	A	✔	✔	4/5
Anne Cholmondeley	✔	✔	A	✔	✔	4/5
Andy Pearson	A	✔	✔	✔	✔	4/5
In attendance:						
Phil Begg	✔	✔	✔	✔	✔	5/5

KEY:

✔	Attended	A	Apologies tendered

Finance & Performance Committee

The Finance & Performance Committee met in shadow form as a Steering Group of Board members, from December 2015 until February 2016 when the Committee was formally established by the Board.

The initial focus of the Committee was on activity and financial recovery given a deteriorating position on both, however with a longer term plan to focus more routinely on finance and operational performance supported by the development of a revised corporate performance report.

The Committee is temporarily chaired by the Trust's Chairman while the focus of the Committee is directed to recovery, with the intention of it being chaired by a Non- Executive Director in the summer of 2016. The current agenda is highly directed to discussing the risks associated with the delivery of the operational plan and financial targets.

The Chief Executive is the lead executive for the Committee, currently supported by the Directors of Finance and Operations who provide the key agenda content. The Director of Finance will become the lead executive director for this committee once the initial recovery has been stabilised.

Meetings are held monthly and the Committee comprises two Non-Executive Directors, the Chief Executive, the Director of Finance and the Director of Operations, although all Non Executives are given an open invitation to attend should they wish.

DIRECTOR	DATE				TOTAL
	17/12/15 #1	5/01/16 #2	26/02/16	15/03/16	
Yve Buckland (Ch)	✔	✔	✔	✔	4/4
Tim Pile	✔	✔	✔	✔	4/4
Rod Anthony	✔	✔	✔	✔	4/4
Jo Chambers	✔	✔	✔	✔	4/4
Paul Athey	✔	✔	✔	✔	4/4
Jonathan Lofthouse	✔	✔	✔	✔	4/4
Although not formal members the following Non-Executive Directors and Directors attended as follows:					
Frances Kirkham	A	✔			
Kathryn Sallah	✔	A	✔		
Tauny Southwood	✔	A			
Anne Cholmondeley	✔		✔		
Phil Begg	✔			✔	

KEY:

✔	Attended
A	Apologies tendered
#1	First meeting was a NED Update on Activity to a Board Steering Group
#2	Second meeting was Finance & Performance Committee in Shadow

Charitable Funds Committee

The Trust Board is the corporate trustee for the charitable funds of the hospital. Charitable funds are examined separately from exchequer funds and trustees discharge their responsibilities in this regard in independence from the Foundation Trust itself. The Committee usually meets four times per year. Membership of the Committee comprises all voting members of the Trust Board, a governor representative, a patient representative and a patient facing staff member.

DIRECTOR	DATE			TOTAL
	29/5/15	14/10/15	17/3/16	
Frances Kirkham (Ch)	✔	A	✔	2/3
Yve Buckland	A	✔	✔	2/3
Rod Anthony	✔	✔	✔	3/3
Kathryn Sallah	A	✔	A	1/3
Tim Pile	A	✔	A	1/3

Tauny Southwood	A	A	A	0/3
Jo Chambers	✔	✔	A	2/3
Paul Athey	A	✔	✔	3/3
Garry Marsh	A	✔	✔	2/3
Jonathan Lofthouse	✔	A	A	1/3
Andy Pearson	A	✔	A	1/3

KEY:

✔	Attended	A	Apologies tendered
Note: February 2016 meeting was cancelled			

Nominations and Remuneration Committees
On 29 October 2014 the Board approved the replacement, and division of responsibilities, of the Nominations and Remuneration Committee

Nominations Committee (Executive Directors)
The Nominations Committee can appoint or remove the Chief Executive and, jointly with the CEO, can appoint and remove other Executive Directors. The Nominations Committee is chaired by the Trust Chairman and meets as required to consider any matters relating to the continuation in office of any Executive Director at any time, including the supervision or termination of service as an individual or an employee of the Trust.

The Nominations Committee reviews the structure, size and composition of the Board and makes recommendations with regard to any changes. It gives full consideration to succession planning, taking into account future challenges, risks and opportunities facing the Trust and the skills and expertise required within the Board of Directors to meet them. The Committee identifies and nominates suitable candidates to fill executive director vacancies. The Committee liaises closely with the Council of Governors' Nominations and Remuneration Committee. All Non-Executive Directors are members and the CEO is a member but in the case of matters relating to the CEO themselves, the CEO shall withdraw from the Committee.

The Nominations Committee met on 16 July 2015 to consider the vacancy of the post of Director of Nursing and Clinical Governance.

Following this meeting Garry Marsh (Interim Director of Nursing and Clinical Governance) was substantively appointed.

Attendance:

MEMBERS	16/7/15
Yve Buckland	✔
Tim Pile	✔
Kathryn Sallah	✔
Rod Anthony	A
Tauny Southwood	A
Frances Kirkham	A
Jo Chambers	A

KEY:

✔	Attended	A	Apologies tendered

Remuneration Committee

The Remuneration Committee is chaired by the Chairman and all other NEDs are also members. The CEO, Director of Finance and Director of Workforce and Organisational Development may also attend by invitation but no executive director may take part in discussions affecting their own remuneration and terms of office.

The Committee has delegated responsibility for setting the remuneration for all executive directors, including pension rights and any compensation payments. The Committee will also recommend and monitor the level and structure of remuneration for senior management.

The Committee provides the Board with advice concerning the terms and conditions of employment, including the remuneration packages for the Chief Executive and the Executive Directors. The Committee also seeks assurance on the robustness of the plans for the delivery of Trust's reward and recognition strategy for the Chief Executive and Executive Directors. The Committee is responsible for setting the remuneration of the Executive Directors.

Full details of the Directors' remuneration are set out in the Remuneration section of the Accountability Report. The Nominations and Remuneration Committee of the Council of Governors is responsible for setting the remuneration of the Chairman and Non-Executive Directors.

MEMBERS	1/4/15
Elizabeth Chignell (Ch)	✔
Yve Buckland	✔
Tauny Southwood	✔
Kathryn Sallah	✔
Rod Anthony	A
Tim Pile	A

KEY:

✔	Attended	A	Apologies tendered

1.13 COST ALLOCATION AND CHARGING GUIDANCE

The Trust has complied with the cost allocation and charging guidance, (Chapter 6 of HM Treasury Managing Public Money).

1.14 POLITICAL DONATIONS

There were no political donations during the financial year.

1.15 BETTER PAYMENT PRACTICE

The Trust paid 91.83% of invoices within 30 days against the target of 95%. Of the remaining balance, 2.70% of invoices were paid late due to disputes relating to the invoice.

The Trust did not incur any late payment penalties during 2015/16 under the Late Payment of Commercial Debts (Interest) Act 1998.

1.16 ENHANCED QUALITY GOVERNANCE REPORTING

Quality governance and quality are discussed in more detail in the Annual Governance Statement (section 4.3) and Quality Report; this section gives a brief overview of the arrangements in place to govern service quality.

1.17 HOW THE FOUNDATION TRUST HAS 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.

Within the year the Quality & Safety Committee (formerly Clinical Governance Committee) has reviewed a self-assessment against the quality governance framework (QGF) and used it to guide its priorities.

The Board receives assurance on quality governance through the Board Assurance Framework, performance against a wide-range of indicators in the Corporate Performance Report and through assurance reports provided by the Quality & Safety Committee, which in turn receives routine updates from the Trust's quality groups.

There is a process of escalation of risk related to quality throughout the Trust; further work is being carried out to strengthen its operation through the relaunch of the risk management policy, which will be supported by a staff training programme.

Board members carry out walkabouts in which they gain first-hand experience regarding the quality of care and the views of patients and staff and others. A programme of Quality & Safety walkabouts is in place.

Assurance is obtained routinely on compliance with CQC registration requirements through Directors and Senior Managers of the Trust having specific responsibilities in respect of CQC standards and more generally in maintaining internal control systems to support those standards.

The Trust was re-inspected by the CQC in July 2015 following the initial inspection in June 2014. In response to the report from the visit released in December 2015, the Trust produced an action plan which addressed the recommendations raised. Delivery of the action plan is monitored by the Trust Management Committee. Progress with the actions at a divisional level is also provided by routine divisional updates, again considered at each meeting of the Trust Management Committee. Finally, progress with the delivery of key milestones within the action plan is considered by the Quality & Safety Committee and Trust Board as part of their routine cycle of business.

1.18 MATERIAL INCONSISTENCIES (IF ANY) BETWEEN:

There are no material inconsistencies between:

- the annual governance statement;
- annual and quarterly board statements required by the Risk Assessment Framework, the corporate governance statement submitted with the annual plan; the quality report, and annual report;
- reports arising from Care Quality Commission planned and responsive reviews of the NHS foundation trust and any consequent action plans developed by the NHS foundation trust.

1.19 PATIENT CARE

Further information concerning patient care activities can be found in more detail within the Quality Report section.

In summary, the Trust has demonstrated significant progress in delivering its Quality Priorities for 2015/16, which included achieving consistent compliance with the WHO Surgical checklist, developing a robust programme of Quality Assurance visits, improving our compliance with National Joint Registry (NJR) standards of consent and reporting and reducing the length of time patients are starved before surgery. Those priorities not achieved in 2015/16 have been taken forward to 2016/17 as part of our continued commitment to excellent patient care.

The Trust continues to work hard to sustain these improvements and we are committed to continue our improvement journey for the coming year. To this end, the Trust has identified eight improvement priorities for 2016/17, progress against which will be monitored using a range of surveys and audits to determine, in a number of cases, improvement against a benchmarked position. Oversight of the performance will be provided overall by the Quality & Safety Committee where a regular progress report will be presented.

The Trust will continue to monitor delivery of the actions to address the recommendations provided in the CQC's inspection report received in December 2015, using the Quality & Safety Committee as the primary Board-level oversight body. Good progress had been made against the delivery of the actions that were due for completion by February 2016. Whilst there has been slippage in delivery of a Learning Disability Strategy, a recovery plan is in place with there being no anticipated risks to delivery. The recruitment of paediatric nurses remains an ongoing challenge for the Trust and discussion about the provision of alternative models of care continues. Further detail can be found in the Annual Governance Statement.

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to NHS Trusts based on delivery of improvement work. Through discussions with our commissioners (Birmingham Cross City Clinical Commissioning Group, BCCCCG) and NHS England, the Trust agreed a number of improvement goals which reflect areas of improvement identified by the Trust. A proportion of the ROH's income was conditional on achieving the quality improvement and innovation goals described within the CQUIN. During 2014/15 the total amount of income conditional upon achieving CQUIN goals was £1.561 million. The payment made was £1.536 million which represents 98.4% of the total value of the 2014/15 CQUIN scheme. Further detail can be found in the Quality Report.

During the year, the Communications Team has engaged with a diverse group patients across the organisation through focus groups, workshops and surveys. The feedback has informed the redevelopment of general patient information, moving from patients receiving a high number of single pages of information, to bringing much of that together into a handbook. The new Royal Orthopaedic Hospital Handbook that has subsequently been created is due to go into print for use in 2016/17. This will be followed by bespoke handbooks for some of the hospital's more frequently undertaken procedures, such as hip replacements. This process is taking place in consultation with surgeons and clinical leads, along with nursing colleagues and physiotherapists to bring together all relevant information in one place. These documents will continue to be developed, due for use with patients in early 2016/17. More broadly, all patient letter templates have been reviewed to ensure consistency in visual style, language and approach, as well as improved accessibility.

A workforce issue was identified with timeliness of response and adherence to the agreed complaints' procedure at the end of June 2015. The Deputy Director of Nursing and Clinical Governance and the Public and Patient Relations Manager undertook a full review of the position and it was identified that there were a number of outstanding complaints that needed to be investigated and responded to that were automatically classified as not compliant with the response requirements. This position continued to affect the reported compliance until the last of these were closed in October 2015. The Trust has a Key Performance Indicator of 80% of complaints to be within the agreed timescale and this is reported monthly to our Commissioning Lead.

1.20 STAKEHOLDER RELATIONS

During the year, the Trust was selected to be represented in one of the new Vanguard models of care, jointly with the Royal National Orthopaedic Hospital Trust and Robert Jones & Agnes Hunt Orthopaedic Foundation Trust. These models are designed to lead on the development of new care structures and will provide an opportunity for the ROH to strengthen collaboration, support improved outcomes and spread good practice. For patients it has the potential to help deliver higher quality care more consistently across the country.

The Trust has an active Patient and Carers' Forum in place, which has met regularly during 2015/16. There are plans during the coming year to refresh the workplan of this body and provide it with a focus on some key areas of work.

The focus of public and patient activity this year has been on creating regular and one-off opportunities for engagement directly with the Trust but continues to look at offering more opportunities for engagement from home that Trust members, in particular, can become involved with, as well as maintaining existing opportunities on site.

- asking for specific feedback on single issues such as the look and feel of the website;
- offering opportunities to become involved in the Transformation work to support the delivery of the 5 year Strategy;
- canvassing representation to join Patient Safety & Quality walkabouts.

1.21 STATEMENT AS TO DISCLOSURE TO AUDITORS

For each individual who is a director at the time that the report is approved:

- so far as the director is aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware; and
- the director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

A director is regarded as having taken all the steps that they ought to have taken as a director in order to do things mentioned above, and:

- made such enquiries of his/her fellow directors and of the company's auditors for that purpose; and
- taken such other steps (if any) for that purpose, as are required by his/her duty as a director of the company to exercise reasonable care, skill and diligence.

1.22 INCOME DISCLOSURES

The Health and Social Care Act 2012 requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. In 2015/16, the ROH's income from the provision of goods and services for other purposes, derived from private patients and other overseas patients, was 0.8% (£618,000), therefore the Trust has complied with the Act in this regard. The Trust does not anticipate this proportion changing within the foreseeable future.

Any financial profit from the treatment of private patients is reinvested into improving care for NHS patients.

SECTION 2:
REMUNERATION REPORT

1.0
ANNUAL STATEMENT ON REMUNERATION

During the year the Remuneration Committee made decisions concerning executive pay in relation to determining whether or not to agree an annual uplift of salary for executive directors. The committee had due regard to the national pay awards made to other staff groups and took the decision to award an annual uplift of salary to executive directors in line with this of 1% and committed to considering a revised reward strategy for executive directors during future years to include variable payments in recognition of individual contribution.

During the year the committee made decisions in relation to the remuneration of the post of Director of Nursing & Clinical Governance. In considering the remuneration for this role, following the resignation of the previous postholder, the committee decided to increase remuneration in recognition of the market rate for suitably experienced candidates.

2.0
SENIOR MANAGERS' REMUNERATION POLICY

	Salary and fees	Taxable Benefits	Annual Performance -related bonuses	Long-term performance-related bonuses	Pension-related benefits	Other Remuneration
Description	Basic pay for Executive role	Expenses incurred in the course of their duties such as public transport, mileage and subsistence as determined by Trust policy	Not Applicable	Not Applicable	NHS Pension Scheme membership	Basic pay for consultant role (Medical Director only)
How that component supports the short and long-term strategic objectives of the foundation trust;	To ensure the Trust is well-led and all short and long term objectives are met, the salary for senior managers must be competitive in order to recruit and retain talented individuals	To ensure senior managers are appropriately compensated for those journeys they have undertaken on behalf of the Trust. The policy for senior managers is the same as that applying to other staff.	Not Applicable	Not Applicable	This enables the Trust to recruit sufficient talent at executive director level and accords with custom and practice in the rest of the NHS.	This is essential to ensure a medically qualified person can occupy the role of Medical Director
An explanation of how that component operates	Executive Director Salaries are determined by the Remuneration Committee of the Trust Board, informed by benchmark salary derived from established national NHS pay surveys. Executive directors are appointed on a permanent basis under a contract of service at an agreed salary	Trust Expenses Policy applies to Senior Managers. Taxable benefits incurred fell within the scope of this policy. Levels of benefits reflect national terms and conditions for other staff groups to ensure consistency	Not Applicable	Not Applicable	This is determined in accordance with NHS Pension Scheme Benefits. No additional payments are made	As determined by national terms and condition of employment
The maximum that could be paid in respect of that component	Fixed salary determined by Remuneration Committee	Not Applicable	Not Applicable	Not Applicable	As determined by NHS Pension Scheme Entitlements	As determined by national terms and condition of employment
Where applicable, a description of the frame-work used to assess performance	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable

Provisions for the recovery of sums paid to directors exist where overpayments have been made in error or annual leave taken in excess of entitlement.

Accompanying notes
There were no new components of the remuneration package,
There were no changes made to existing components of the remuneration package other than the pay award referred to above;

The policy on remuneration for other employees is to utilise national terms and conditions of employment, with local policies relating to pay progression. The approach for senior managers is currently as determined above.

Senior managers paid in excess of £142,500
There are two Directors whose remuneration exceed £142,500 who were in post prior to 1 April 2015. The remuneration for both postholders was assessed and benchmarked against comparable Trusts, utilising published independent market salary information

	Fee payable	Any additional fees payable for any other duties to the foundation trust	Such other items that are considered to be remuneration in nature	Long-term performance-related bonuses	Pension-related benefits	Other Remuneration
Description	Fee for the Chair , Committee Chairs and other NEDs	Not applicable	Expenses incurred in the course of their duties such as public transport, mileage and subsistence as determined by Trust Policy.	Not Applicable	NHS Pension Scheme membership	Basic pay for consultant role (Medical Director only)
How that component supports the short and long-term strategic objectives of the foundation trust;	To ensure the Trust is well-led and all short and long term needs met, the fee for NEDs must be competitive in order to recruit and retain talented individuals	Not applicable	To ensure NEDs are appropriately compensated for those journeys they have undertaken on behalf of the Trust. The policy for NED expenses is the same as that applying to other staff	Not Applicable	This enables the Trust to recruit sufficient talent at executive director level and accords with custom and practice in the rest of the NHS.	This is essential to ensure a medically qualified person can occupy the role of Medical Director
An explanation of how that component operates	The chair and non-executive members are entitled to be remunerated by the Trust for so long as they continue to hold office as chair or non-executive member. They are entitled to receive remuneration only in relation to the period for which they hold office. There is no entitlement to compensation for loss of office. The level of remuneration is determined by the Governors with due regard to the remuneration paid in other Foundation Trusts	Not applicable	Mileage and subsistence allowances for NEDs are set by the Council of Governors.	Not Applicable	This is determined in accordance with NHS Pension Scheme Benefits. No additional payments are made	As determined by national terms and condition of employment
The maximum that could be paid in respect of that component	The rate of remuneration payable to the Chairman of the Trust is £35,000 pa for up to 2 days a week. The Chair of the Audit Committee and the Senior Independent Director are remunerated at a rate of £14,000 pa. The current rate of remuneration payable to other non-executives is £11,000 pa for approximately 3 days a month.	Not applicable	Not applicable	Not Applicable	As determined by NHS Pension Scheme Entitlements	As determined by national terms and condition of employment
Where applicable, a description of the frame-work used to assess performance	Performance of NEDs is assessed by the Chairman annually, and for the Chairman, by the Lead Governor and Senior Independent Director	Not applicable	Not applicable	Not Applicable	Not Applicable	Not Applicable

2.3 SERVICE CONTRACTS OBLIGATIONS

There were no obligations on the Trust which:

- were contained in all senior managers' service contracts or;
- were contained in the service contracts of any one or more existing senior managers (not including any obligations in the preceding disclosure); and/or
- the Trust proposes would be contained in senior managers' service contracts to be entered into

and which could give rise to, or impact on, remuneration payments or payments for loss of office but which are not disclosed elsewhere in the remuneration report.

2.4 POLICY ON PAYMENT FOR LOSS OF OFFICE

Where possible, all Executive Directors are employed on permanent contracts of employment with a six month notice period. Where the Trust has a requirement to use off-payroll or seconded executive directors and NEDs, they are usually employed for a fixed-term basis, and the Trust acts to ensure a permanently employed appropriate replacements is identified as soon as possible

No executive directors have provision for other payments over and above their contractual notice period or other statutory entitlements, to be made on termination of employment.

2.5 STATEMENT OF CONSIDERATION OF EMPLOYMENT CONDITIONS ELSEWHERE IN THE FOUNDATION TRUST

The pay and conditions of employees were taken into account when setting the remuneration approach for senior managers; by ensuring consistency in determination of non-pay taxable benefits to ensure no favourable treatment for Executive Directors.

The staff governors contribute to the determination of non-executive pay, alongside other governors, however they have no further responsibility to consult more widely to ensure their views reflect those of the wider staff and community and do not have any involvement in the determination of executives' remuneration.

In determining pay for executive directors, the remuneration levels for other NHS trusts are reviewed, utilising published and recognised remuneration reports.

3.0
ANNUAL REPORT ON REMUNERATION
3.1 SERVICE CONTRACTS

Name and title	Date of their service contract	Unexpired term	Details of notice period
Dame Yve Buckland Chairman	1 May 2014	Until 31 April 2017	Note 1
Mr Timothy Pile Non-Executive Director and Vice Chairman	1 January 2016	Until 31 Dec 2018	Note 1
Mrs Jo Chambers Chief Executive Officer	1 December 2013	Not applicable	6 months
Mr Paul Athey Director of Finance	1 June 2013	Not applicable	6 months
Mr Andrew Pearson Medical Director	11 March 2013	Not applicable	6 months
Mr Jonathan Lofthouse Interim and substantive Director of Operations	20 October 2014	Not applicable	6 months
Mr Garry Marsh Interim Director of Nursing and Governance	16 February 2015 as interim, substantive from 1 September 2015	Not applicable	6 months
Prof Phil Begg #1 Director of Strategy & Transformation	1 November 2014	Not applicable	6 months
Ms Anne Cholmondeley #1 Director of Strategy & Transformation	7 September 2009	Not applicable	6 months
HH Frances Kirkham Non-Executive Director	11 February 2014	Until 10 February 2017	Note 1
Professor Taunton Southwood Non-Executive Director	1st February 2014	Until 31 January 2017	Note 1
Mr Rod Anthony Non-Executive Director	1 June 2014	Until 31 May 2017	Note 1
Mrs Kathryn Sallah Non-Executive Director	1 April 2015	Until 31 March 2018	Note 1

Notes: #1 Non voting Director

Non-Executive Directors notice periods are as follows:

- NEDs may resign from office by giving one month's notice in writing to the Company Secretary.
- NEDs may be removed from office with or without notice by a resolution of the Council of Governors with the approval of three-quarters of the members of the Council of Governors.

3.2 REMUNERATION COMMITTEE

The Directors Report (within the Accountability Report) provides the following details in respect of the Remuneration Committee:

- Details of the membership of the remuneration committee. This means the names of the chair and members of the remuneration committee should be disclosed (Code of Governance A.1.2).

- The number of meetings and individuals' attendance at each should also be disclosed (Code of Governance A.1.2).

Anne Cholmondeley, Director of Workforce and Organisational Development provided advice to the committee in considering their responsibilities and decisions. She had no conflicts of interest in relation to this role because her own terms and conditions of employment were governed by Agenda for Change and was therefore outside the remit of the remuneration committee.

3.3 DISCLOSURES REQUIRED BY HEALTH AND SOCIAL CARE ACT

The Trust believes that all relevant disclosures are detailed elsewhere in the report.

4.0
REMUNERATION SUBJECT TO AUDIT (*This element of the annual report has been audited)

Name and Title	2015-16 (12 months to 31st March 2016)					
	Salary and fees (bands of £5,000) £000	Taxable Benefits Rounded to the nearest £100	Annual Performance -related bonuses (bands of £5,000) £000	Long-term performance-related bonuses (bands of £5,000) £000	Pension -related benefits (bands of £2,500) £000	Other Remuneration (bands of £5,000) £000
Mr T Pile – Non-Executive Director Vice Chairman	15-20	0	0	0	0	0
Dame Y Buckland – Chairperson	30-35	0	0	0	0	0
Mrs J Chambers – Chief Executive	150-155	200	0	0	39.5-42.0	0
Mr P Athey – Director of Finance	95-100	0	0	0	(2.0-2.5)	0
Mr A Pearson – Medical Director	20-25	0	0	0	27.5-30	115-120
Mr J Lofthouse – Director of Operations	110-115	0	0	0	0	0
Mr G Marsh – Director of Nursing and Governance (Substantive from 1 September 2015)	55-60	0	0	0	Note 1	0
Mrs F Kirkham – Non-Executive Director	10-15	0	0	0	0	0
Mr T Southwood – Non-Executive Director	10-15	0	0	0	0	0
Mr R Anthony – Non-Executive Director and Audit Committee Chair	10-15	0	0	0	0	0
Mrs K Sallah – Non-Executive Director	10-15	0	0	0	0	0
Professor P Begg – Director of Strategy and Transformation	90-95	0	0	0	0	0
Ms A Cholmondeley – Director of Workforce and Organisational Development	80-85	0	0	0	0	0

*This element of the annual report has been audited.

Notes

1. Pension-related benefits are calculated by taking 20 times multiples of Director's annual rate of pension, plus their lump sum entitlement, and subtracting the equivalent figures for the previous year. The Directors indicated joined or left the Trust in either the current or prior year. As a result, the calculation would give a misleading result to the

readers of the financial statements, and it has therefore been omitted from the financial statements for the current year.

2. There are two Directors whose remuneration exceed £142,500 who were in post prior to 1 April 2015. The remuneration for both postholders was assessed and benchmarked against comparable Trusts, utilising published independent market salary information. The Medical Director's salary is comprised of two elements:- remuneration for role as Medical Director and remuneration for role as a consultant surgeon of the Trust
3. No payments for loss of office have been made during the year.
4. There have been no changes in year to Director or Senior Manager remuneration. For those Directors whose terms and conditions are not governed by national arrangements, their terms and conditions of employment mirror Agenda for Change terms with the exception of basic pay as detailed in the table below and contractual notice periods.

Name and Title	2014-15 (12 months to 31st March 2015)					
	Salary and fees (bands of £5,000) £000	Taxable Benefits Rounded to the nearest £100	Annual Performance -related bonuses (bands of £5,000) £000	Long-term performance-related bonuses (bands of £5,000) £000	Pension -related benefits (bands of £2,500) £000	Other Remuneration (bands of £5,000) £000
Mr T Pile – Non-Executive Director (1.1. 13) & Acting Chairman (1.2.1 4 to 30.4.14)	15-20	0	0	0	0	0
Dame Y Buckland – Chairperson (from 1 May 2014)	30-35	0	0	0	0	0
Mrs J Chambers – Chief Executive	145-150	300	0	0	120-122.5	0
Mr P Athey – Director of Finance	95-100	0	0	0	47.5-50	0
Mr A Pearson – Medical Director	20-25	100	0	0	27.5-30	120-125
Mrs A Markall – Director of Operations (from 1 .4.12 to 31.8.14)	35-40	0	0	0	Note 4	0
Mr J Lofthouse – Interim and substantive Director of Operations (from 11 .8. 14), (Substantive from 20.10.14) Note 1	105-110	0	0	0	Note 4	0
Mrs H Shoker – Interim and Substantive Director of Nursing and Governance (from 1.10.13) (Substantive from 1.4.14 to 31.1.15)	110-115 Note 6	0	0	0	Note 3	0
Mr G Marsh – Interim Director of Nursing and Governance (from 16 .2.15) Note 2	10-15	0	0	0	0	0
Mrs F Kirkham – Non-Executive Director	10-15	0	0	0	0	0
Mr T Southwood – Non-Executive Director	10-15	0	0	0	0	0
Mrs E Chignell (previously Miss E Mountford) – Non-Executive Director	10-15	0	0	0	0	0
Mr M Flaxman – Interim Non-Executive Director and Audit Committee Chair (from 1.3.14 to 31.5.14) Note 3	0-5	0	0	0	0	0
Mr R Anthony – Non-Executive Director and Audit Committee Chair (from 1.6.14)	10-15	0	0	0	0	0

*This element of the annual report has been audited.

Notes

1. Mr J Lofthouse joined the Trust on an interim basis on 11 August 2014 via a contract with Gatenby Sanderson while a

substantive replacement for Mrs A Markall was sought. Mr Lofthouse took up the substantive post from 20 October 2014 and was subsequently transferred onto the Trust's payroll.

2. Mr G Marsh is currently seconded to the Trust from United Lincolnshire Hospitals NHS Trust as Interim Director of Nursing and Governance following the departure of Mrs H Shoker. The contract started on 16 February 2015. Mr Marsh is paid by United Lincolnshire Hospitals NHS Trust who then recharge the costs to the Trust.
3. Mr M Flaxman was contracted as a non-executive director from 1 March 2014 through In-Form Solutions Ltd. The Trust felt that, due to Board changes, Mr Flaxman's services were necessary in order to provide the Trust with an appropriately skilled Audit Committee Chair, in addition to ensuring there are sufficient numbers of Non-executive Directors on the Board. His contract lasted 3 months, and was replaced by the substantive engagement of Mr R Anthony as non-executive director and Chair of Audit Committee.
4. Pension-related benefits is calculated by taking 20 times multiples of Director's annual rate of pension, plus their lump sum entitlement, and subtracting the equivalent figures for the previous year. The Directors indicated joined or left the Trust in either the current or prior year. As a result, the calculation would give a misleading result to the readers of the financial statements, and it has therefore been omitted from the financial statements for the current year.
5. The salary and fees figure provided for Mrs H Shoker includes an amount paid to her in the year in lieu of notice.

4.1 FAIR PAY MULTIPLE

Trusts 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 financial year 2015/16 was £150-155k (2014/15: £145-150k). This was 5.11 times (2014/15: 4.9 times) the median remuneration of the workforce, which was £31k (2014/15: £31k).The highest-paid director salary does not necessarily match the tables above, as all salaries are required to be annualised before inclusion in the ratio calculation.

In 2015/16, 16 employees (2014/15: 12) received remuneration in excess of the highest-paid director. Annualised remuneration ranged from £2k to £186k (2014/15: £2k to £183k), with individuals at the lower end of the salary range including apprentices used by the Trust and individuals performing bank work on an ad-hoc basis.

The multiple has increased this year due to an increase in the median remuneration of the workforce included in the calculation. This number has increased largely as a result of agency staff costs within the year calculation. 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

5.0 SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS

Pension Benefits* 2015-16

Name and Title	Real increase/ (decrease) in pension and related lump sum at age 60 (bands of £2500) £000	Total accrued pension and related lump sum at age 60 at 31 March 2016 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Real increase/ (decrease) in Cash Equivalent Transfer Value £000	Employer's Contribution to Stakeholder Pension To nearest £100
Mrs J Chambers – Chief Executive (from 1 December 2013)	5.0-7.5	210-215	1,006	950	43	0

Mr G Marsh – Director of Nursing and Governance (from 16 February 2015) Note 1	0-2.5	0	0	0	0	0
Mr A Pearson – Medical Director (from 11 March 2013)	12.5-15	170-175	830	459	364	0
Mr J Lofthouse – Director of Operations from 20 October 2014) note 2	0-2.5	0-5	7	7	0	0
Mr P Athey – Director of Finance (from 1 June 2013)	(0-2.5)	75-80	240	238	(1)	0

*This element of the annual report has been audited

Notes

1. Mr G. Marsh was on secondment with the Trust in the role of Interim Director of Nursing & Governance from 16 February- 1 September 2015.
2. The figures shown for Mr J Lofthouse are in relation to contributions made into the NHS England Pension scheme only. Mr Lofthouse has previously made contributions into the NHS Scotland pension scheme and these contributions had not been transferred as at the year end.

5.1 TOTAL PENSION ENTITLEMENT

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures, and from 2007-08 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The Real Increases in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee and uses common market valuation factors for the start and end of the period.

6.0 DIRECTORS AND GOVERNORS IN OFFICE AND EXPENSE CLAIMS

This information has been audited.

The total number of Directors and Governors in office in the financial year, and their expense claims, has been shown

below;

	2015-16	2014-15
Number of Directors in office	13	14
Number of Directors with expense claims	6	6
Financial value of expense claims made by Directors (£00)	15.61	10.06
Number of Governors in office	16*	25
Number of Governors with expense claims	1	1
Financial value of expense claims made by Governors (£00)	4.61	4.61

* During the year a stakeholder governor from both BCC and BCU was not in post

Mrs Jo Chambers
Chief Executive
27th May 2016

SECTION 3:
STAFF REPORT

1.1 ANALYSIS OF AVERAGE STAFF NUMBERS

During the course of the year, the Trust employed an average number of 988 staff per month (Heads) and 864.1 (Whole Time Equivalent). Whilst there have been some recruitment challenges in theatres and HDU in particular, the numbers of staff employed have been very much in line with our expectations. Most recently, we have been successful in securing new consultants in Oncology, Anaesthesia and Spinal surgeons to both enhance services available for patients and to replace long-standing consultants who are due to retire during 2016/17.

1.2 BREAKDOWN OF STAFF BY THE TYPE OF EMPLOYMENT CONTRACT

Average Number of Staff In Post (01 Apr 15 to 31 Mar 16) Staff Group	FTE		
	FTC	Locum	Permanent
Add Prof Scientific and Technic	2.78	0.00	26.09
Additional Clinical Services	9.25	0.00	117.49
Administrative and Clerical	31.70	0.00	229.53
Allied Health Professionals	0.50	0.00	53.96
Estates and Ancillary	3.80	0.00	69.94
Healthcare Scientists	0.45	0.00	6.60
Medical and Dental	39.21	0.00	60.89
Nursing and Midwifery Registered	8.47	0.00	204.39
Students	0.00	0.00	0.83
Grand Total	**94.79**	**0.00**	**769.31**

In addition the Trust also had access to the following bank workers:

Staff Group	Existing staff who also hold registration with the Trust's banks	Bank only workers
Add Prof Scientific and Technic	26	9
Additional Clinical Services	137	114
Administrative and Clerical	173	111
Allied Health Professionals	31	15
Estates and Ancillary	35	42
Medical and Dental	2	29
Nursing and Midwifery Registered	206	56
Grand Total	**610**	**376**

In this table, the 'bank and substantive' column illustrates that many of the Trust's own staff also hold bank registration agreements to enable them to undertake and receive payment for extra shifts, in addition to their own substantive contracts of employment. The 'bank only' column refers to people who are registered for ad hoc work only.

In addition, the Trust employed other agency staff during the course of the year who were not on the payroll. These are covered in the section relating to 'off payroll disclosures' later in the report.

1.3 BREAKDOWN OF STAFF AT YEAR END BY GENDER

In terms of gender composition, the Trust's substantive workforce as at 31 March 2016 stood as follows;

	Male	Female	Total
Directors	7	5	12
Senior Managers	8	16	24
Employees	285	690	975

1.4 SICKNESS ABSENCE

At the end of March 2016 the sickness absence rate for the year was 4.23% (versus 4.52% in March 2015); this is the lowest (most favourable) position the Trust has seen in the last 5 years. This improvement has been the result of greater performance management of sickness absence over the year.

1.5 POLICIES AND ACTIONS APPLIED DURING THE FINANCIAL YEAR

1.5.1 POLICIES APPLIED DURING THE FINANCIAL YEAR FOR GIVING FULL AND FAIR CONSIDERATION TO APPLICATIONS FOR EMPLOYMENT MADE BY DISABLED PERSONS, HAVING REGARD TO THEIR PARTICULAR APTITUDES AND ABILITIES

The Trust has a Recruitment and Selection Policy and an approach which ensures fairness and equity for all people with protected characteristics, including people with a disability. Reasonable adjustments are always made for people with a disability who are shortlisted for interview to enable them to perform their best during the selection process.

1.5.2 POLICIES APPLIED DURING THE FINANCIAL YEAR FOR CONTINUING THE EMPLOYMENT OF, AND FOR ARRANGING APPROPRIATE TRAINING FOR, EMPLOYEES WHO HAVE BECOME DISABLED PERSONS DURING THE PERIOD:

The Sickness Absence Policy, agreed with the Trust's trade unions, is also instrumental in ensuring staff with disabilities, or staff who become disabled during the course of their employment, are fairly treated and supported. Equally, the Capability Policy allows the Trust to retain staff and to enable them to perform their best in work, in line with clear expected standards.

1.5.3 POLICIES APPLIED DURING THE FINANCIAL YEAR FOR THE TRAINING, CAREER DEVELOPMENT AND PROMOTION OF DISABLED EMPLOYEES

The Trust has a range of training and education policies which ensure equality of access to learning opportunities for all staff, irrespective of their background or disability. During the year, the Trust has continued to invest significantly in the development of staff in pay bands 1-4 who had historically received less training and career development when compared to other staff groups.

1.5.4 ACTIONS TAKEN IN THE FINANCIAL YEAR TO PROVIDE EMPLOYEES SYSTEMATICALLY WITH INFORMATION ON MATTERS OF CONCERN TO THEM AS EMPLOYEES

The Trust has an established and effective approach to providing information to staff through a monthly team brief, a Chief Executive's Question Time briefing, internal bi-monthly journal and through the formal consultative forums held with trade union representatives.

1.5.5 ACTIONS TAKEN IN THE FINANCIAL YEAR TO CONSULT EMPLOYEES OR THEIR REPRESENTATIVES ON A REGULAR BASIS SO THAT THE VIEWS OF EMPLOYEES CAN BE TAKEN INTO ACCOUNT IN MAKING DECISIONS WHICH ARE LIKELY TO AFFECT THEIR INTERESTS

During the course of the year, 'New Beginnings' sessions were held with staff to review the first year of the Trust's five year strategy, engage with staff to find out what mattered to them and determine some priorities for the year ahead. More than half of the staff in the Trust attended these sessions, which ran over a three month period from which action has been taken to improve incident reporting and learning from clinical incidents, in order to enable staff to feel more confident that raising concerns will result in change. Existing formal consultative arrangements have also continued

ensuring an open and honest dialogue with trade union colleagues.

1.5.6 ACTIONS TAKEN IN THE FINANCIAL YEAR TO ENCOURAGE THE INVOLVEMENT OF EMPLOYEES IN THE TRUST'S PERFORMANCE

The monthly Team Brief regularly contains detail around the Trust's financial performance and the Chief Executive's Question Time is also a vehicle for check and challenge relating to the direction or performance of the Trust.

In addition, the Trust has implemented a 'Transformation into Action' programme, bringing together clinical and managerial staff from different departments to facilitate change in the patient pathways enabling a higher quality of patient experience and improved planning of the Trust's resources. All staff in the Trust have been informed weekly about the success of this work as measured against the numbers of patients who were cared for during that week.

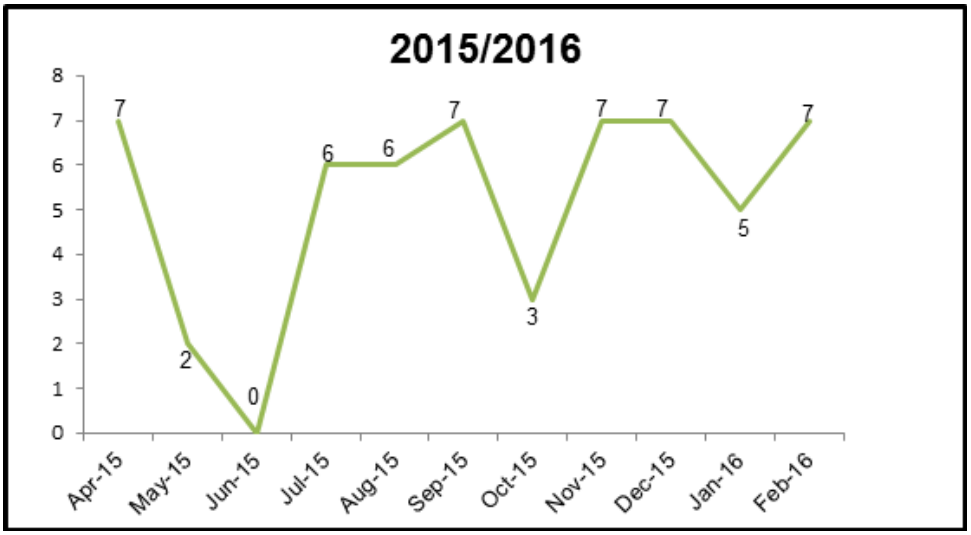
1.6 OCCUPATIONAL HEALTH AND HEALTH AND SAFETY PERFORMANCE

The Trust has continued its Occupational Health Service to staff via the services of the Heart of England NHS Foundation Trust's Occupational Health Department. This has the benefit of offering off site treatment as necessary but also with on-site support, including the provision of influenza vaccinations. Additionally, the Trust has continued with its independent counselling service, which continues to be well received by the staff who use the service.

The table below provides a brief snapshot of the number of accidents per month sustained by staff, visitors and contractors on Trust premises.

Although difficult to quantify, it is felt the reporting culture within the Trust remains largely positive; staff do see the value in reporting incidents. Resulting actions documented by managers further demonstrates a proactive culture, evidences our duty of care and contributes to a robust health and safety culture.

Average number of accidents per month (1 Apr 15- 29 Feb 16) = **5.18**



1.6.1 ACCIDENTS BY CATEGORY (1 SPRIL 2015 - 29 FEBRUARY 2016)

Accident Category	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16
Manual Handling Injuries	2	0	0	1	2	1	0	1	0	1	2
Burns / Scalds	0	0	0	0	1	0	1	1	0	0	0
Contact with hazardous substances (COSHH)	0	0	0	0	0	0	0	0	0	0	0

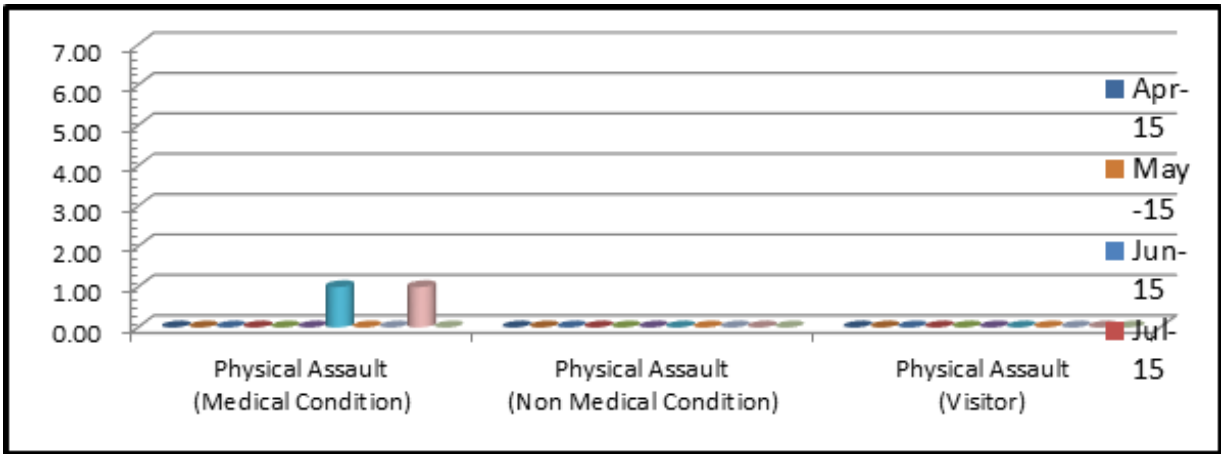
Road traffic accident / incident	0	0	0	0	0	0	0	0	0	0	0
Sharps injuries	1	0	0	1	1	0	0	2	2	1	3
Slips, trips and falls (staff, visitors & contractors)	2	2	0	1	2	3	1	0	3	2	1
Impact Injury (with static or moving object)	2	0	0	3	0	3	1	3	2	1	1
Total figure for each month	**=7**	**=2**	**=0**	**=6**	**=6**	**=7**	**=3**	**=7**	**=7**	**=5**	**=7**

1.6.2 REPORTING OF INJURIES, DISEASES, DANGEROUS OCCURANCES (RIDDOR)

During the year one RIDDOR was submitted to the HSE:

Date of Incident	Summary	Date submitted
8 July 2015	Nurse exiting Nurse's accommodation. Failed to see change of level caused by step. Resulted in a trip and fall. Bruising and swelling to her knee. Over 7 day's ill health sickness absence.	4 Aug 2015

1.6.3 PHYSICAL ASSAULTS SUSTAINED BY STAFF



1.7 INFORMATION ON POLICIES WITH RESPECT TO COUNTERING FRAUD AND CORRUPTION

The Trust has a Counter Fraud Policy which sets the framework for fraud and corruption prevention and action. The Local Counter Fraud Specialist remains active in the Trust in policy development, staff education and provision of re-active support.

1.8 EXPENDITURE ON CONSULTANCY

The Trust spent £158,000 on consultancy costs during 2015/16. This related to a number of small projects including service and serious incident reviews and support on IT development and procurement.

1.9 OFF PAYROLL ENGAGEMENTS

The Trust is required as part of this report to disclose its policy in relation to the engagement of individuals via off-payroll arrangements. At present the Trust does not have a specific policy in relation to the circumstances in which off-payroll engagements would be utilised, however these would always be procured via the Trust's normal procurement procedures with value for money being considered. The Trust does have a policy in relation to the management of these arrangements once in place. The Trust monitors engagements which are more than £220 per day and are expected to last at least six months. Individuals who fall into this category are required to provide assurance to the Trust that the income they receive is properly accounted for in relation to tax. Contracts for these individuals include a clause which states that this information must be provided when requested by the Trust; failure to do so could result in the contract being terminated. Where information is not provided the Trust notifies HMRC. To date no contracts have been ended or notified to HMRC due to the failure to provide the required assurance to the Trust.

Off-payroll engagements as of 31 March 2016, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2016	1
Of which…	
No. that have existed for less than one year at time of reporting	1
No. that have existed for between one and two years at time of reporting	0
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	0
No. that have existed for between four and five years at time of reporting	0

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, assurance has been sought

New off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	0
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	0
No. for whom assurance has been requested	0
Of which…	
No. for whom assurance has been received	0
No. for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received	0

Those individuals where contractual clauses were not included in their contracts were instead requested to complete the off-payroll engagements' assurance statement provided by HMRC in their guidance on IR35 arrangements. The Trust continues to review its procedures with regard to the use of off-payroll contractors to reflect the evolution in guidance as it is received from HMRC.

Off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016

No. of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements.	13

1.10 EXIT PACKAGES

No exit payments have been made during the year.

2.0 STAFF SURVEY RESULTS

2.1 COMMENTARY

The Trust participates in the National Staff Survey (NSS) each year, and in the quarterly Staff Friends and Family test.

To inform our progress of our five year strategy, an analysis of long term trends in the NSS results was undertaken in the spring of 2015, and the results of this were shared with staff through a series of 'New Beginnings' engagement events from April to June 2015. More than 500 staff attended, which is in excess of 50% of our workforce.

From these events, priorities for action were identified – principally around 'raising concerns' - and underlying issues have been identified. These are being addressed, but will take time to resolve, as there are systematic changes to be made.

To ensure that we obtain the most accurate picture of staff views, in 2015 we decided to move from a sample approach to a full census staff survey, and therefore all staff were invited to participate in the NSS.

The results of the 2015 survey show that, whilst some staff report a very positive experience and in particular welcome the positive changes being made to improve patient experience, not all staff have yet seen evidence of improvement and we therefore aim to accelerate our efforts in addressing the underlying causes of lower engagement.

2.2 SUMMARY OF PERFORMANCE

Summary performance - NHS Staff Survey

Details of the key findings from the latest NHS Staff Survey

	2014 Survey		2015 Survey		
	Trust	National average indicator	Trust	National average indicator	Improvement/ deterioration
Response rate (see note 1)	52%	Average	55%	Above average	3%
Number of staff participating (sample 2014, census 2015)	286		505		
Top 4 ranking scores					
KF 11 Percentage of staff appraised in last 12 months	87	84	93	88	+6
KF 15 Percentage of staff satisfied with the opportunities for flexible working patterns	n/a	n/a	56	53	n/a
KF 27 Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	n/a	n/a	41	37	n/a
KF17 Percentage of staff suffering work related stress in last 12 months *(lower is better)*	28	35	29	34	-1
Bottom 4 ranking scores					
KF30 Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.57	3.63	3.61	3.85	0.04
KF31 Staff confidence and security in reporting unsafe clinical practice	62	70	3.57	3.75	not comparable
KF13 Quality of non-mandatory training, learning or development	n/a	n/a	3.95	4.05	n/a
KF 4 Staff motivation at work	3.82	3.90	3.87	3.98	0.05

Notes:

Our comparator group is 'acute specialist Trusts'
'n/a' indicates a new 'key Finding' for the 2015 NSS
'Not comparable' indicate a change in the basis of score in 2015 NSS.
KF 17 – as lower is better, the higher score in 2015 is reported as deterioration

2.3 FUTURE PRIORITIES AND TARGETS

Our key priorities remain the same as last year, as we will continue to focus on the underlying issues relating to 'raising concerns' until they are resolved.

We recognise that we need this vital area of work to be right, and in making it so will regain the confidence of our staff that we are listening to their concerns and taking action.

2.4 PLANS AND MECHANISMS TO MONITOR PERFORMANCE

- We will complete a full review and refresh of our concern reporting system by August 2016.
- A comprehensive communication and training programme will follow, to be completed in October 2016.
- We will adopt the national 'Freedom to Speak Up' policy and appoint a 'Speak up' Guardian by the end of September 2016.
- Improvements will be measured through the next NSS, and through the Staff Friends and Family Test where we will use additional questions related to 'raising concerns' to track our progress.
- Usage of the incident reporting system is tracked monthly, and we expect to see changes to trends once the improvements to the system are completed.
- We will also explore with staff their concerns about the quality of non-mandatory training to identify whether this relates to access to non-mandatory training or the quality of learning available.

SECTION 4:
COUNCIL OF GOVERNORS
1.0
THE WORK OF THE COUNCIL OF GOVERNORS 2015/16

Further information on the way in which the Board of Directors and Council of Governors operate jointly can be found in the Directors' Report.

Structure and Members

The Council of Governors comprises 18 members, of which 9 are elected to represent public constituencies, 4 members are elected as staff representatives, and 5 members are appointed from key local stakeholders and partners.

The Trust's Governors are elected or appointed by our constituency members to represent their interests and help shape the Trust's work. They play a key part in the Trust's governance structure and hold the Board of Directors, via the NEDs, to account. In addition they are directly responsible for appointing the Chairman and NEDs as well as the Trust's external auditors.

In accordance with the Constitution, the Trust's Public and Staff Governors have been elected through a formal election process and Appointed Governors were nominated by their respective organisations. However, for the majority of 2015/16 two stakeholders did not provide a nominated governor.

The role of Governor is important as it is our Governors who provide a direct link between the Trust, local communities and staff. Governors engage with their Members to gather feedback and views to ensure their voice is heard by the Trust. They have the opportunity, as part of the Council of Governors, to work with the Board of Directors to help shape the Trust's plans for the future.

Key aspects of the Governors' role include:

- Engaging with the local community and staff and representing their views;
- Contribution to the development of the Trust's Annual Plan;
- Appointing Non-Executive Directors and Chair of the Trust and setting their terms and conditions;
- Overseeing the work of the Trust;
- Contributing thoughts, views and opinions at Council of Governors meetings;
- Holding the NEDs to account for the performance of the Trust Board;
- Appointing the auditors and the Chairman and NEDs of the Trust.

The Chairman of the Board of Directors is also Chairman of the Council of Governors which ensures that there is continuity of communication between the two bodies. Executive directors and NEDs attend meetings as required and the Council is able ask directly for supplementary information. The Council of Governors meets quarterly in public.

The Council of Governors has elected Alan Last as their Lead Governor but he had no cause to exercise this role during the year in regard to dialogue with Monitor regarding the performance of the NEDs.

1.1 DOING ITS JOB – AS A WHOLE COUNCIL

The Council of Governors is continuing to work closely with the Board to develop the Trust's strategy. Council members are invited to attend two public Board meetings each year.

1.2 GOVERNOR REPRESENTATION ON TRUST COMMITTEES/GROUPS

The Council nominates members to attend Trust advisory groups and committees as observers, so they are able to report back directly to the Council on work being undertaken by the Trust.

Members of the Council currently attend as observers at the following groups:

- Quality & Safety Committee

- Charitable Funds Committee
- Privacy & Dignity Group
- Estates Group
- PLACE assessment Group
- Patient and Carers' Forum

In this way the Council actively engages in the work of the Trust and is directly able to assess the work of the Board and observe the work of the Chairman in a context other than as Chairman of the Council of Governors.

1.3 COUNCIL OF GOVERNORS NOMINATIONS AND REMUNERATION COMMITTEE

The Nominations and Remuneration Committee of the Council of Governors is supported by the Director of Workforce and Organisation Development and the Associate Director of Governance & Company Secretary.

This Committee reviews NED remuneration based on available benchmark data and also supports the Council in relation to the appointment of additional NEDs on behalf of the full Council prior to making recommendations for appointment to the full Council.

1.4 CONTACTING THE GOVERNORS:

The Governors at the ROH can be contacted through the Associate Director of Governance & Company Secretary, the Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Northfield, BImringham, B31 2AP.

2.0 GOVERNOR CONSTITUENCIES

The Trust has several classes of member.

2.1 PUBLIC MEMBERS:

Public members of the Trust come from two identified constituencies across England and Wales.
During 2015/16 the Trust had two public constituencies within its public membership:

- Birmingham & Solihull (5 seats)
- Rest of England & Wales (4 seats)

All election boundaries for public members (including patients) are coterminous with either PCT or local authority boundaries. Public membership eligibility is restricted to those who live within the relevant boundary and are over 16 years of age.

2.2 STAFF MEMBERS:

During 2015/16 the Trust had two constituencies within its staff membership:

- Clinical (2 seats)
- Non-clinical (2 seats)

Staff membership is open to those with a permanent or 12 month fixed term contract with the Trust for employment.

2.3 APPOINTED GOVERNORS:

The Trust has a number of Appointed Governors, who represent local stakeholder organisations and put forward the views of their organisations at the Council of Governors meetings. The following organisations make nominations to the Council of Governors:

- University of Birmingham
- Bournville Village Trust
- Member of Parliament

During 2015-16 there was no nominee on the Council of Governors from Birmingham City Council and the nominee from Birmingham City University stood down and was not replaced.

2.4 GOVERNOR ELECTIONS 2015/16

Elections to the Trust's Council of Governors for vacancies arising in 2015/16 were overseen by UK Engage and the election was conducted using the single transferable vote electoral system.

During 2015/16 one set of elections was called during to fill the following seats:

- Birmingham & Solihull 2 seats
- Rest of England and Wales 1 seat

Governor Election Results - July 2015

Public Elections:
Birmingham & Solihull - Two seats to be elected

Number of eligible voters:		3767
Total number of votes cast:		628
Turnout:		16.67%
Number of votes found to be invalid:		1
Blank or Spoilt form	No	1
No declaration form received	No Declaration	
Total number of valid votes to be counted:		**627**

The following candidates were elected (in order of election):
Marion Betteridge- This is Marion's second term of office which will run until 31 July 2018
Petro Nicolaides- This is Petro's first term of office which will run until 31 July 2018

Public: Rest of England and Wales - One seat to be elected

Number of eligible voters:		1900
Total number of votes cast:		380
Turnout:		20%
Number of votes found to be invalid:		2
Blank or Spoilt form	No	2
No declaration form received		
Total number of valid votes to be counted:		**378**

The following candidate was elected:
Carol Cullimore - This is Carol's first term of office which will run until 31 July 2018.

2.4.1 STAFF ELECTIONS:

In June 2015 an election took place for the two constituencies within its staff membership:

- Staff non-clinical 1 seat
- Staff clinical 1 seat

Both elections were uncontested:

Alexandra Gilder was elected Non Clinical Governor with a term of office until 31 July 2018
Karen Hughes was elected Clinical Staff Governor with a term of office until 31 July 2018.

2.4.2 ELECTIONS DURING 2016/2017

During Quarter 1 of 2016/17 a planned election will be undertaken as terms of office will ending during this time:

- Birmingham and Solihull 1 seat
- Rest of England and Wales 2 seats

2.5 GOVERNOR PROFILES

The profile and details of the term of office for each Governor who served on the Council of Governors from 1 April 2015 until 31 March 2016 are provided below.

Birmingham & Solihull (5 seats)

- **Marion Betteridge** - Marion was re-elected for a second term of office in 2015. Marion has lived in Northfield for the last fifty years and has been a volunteer at the ROH for a number of years doing a range of jobs that assist patients. Marion wanted to give something back which is why she became a Governor. She is proud to help the hospital continue to provide its excellent care and treatment. Marion's term of office will end 31.7.18.

- **Jean Rookes** - Jean is particularly interested in encouraging patient and public involvement, assessing clinical environments and in patient privacy and dignity. Jean is also a volunteer conducting patient surveys. Jean's first term of office ends on 19.4.16.

- **Sue Arnott** - Sue has been a patient at the ROH for 30 years and has received many joint replacements and much physiotherapy at the ROH. Sue has a clear understanding of the need for balancing budgets with improvement to services within the cost constraints imposed on all health related services and is acutely aware of the importance of research to enable patients to benefit from advancements in treatment and care. Sue's first term of office will end on 9.12.2017.

- **Anthony Thomas** - As a past and future patient Tony wants to give something to an excellent organisation. Apart from being a Governor, Tony is a member of the Patient and Carers Forum, is involved in the annual PLACE inspections and is involved with the Falls Working Group to try to avert patients suffering injury whilst in hospital. Tony's first term of office runs until 9.11.17.

- **Dia Martin** - Dia has worked at the ROH for over 25 years and having worked as a night sister in theatres and as an orthopaedic operation practitioner was involved in helping to make major changes at the hospital and understood the complexities of making such changes. Dia's was elected to the Council of Governors for 3 years and her term of office ended in July 2015.

- **Petro Nicolaides** - Petro has been a patient with ongoing treatment since January 2010. He is extremely grateful to the hospital for what it has done and continues to do for him and therefore decided to put himself forward to make a contribution back to the hospital. Petro runs a small Financial and Business Consultancy Practice locally and serves as a School Governor in a local secondary school. Petro was elected to the Council of Governors for 3 years until 31.7.18.

Rest of England and Wales (4 seats)

- **Alan Last** - Alan is our lead governor. Alan worked for 40 years in the NHS of which 28 years were spent working in Birmingham hospitals. He understands the NHS' good points and failings and firmly believes in its core values and feels the people who use its services must be fully represented in decision making at every level. He believes the ROH is a precious and successful resource and represents the views of patients and the public by being available to listen to views and bring them to the attention of senior managers. This is Alan's third term of office which will end 9.11.17.

- **Yvonne Scott** - As a retired nurse, Yvonne is interested in health matters and has been a patient at the ROH for over 30 years and owes her mobility to her surgeon's skill. Yvonne completed her third term of office as a Governor in July 2015.

- **Robert Talboys** - Rob became a patient of the ROH in 1996. Without the care and dedication of all the staff, life would be very different for him today which is why he tries to do his best to repay what has been done and continues to be done for him. Rob's first term of office as a Governor ends on 19.4.16.

- **Stella Noon**- Stella was elected as a governor when the hospital first became a Foundation Trust. She has a long association with the hospital as a student, member of staff and three times as a patient. Stella believes that the success of the ROH is due to the dedication of the staff who are the greatest resource the hospital has and their welfare is paramount. Stella's third term of office as a Governor ends on 19.4.15.

- **Carol Cullimore** - Carol was elected as a Governor in July 2015 and her first term of office will come to an end on 31.7.2018. Carol has recently retired from nursing after 45 years and is new to the role of governor. She has also been a patient of the ROH for over 20 years and hopes she can bring her expertise as a nurse and as a patient together to recognise the challenges faced by the Trust and to give something back to help make a difference.

Clinical Staff Representatives (Two seats)

- **Karen Hughes**- (re-elected for second term) Term will end 31.7.18). Karen has been a registered nurse since 1989 and has a background in surgical nursing. Karen has worked at the ROH a clinical nurse tutor since 2010. She is currently undertaking a Masters Degree in Advanced Healthcare Practice. Karen is passionate about high quality standards of care and the good stewardship of valuable NHS resources.

- **Ronan Treacy** - Ronan is a Consultant Orthopaedic Surgeon and for the past twenty years he has been involved in the renaissance of hip resurfacing and ran the revision hip service for nearly ten years and amassed a wealth of experience. For the past decade, in addition to a busy clinical practice, he has taught, lectured and operated globally. He has the largest international experience of MoM hip resurfacing and continues to publish widely. In 2008, he was recognised by the Lord Mayor of Birmingham for his outstanding contribution to Orthopaedics in the city. In 2010, he was awarded an Honorary Doctorate by the University of Birmingham. In 2013, Ronan was elected as Staff Governor to the Royal Orthopaedic Hospital Foundation Trust for a period of three years and his term of office expires on 17.7.16.

Non-Clinical Staff Representative (Two seats)

- **Susan Lococo**- Sue works as MDT Co-ordinator & National Ewing's MDT Co-ordinator. She believes the ROH is a unique hospital which helps a wide spectrum of patients. She particularly enjoys multi-disciplinary team meetings and making sure patients have a good treatment plan and a positive medical outcome. Sue's first term of office will end on 17.7.16.

- **Alexandra Gilder** - Alex has worked as the Deputy Director of Finance at the Royal Orthopaedic Hospital since January 2014, having previously worked at a large accountancy firm as an NHS audit and advisory specialist. Before pursuing a career in finance, Alex gained her degree in Microbiology and Virology, and worked as a Healthcare Assistant in a residential care home. She is therefore very interested in the improvement of patient care and patient experience whilst also understanding the financial pressures that exist within the NHS. Alex is very proud to work for the ROH and the NHS and wants to help it further improve over her term. Alex was elected for 3 years until 31.7.18

- **Alison Braham** was a non-clinical staff representative on the Council of Governors and left the Trust on 31.5.15

Partner Nominees - 31 March 2015 to April 2016

- **University of Birmingham - Andrew Clark** - Andy Clark is Professor of Inflammation Biology in the Institute of Inflammation and Ageing. He is a molecular biologist with a long-standing interest in how expression of inflammatory mediators is switched off, contributing to the resolution of inflammation. He is also interested in mechanisms of action of endogenous anti-inflammatory lipids, cytokines and steroid hormones. Andy has received major funding from the Wellcome Trust, MRC and Arthritis Research UK. He has published more than 70 articles and book chapters, many of which have been cited several hundred times. Andy recently stepped down from his position as a governor.

- **Bournville Village Trust - Paul Sabapathy CBE** has been a nominated Governor for the past 6 years and is a Trustee of the world famous Bournville Village Trust who own the freehold of ROH as the Cadbury family donated the ROH building and land to the people of Birmingham for health purposes. Paul is former Lord- Lieutenant of the West Midlands and was the first non-white person to hold this prestigious position. As a former Chief Executive and Chairman in the NHS, Paul is passionate about the provision of joined up, patient centred high quality health and social care, by well led, highly skilled and well-motivated staff at ROH. He is a great believer in hospitals focused on specialities like orthopaedics as a patient and Governor at ROH which enables greater specialisation and focus at ROH without the distraction of competing specialities and priorities for the limited available resources. This specialisation

has greater benefit for patients experience and outcome.

- **Member of Parliament - Richard Burden MP** - Richard is the MP for Birmingham Northfield and has represented the area since 1992. Having lived in Birmingham for most of his adult life, he is proud to have represented the city and constituents in Parliament for so many years. It is one of the reasons one of the central themes of his work has always been to argue for the voice of local people to be heard in the corridors of power.

- **Birmingham City University** - the nominee withdrew from the Council early in the year.

- **Birmingham City Council**- no nominee during the year.

2.6 ATTENDANCE BY GOVERNORS AT COUNCIL OF GOVERNOR MEETINGS 2015/16

During the period 1 April 2015 to 31 March 2016 the Council of Governors formally met on five occasions including the Annual Members' Meeting. A summary of its business is outlined below. A record of the number of attendances by each Governor at these meetings is included in the table below:

GOVERNOR	MEETING DATES							TOTAL
	21/5/15	16/7/15 #1	22/9/15 #2	14/10/15	AMM	9/12/15	9/3/16	
Yve Buckland (Ch)	✔	✔	✔	✔	✔	✔	✔	5/5
Alan Last	✔	A	✔	✔	✔	A	✔	4/5
Stella Noon	✔	✔	✔	✔	A	✔	✔	4/5
Robert Talboys	✔	✔	A	A	A	A	✔	2/5
Sue Arnott	✔	✔	✔	✔	✔	✔	✔	5/5
Marion Betteridge	✔	✔	✔	✔	✔	✔	✔	5/5
Jean Rookes	✔	A	✔	✔	A	A	✔	3/5
Anthony Thomas	A	✔	✔	A	A	A	✔	2/5
Susan Lococo	✔		✔	A	A	A	A	1/5
Ronan Treacy	✔		A	✔	✔	✔	✔	5/5
Karen Hughes	✔		✔	✔	✔	✔	✔	5/5
Andy Clark	✔	✔	✔	A	A	✔	A	3/5
Richard Burden	A		✔	A	A	A	A	0/5
Paul Sabapathy	✔		A	A	A	✔	✔	3/5
Yvonne Scott	✔							1/1
Dia Martin #3	✔	✔						1/2
Alison Braham #3	✔							
Marion Thompson #3	✔							
Carol Cullimore #4			✔	✔	✔	✔	✔	4/4
Petro Nicolaides #4			✔	✔	✔	✔	✔	4/4
Alex Gilder #4			✔	✔	✔	✔	✔	4/4

KEY:

✔	Attended
A	Apologies tendered
	Not in post or not required to attend
#1	Informal Governor Briefing

#2	Council of Governors Workshop
#3	Ceased membership of Council of Governors during the year
#4	Elected to Council of Governors in July 2015

In addition to the quarterly Council of Governor meetings two additional Governor sessions were held during 2015/16: An informal Public and Stakeholder Governor session was held on 16 July 2015. The focus of this session was to brief Governors on the forthcoming CQC inspection and review progress that had been made in improving governance at Council meetings, Governor communications and other matters of concern to Council of Governors' members. The session highlighted the role of Governors holding NEDs to account. An outcome of this session was that at future Governor meetings the NEDs would need to provide direct input into the Council on the work of specific committees and explain how they hold the Board to account.
Following on from this session, a Council of Governors' Workshop was held on 22 September 2015 which focused on holding the Non-Executive Directors to Account. The lead governor of Birmingham and Solihull Mental Health NHS Foundation Trust provided an insight into how this had been achieved at their trust.

2.7 QUARTERLY COUNCIL OF GOVERNOR MEETINGS

The main topics covered at Council of Governor meetings during the year were:

- Strategic Context including Vanguard models of care,
- Agency staff
- Activity Update and Cost Improvement Plan Recovery
- CQC
- Finances and Activity
- Patient Shadowing
- Feedback from the Patient and Carers' Forum
- Delivery of the Communications & Engagement Strategy
- Non-Executive and Chair Appraisals
- Non Executive Recruitment
- Quality Account- Governor selected indicator
- Delivery of the Communications & Engagement Strategy

The Chairman of the Clinical Governance Committee (since renamed Quality & Safety Committee) attended the meeting on 14 October to provide an update on the work of that Committee and highlighted how work had been undertaken to strengthen the Committee to ensure it was focused on the right kind of assurances. A revised workplan had been developed which enabled the Committee to hold the Executive to account more appropriately and the Clinical focus was being broadened. The Governors would be offered the opportunity to observe at meetings to ensure the triangulation of matters considered by the Committee and that these were reported both to the Board of Directors and the Council of Governors.

The Chairman of the Audit Committee attended the 9 December meeting to update the Council on work being carried out by the Audit Committee and, in particular, the outcome of the Audit Committee Workshop which had considered how the Audit Committee could better support the Trust Board. He discussed how the Quality & Safety Committee and Audit Committee were working more closely to ensure the Trust Board received improved assurance.
The Vice-Chairman of the Trust, who also chairs the Transformation Committee, attended the 9 March meeting. He provided an update on the financial position and activity in the Trust and highlighted how the Board had introduced a Finance & Performance Committee which was providing additional challenge and information to the Board of Directors. He also provided an update on the work of the Transformation team and explained that a strategy had been developed which would need to be driven through the organisation.

The Chief Executive attended Council of Governors meetings to provide an update and other Executive Directors and senior managers, although not mandatorily required to attend, do join the meetings at the request of the Council of Governors should any items on the agenda merit their contribution.

A record of attendance by Executive Directors at Council of Governor Meetings during 2015/16 is provided in the table below:

NED/DIRECTOR	MEETING DATES				
	21/5/15	14/10/15	AMM 14.10.15	9/12/15	9/3/16
Jo Chambers	✔	✔	✔	✔	
Tauny Southwood	✔				
Kathryn Sallah	✔	✔			
Tim Pile		✔			✔
Rod Anthony				✔	✔
Frances Kirkham					✔
Anne Cholmondeley	✔		✔		
Paul Athey			✔		✔
Phil Begg			✔		
Andy Pearson			✔		
Garry Marsh	✔		✔		

KEY:

✔	Attended

2.8 GOVERNOR TRAINING

During the year, the Trust has undertaken a review of the delivery of Governor training in an attempt to make this meaningful for the Council.

All members of the Council have been offered the opportunity to attend the Governwell Core Skills module, with particular focus on Council Members without an NHS background. Governors have reported that this has been of significant help to aid their understanding of their roles and responsibilities within the FT structure.

In addition, Trust-specific training has been developed in-house and delivered to address identified needs, both individually and collectively. Training sessions delivered during this year include the Risk Assessment Process and how to interpret the level of risk and accountability with an emphasis on how this differs from Being Accountable and Effective Questioning skills.

Governors have provided feedback to the Trust on the sessions and this training has been exceptionally well received. The training on Accountability has also been delivered to another Trust with similar positive feedback.

2.9 THE COUNCIL OF GOVERNORS REGISTER OF INTERESTS

This is available for inspection on application to the Trust's Associate Director of Governance & Company Secretary, The Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Northfield, Birmingham, B31 2AP.
No member declared a material conflict of interest during the year and all interests were registered and available for inspection.
Members of Council receive no remuneration, but are entitled to claim expenses at an agreed rate.

3.0 ENGAGING OUR MEMBERSHIP

The Trust reviewed its management arrangements of the Membership during the year and transferred responsibility to

the Communications Team. This is to ensure more effective communication channels between Governors and Members and to improve the range of Membership Activity on site, in line with the Trust's Strategic Objectives.

Members and Governors were invited to become involved in the work of the Trust in a number of new ways during the year which included:

- Attending workshops on the development of the new Trust Website to provide different perspectives;
- Attending training to become Lay Assessors for the implementation of the Equality Delivery across the Trust;
- Beginning the Process of Governors becoming involved in recruitment panels for key staff within the Trust;
- Information about Governors and the work that they are involved in being included in key communication publications, such as the Trust newsletter and on the website
- The reinstatement of membership newsletters to inform members explicitly of the work of their Governors.

A new Membership Engagement Strategy will be created in 2016/2017 to continue to build on these initiatives.

3.1 ENGAGING OUR MEMBERSHIP AND STRATEGY

The focus of membership activity has continued to be creating regular and one-off opportunities for members to engage directly with the Trust, rather than on growth of numbers.

Members continue to:

- Be involved in the Simulated patient Programme
- Help conduct Patient Surveys and Friends and Family survey
- Become Mystery shoppers
- Assist with outcomes data collection
- Support new projects for improving service quality
- Be involved with the Research and Development Department in delivering trials and collecting information.
- Assist with the production of Patient Information that is written in plain English
- Engage in volunteer opportunities specifically designed to support diversity within membership such as the Young Volunteer Programme for members under the age of 25 and the Access to Nursing Volunteer Scheme for members from diverse social backgrounds.

Any member may contact the Trust's Associate Director of Governance & Company Secretary at the Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Birmingham B31 2AP. 0121 685 4000

3.2 MEMBERSHIP SIZE AND MOVEMENTS

Public constituency	2015 - 16	2016-17 (estimated)
At year start (April 1)	5,721	5,516
New members	7	700
Members leaving	221	200
At year end (March 31)	5,516	6,016
Staff constituency	978	984
At year start (April 1)	181	224**
New members	182	170*
Members leaving	989	1038
At year end (31 March)	978	984

*** Based on projected leavers at 17.32% raw turnover **being replaced in year plus a projected growth as per the Trust's Workforce Plan**

3.3 ANALYSIS OF CURRENT MEMBERSHIP

The Trust plans to develop its membership base in 2016/17 but, as in previous years, does not seek significant growth

and will continue to focus on varied opportunities for engagement with existing members. By the end of the year it aims to increase its membership to 6,000 members.

Public constituency	Number of members	Eligible membership
AGE (YEARS):		
0-16	2	311,202
17-21	55	101,006
22+	5,132	905,638
Not stated	296	327
ETHNICITY:		
White	3,824	805,880
Mixed	114	52,009
Asian or Asian British	411	299,201
Black or Black British	273	99 599
Other	76	11,762
Not Stated/Do not wish to state	858	787
SOCIO-ECONOMIC CATEGORY		
AB	1,362	74,277
C1	1,544	112,334
C2	1,165	65,459
DE	1,375	121,879
Data not available	121	85
GENDER:		
Male	2,102	649,908
Female	3,333	667,937
Unspecified	86	50

SECTION 5:

1.0
CODE OF GOVERNANCE AND FT REPORTING MANUAL DISCLOSURE REQUIREMENTS

1.1 DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS

The Royal Orthopaedic Hospital NHS Foundation Trust 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.

1.2 STATUTORY REQUIREMENTS

The Code of Governance contains a number of statutory requirements, which the Trust is complaint with and do not require disclosure statements in the Annual report.

1.3 PROVISIONS REQUIRING A SUPPORTING EXPLANATION

The Code of Governance contains a number of provisions that require the Trust to give a supporting explanation whether the Trust is compliant or not. The relevant disclosure statements are detailed below.

Code of Governance reference	Summary of requirement	Reference in Annual Report/ Response
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.	Detail included in the Accountability Report (Section 1: Directors Report)
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director) 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.	Detail included in the Accountability Report (Section 1: Directors Report)
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.	Detail included in the Accountability Report (Section 4: Council of Governors Report)

Code of Governance reference	Summary of requirement	Reference in Annual Report/ Response
n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	Detail included in the Accountability Report (Section 4: Council of Governors Report)
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.	Detail included in the Accountability Report (Section 1: Directors Report)
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.	Detail included in the Accountability Report (Section 1: Directors Report)
n/a	The annual report should include a brief description of the length of appointments of the NEDs, and how they may be terminated	Detail included in the Accountability Report (Section 1: Directors Report)
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.	Detail included in the Accountability Report (Section 1: Directors Report)
n/a	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 NED.	Detail included in the Accountability Report (Section 1: Directors Report)
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.	Detail included in the Accountability Report (Section 1: Directors Report)
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.	Detail included in the Accountability Report (Section 4: Council of Governors Report)

Code of Governance reference	Summary of requirement	Reference in Annual Report/ Response
n/a	If, during the financial year, the governors have exercised their power* under pa paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this m must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as aaamended by section 151(8) of the Health & 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	This power was not exercised during 2015/2016
B6.1	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.	Detail included in the Accountability Report (Section 1: Directors Report)
B.6.2	Where there has been external evaluation of the board and/or governance of the trust, 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.	Not applicable
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).	Detail included in the Accountability Report (Section 1: Directors Report and Section 7: Annual Governance Statement)
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.	Detail included in the Accountability Report (Section 7: Annual Governance Statement)
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.	Detail included in the Accountability Report (Section 1: Directors Report and Section 7: Annual Governance Statement)

Code of Governance reference	Summary of requirement	Reference in Annual Report/ Response
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.	Not applicable
C.3.9	A separate section of the annual report should describe the work of the 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.	Detail included in the Accountability Report (Section 1: Directors Report)
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a NED elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	No executive directors were released to serve elsewhere.
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 NEDs, 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.	Detail included in the Accountability Report (Section 1: Directors Report and Section 4: Council of Governors Report)
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.	Detail included in the Accountability Report (Section 4: Council of Governors Report)
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.	Detail included in the Accountability Report (Section 4: Council of Governors Report)

Code of Governance reference	Summary of requirement	Reference in Annual Report/ Response
n/a	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.	Detail included in the Accountability Report (Section 4: Council of Governors Report)
n/a	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.	Alternative disclosure included in the Accountability Report (Section 1: Directors Report)

2.0 COMPLY OR EXPLAIN REQUIREMENTS

The Trust believes that it complies with all of the requirements of the code of governance in the "comply or explain" category except as detailed below:

Code of Governance reference	Summary of requirement	Explanation in where the trust has departed from the Code of Governance, explaining the reasons for the departure and how the alternative arrangements continue to reflect the main principles of the Code of Governance
B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and NEDs.	The Trust Board has a nominations committee for executive directors only. For NED appointments the Council of Governors' Nominations and Remuneration committee plays an equivalent role; this arrangement avoids the need for governors to be members of two committees. Both committees ensure that there is a formal, rigorous and transparent procedure for the appointment of new directors to the board and that Directors of the Trust meet the "fit and proper" test requirements. The Trust Chairman chairs both Council and Board Committees, and ensures that the requirements of a unitary Board are met.

Code of Governance reference	Summary of requirement	Explanation in where the trust has departed from the Code of Governance, explaining the reasons for the departure and how the alternative arrangements continue to reflect the main principles of the Code of Governance
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.	Largely compliant but some work in progress: The Chair includes a reflective element to the discussions at each meeting of the Council of Governors. A number of changes have been made to the conduct of Council meetings as a result and further networking and training opportunities have been identified for Council members. A communications strategy aimed at the public describing how Council members have discharged their responsibilities is being developed.
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.	Largely compliant but some work in progress: The governors have reflected upon which local community forums and stakeholders need to be represented on the Council and Patients and Carers Forum. There has been a review of the overlap between the Council and the Patients and Carers Forum and arrangements have been simplified. The Board will clarify these arrangements on the website once they have been reviewed and assessed for effectiveness.

SECTION 6:

1.0
REGULATORY RATINGS REPORT

In 2015/16, Monitor introduced the Financial Sustainability Risk Rating (FSRR) as a replacement for the Continuity of Services Risk Rating. The FSRR places a greater emphasis on financial performance, and the link between planned and actual in year performance.

The financial challenges faced by the Trust in 2015/16, as evidenced by the year end deficit, are clearly shown in the metrics measured as part of the FSRR, leading to the Trust delivering an FSRR of 2 for the final three quarters of 2015/16. Under the previous Continuity of Services Risk Rating, which placed a greater importance on cash and liquidity, the Trust would have continued to have been rated as a 3.

The Trust's FSRR rating of 2 is in line with plan at a total level, as both Capital Service Cover and Income and Expenditure Margin would have been rated as a 1 even if the Trust had delivered its original planned deficit. Underperformance against this position impacted negatively on the Trusts rating for 'Income &Expenditure margin – Variance from plan' but this did not reduce the overall rating.

Since Quarter 2 of 2015/16, the Trust governance rating has been changed to 'Under Review'. This change is as a result of the Trust's deteriorating financial position, and has resulted in additional monitoring and information requirements being requested from our regulator. No formal action was taken by regulators in 2015/16.

2015/16	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Capital Service Cover	1	1	1	1
Liquidity	4	4	4	4
I&E Margin		1	1	1
I&E Margin – Variance from plan		1	2	1
Continuity of Services Risk Rating	3			
Financial Sustainability Risk Rating		2	2	2
Governance Rating	Green	Under Review	Under Review	Under Review

2014/15	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Capital Service Cover	3	4	4	3
Liquidity	4	4	4	4
Continuity of Services Risk Rating	4	4	4	4
Governance Rating	Green	Green	Green	Green

Mrs Jo Chambers
Chief Executive
27th May 2016

SECTION 7:
STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. 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 Monitor.

Under the NHS Act 2006, Monitor has directed The Royal Orthopaedic Hospital NHS foundation trust 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 Royal Orthopaedic Hospital NHS foundation trust 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 judgements 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 financial statements.
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements 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 NHS foundation trust and to enable him/her 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 NHS foundation trust 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.

Mrs Jo Chambers
Chief Executive
27th May 2016

SECTION 8:
ANNUAL GOVERNANCE STATEMENT

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 ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Royal Orthopaedic Hospital NHS Foundation Trust, 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 Royal Orthopaedic Hospital NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

How leadership is given to the risk management process

The Chief Executive Officer has overall responsibility for having an effective risk management system in place within the Trust and for meeting all statutory requirements.

During the year, there has been a clarification of responsibilities in respect of risk management, with the recruitment of an Associate Director of Governance & Company Secretary, who has taken on operational responsibility for the risk management framework within the Trust. This separates out risk management from the clinical governance area, headed up by the Director of Nursing & Clinical Governance. The Director of Finance retains responsibilities for financial risk, systems and processes.

The Trust considered its Board committee structure in the year, in order to ensure risk is appropriately discussed and managed within the organisation and includes fully all disciplines. As a result of this review, an additional committee was established in year with oversight of finance and operational performance matters.

The Trust Board therefore now has four committees to oversee risk management: the Quality & Safety Committee (formerly Clinical Governance Committee), the Finance & Performance Committee, the Audit Committee and the Transformation Committee. Figure 1 sets out the reporting Board & Committee framework within the Trust.

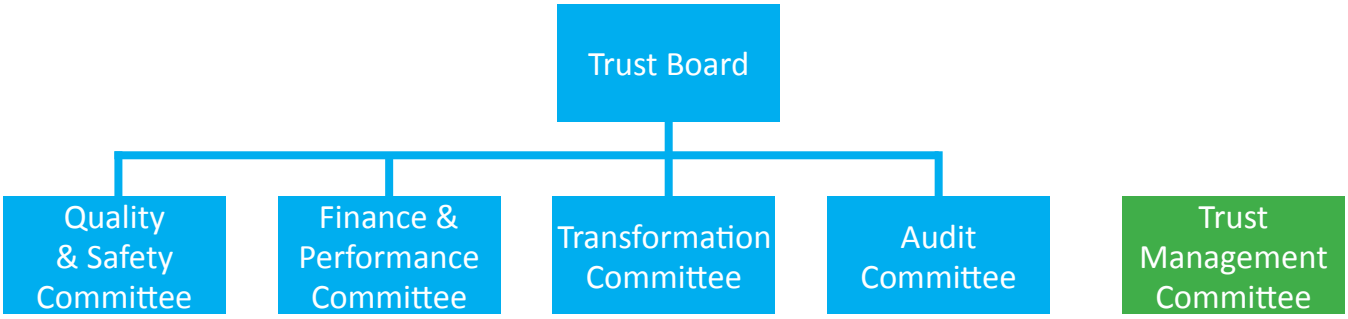


Figure 1: Trust Board & Committee structure

Quality & Safety Committee: The Quality & Safety Committee has designated responsibility for oversight of clinical risk management and is chaired by a NED of the Trust. The Director of Nursing and Clinical Governance is the lead executive for this Committee. The Trust's lead Clinical Commissioning Group has a standing invitation to attend the meetings and a governor observer is usually in attendance. The Quality & Safety Committee meets monthly and regularly reviews clinical risks through consideration of the Corporate Risk Register, which also includes risks of a clinical nature that are of sufficient severity and/or impact as to warrant inclusion on the Board Assurance Framework. The Committee's cycle of routine business also requires a set of subcommittees and groups with a clinical focus to report to the Committee on their work and to highlight any risks within their remit which may not otherwise be included on the formal risk registers. This process includes the evaluation of mitigating actions that have taken place to understand and assess the outcomes of these actions.

Finance & Performance Committee: The Finance & Performance Committee met in shadow form as a Steering Group of Board members, from December 2015 until February 2016 when the Committee was formally established by the Board. The initial focus of the Committee was on activity and financial recovery given a deteriorating position on both, however with a longer term plan to focus more routinely on finance and operational performance supported by development of a revised corporate performance report. The Committee is temporarily chaired by the Trust's Chairman while the focus of the Committee is directed to recovery, with the intention of it being chaired by a Non Executive in the summer of 2016. The current agenda is highly directed to discussing the risks associated with the delivery of the largely operational plan and financial targets. The Chief Executive is the lead executive for the committee, currently, supported by the Directors of Finance and Operations who provide the key agenda content. The Director of Finance will become the lead executive director for this committee once the initial recovery has been stabilised. The Trust has appointed an additional post (Associate Director (Turnaround)) to assist with the recovery workstreams.

Audit Committee: The Audit Committee is chaired by a Non Executive of the Trust, meets at least five times a year. The Director of Finance is the lead executive for the Committee. The Audit Committee ensures the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance. It maintains an oversight of the foundation trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements. It reviews the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

Transformation Committee: The Transformation Committee is chaired by a Non Executive of the Trust and meets around six times a year. The Director of Strategy and Transformation is the lead executive for the Committee. It maintains oversight of the key risks to delivery of the Trust's Transformation Programme. It regularly reviews and tracks the progress of key deliverables within the Trust's Strategic Plan via routine monitoring reports from seven workstreams. The Committee reviews the impact of delays and underperformance in individual initiatives on the wider programme to ensure that risks are mitigated, interdependencies are managed and to help identify solutions where appropriate.

All committees report back to the Board as part of its formal agenda through the use of an assurance report that presents matters agreed at committee meetings that require escalation or are of concern, together with any key action that has been taken.

The Chief Executive chairs a monthly meeting of the Trust Management Committee which comprises the Executive Directors, Divisional General Managers, Associate Medical Directors and other key senior managers, both from clinical and corporate areas. The agenda for the Trust Management Committee covers operational delivery, financial performance, clinical governance and risk management. The body also acts as the advisory group to the CEO on the approval of new and substantially amended policies. The Trust Management Committee provides a forum for the CEO to hold colleagues to account and offers assurances to the Board and its Committees on the day to day management and decision-making

in the organisation when needed, including via a report back to the Board on the matters discussed and key decisions taken by TMC in the CEO's update at the public sessions of the Trust Board meetings.

The Trust has an electronic risk register system that facilitates both local and corporate risk registers and the Board Assurance Framework.

How staff are trained or equipped to manage risk in a way appropriate to their authority and duties

The education and training of all staff on the principles of risk management is an essential element of the Trust's Risk Management Strategy. Risk management update training is provided to new staff as part of the induction programme to the organisation and all existing staff receive annual updates on key elements as per the mandatory training programme identified through the Trust Training Needs Analysis. Following the launch of the new risk management policy in early 2016/17, further refreshed training is planned.

Ways in which the Trust seeks to learn from good practice

The Trust seeks to learn from good practice in governance and the management of risk through a number of means including partnering with other organisations, external reviews by experts and internal activities such as Trust Business and Learning Day learning events for staff.

The risk and control framework

The key elements of the risk management framework

To ensure a consistent and systematic approach to risk, the Trust has used during the year, a systematic approach to risk management. The prioritisation of risks is identified through the use of a risk assessment matrix which enables the Trust to assess the level of risk based upon the measurement of likelihood and consequence of occurrence.

Figure 2: Risk management process

The risk management framework includes:

- Identification of hazards and risks and their communication to all stakeholders
- Risk analysis and control including prevention and reduction of loss
- Developing and maintaining a risk register
- Managing, reporting and recording of near miss and incidents
- Investigation of serious incidents and root cause analysis
- Complaints and claims management
- Education of staff on safety awareness including feedback from incidents, complaints and claims
- Ensuring compliance with law and professional or other relevant standards

Work commenced in the spring of 2016 to refresh the Trust's risk management processes, through the development of a revised risk management policy. The policy aims to provide clearer guidance on how to escalate and de-escalate risks from ward and department level, up through to divisions and should the combination of severity and likelihood be sufficiently high, up to the Corporate Risk Register and Board Assurance Framework. The policy also provides a refreshed format for risk registers and guidance to enable staff to describe risks in a consistent and robust way.

How risk appetites are determined

The Trust recognises that eliminating all risk is not possible and that systems of control must not be so rigid that they stifle innovation, creativity and the imaginative use of resources. In this context the Board of Directors interpret "acceptable" levels of risk as follows:-

An acceptable risk is one which has been accepted after proper evaluation (risk assessment) and is one where effective and appropriate controls have been implemented. The acceptance of a risk should represent an informed decision to accept the likelihood of that risk. It must be:-

- Identified and entered on the Risk Register
- Quantified (impact and likelihood)
- Reviewed and have been deemed acceptable by the relevant committee
- Controlled and kept under review

As a general principle the Trust will seek to eliminate or control risks which have the potential to:

- Harm patients, staff, volunteers, visitors, contractors and other stakeholders
- Harm the reputation of the organisation
- Have severe financial consequences which would prevent the Trust from carrying out its functions

Further work is planned during 2016/17 to review the Board's risk appetite given the significant changing external context in which the Trust is operating at present.

The key elements of the quality governance arrangements, including how the quality of performance information is assessed and how assurance is obtained routinely on compliance with CQC registration requirements

Within the year the Quality & Safety Committee has reviewed the Trust's position against Monitor's Quality Governance Framework (QGF) and used it to guide its priorities. The introduction of the Well Led Framework has since subsumed the QGF and therefore the Trust has plans to undertake its formal assessment against the Well Led Framework through a process which commences in the summer of 2016, preceded by an informal assessment which will direct the Trust's areas of focus in advance.

The Five Year Strategic Plan was underpinned by quality of care considerations, and progress against the Strategic Plan is overseen by the Transformation Committee and the Board itself.

The Board receives assurance on the quality of care through the Board Assurance Framework, performance against a wide range of indicators in the Corporate Performance Report and through assurance provided by the Quality & Safety Committee, which considers in detail a monthly report on Quality & Patient Safety. The Quality & Safety Committee provides upward assurance on the activities undertaken by subgroups covering particular aspects of quality, for example drugs and therapeutics and infection control. Much work has been undertaken during the year to strengthen the quality and content of the upward reports and a prescribed format is now in place for this which subgroup chairs use.

There is a process for the escalation of risk related to quality throughout the Trust; further work is being carried out to strengthen its operation through the relaunch of the risk management policy.

Board members carry out walkabouts in which they gain first-hand experience regarding the quality of care and the views of patients, staff and others. A programme of Quality & Safety walkabouts is in place, led by the Deputy Director of Nursing & Clinical Governance which involves Non Executives and members of the Council of Governors. The CEO holds regular briefings with Heads of Department for dissemination to teams and feedback from the organisation.

Quality information is scrutinised by the Clinical Quality Committee, chaired by the Deputy Director of Nursing & Clinical Governance, before submission to the Quality & Safety Committee and ultimately to the Board. Work is ongoing to develop enhanced approaches to data reporting through the ongoing evolution of the Corporate Performance

Report to enable greater and more informed scrutiny. The governance of clinical outcomes data is being reviewed and a new subgroup of the Quality & Safety Committee has been established with a remit to scrutinise clinical audit and effectiveness, this being complementary to the agenda of the Clinical Quality Committee.

Assurance is obtained routinely on compliance with CQC registration requirements through Directors and Senior Managers of the Trust having specific responsibilities in respect of CQC standards and more generally in maintaining internal control systems to support those standards. A key area of focus during the year has been on improving the systems to support the Trust's compliance with the Fundamental Standard concerning Duty of Candour, with weekly tracking of serious incidents falling under this regulation by the executive and reports on compliance being considered by the Quality & Safety Committee.

The Trust was reinspected by the CQC in July 2015, following the initial inspection in June 2014. In response to the report from the visit released in December 2015, the Trust produced an action plan which addressed the recommendations raised. Delivery of the action plan is monitored by the Trust Management Committee. Progress with the actions at a divisional level is also provided by the routine divisional updates, again considered at each meeting of the Trust Management Committee. Finally, progress with the delivery of key milestones within the action plan is considered by the Quality & Safety Committee and Trust Board as part of their routine cycle of business.

How risks to data security are being managed and controlled

Data Security is monitored via the Information Governance (IG) Group, whose membership includes the Director of Finance in his capacity as Senior Information Risk Owner at Board level. This group maintains a Risk Register and an action list which addresses issues which are reviewed and actioned quarterly. Lessons learned are fed into IG training.

The main control for Information governance is the IG Toolkit and the IG Group monitors compliance with the Toolkit via its quarterly meetings. This year the overall score was 75%- 'Satisfactory', meaning that the Trust has scored at least 2 for every criteria. The Trust will seek to improve its scores in 2016/17 through increased auditing activity and assessment of effectiveness of policies and procedures by gaining feedback from staff and patients. Other specific IG controls include that Trust portable devices i.e. laptops, tablets, data sticks and personal digital assistants (PDAs), have encryption software installed and no personal devices can operate on the Trust network.

Information flows containing personal/sensitive data in and out of the Trust have been identified, reviewed and risk assessed, and transfer methods changed where required.

Information assets (IT systems and papers) have been risk assessed to ensure that data is held securely with appropriate access controls in place.

All staff receive annual IG training via mandatory training supplemented by the e-learning for the IG Training Toolkit to ensure up to date knowledge about the importance of the confidentiality and security of information.

Description of the organisation's major risks, including significant clinical risks, separately identifying in-year and future risks, how they are/will be managed and mitigated and how outcomes are/will be assessed

The following is an extract from the Trust's Board Assurance Framework, which details the strategic risks with the highest pre-mitigation and controlled residual risk scores and therefore represent the area where the Trust Board has been focussing its attention in 2015/16.

RISK	CONSEQUENCE	IN YEAR/FUTURE	HOW THEY ARE/WILL BE MANAGED AND MITIGATED AND HOW OUTCOMES ARE/WILL BE ASSESSED
Inability to manage internal costs, deliver key programmes or respond to tariff deductions	The Trust's status as a Going Concern is called into question	IY/F	Mitigation/Controls: • Formal structure for Transformation Programme is in place • Oversight by Finance & Performance Committee • Check and challenge of financial performance and Cost Improvement at all levels of the Trust Outcome Assessment: • Delivery of the Trust's Cost Improvement Programme • Progress made with the Transformation Programme • Reduction in reliance on temporary staffing
Information and Business Intelligence is insufficient in quantity, usefulness or reliability	Operational decisions and/or management of the business on a day to day basis is ineffective	IY/F	Mitigation/Controls: • Robust manual interrogation of data • Triangulating key clinical indicator performance • Daily huddles to validate previous day's performance • Development of enhanced suite of measures to provide assurance of ongoing performance • Implementation of new IT solutions including systems supporting medicines prescribing & administration, theatre stock control and patient appointment scheduling Outcome Assessment : • Delivery of activity trajectory within operational plan • Financial performance is sound. • Incidents, complaints and litigation levels
Long waiting times for spinal deformity treatment	Deteriorating financial position should fines continue to be applied by commissioners; poor patient experience/ outcomes	IY/F	Mitigation/Controls: • Appointment of additional spinal deformity consultants • Sourcing additional capacity from external sources • Revised commissioning arrangements and penalty regime Outcome Assessment: • Reduction in the waiting list for spinal deformity cases • Suspension of commissioner fines
Inability to control the use of unfunded medical temporary/ agency staffing	Breaches to the agency cap set by NHSI Inability to meet the financial projections within the operating plan by virtue of spend on temporary staffing pay	IY/F	Mitigation/Controls: • Employment of Physician Associates • Continued recruitment activity into key positions Outcome Assessment: • Temporary staffing spend reduces • Reduced number of breaches to the agency cap

The risks last year mainly centred on the inadequate capacity and capability within the organisation to deliver strategic change or to organise its resources appropriately due to this risk. This has been mitigated in year largely as a result of the implementation of the new Divisional management structure in the autumn of 2015, which streamlined the delivery of services. This is set out in more detail in Section 5 of this Statement. An additional risk concerned the possibility that remuneration of the Trust's specialist work by the national tariff was insufficient. In this case, the delay to the publication of the new national tariff has created some stability for the present time.

The principal risks to compliance with the NHS foundation trust condition 4 (FT governance)

In relation to the above risks and actions identified to mitigate those risks these can be summarised as follows:

AREA	PRINCIPAL RISKS	ACTIONS IDENTIFIED TO MITIGATE THESE RISKS
The effectiveness of governance structures	The re-inspection by the CQC in July 2015 identified that the Trust's adherence with the Duty of Candour standard required strengthening	The Trust has implemented a new process and policy for the management of incidents meeting the Duty of Candour regulation threshold. A comprehensive training programme for the management of cases under the Duty of Candour regulation was delivered in year. A review by the Clinical Commissioning Group in March 2016 identified that for all seven cases reviewed, all necessary procedural steps for compliance with the regulation had been met.
The responsibilities of directors and subcommittees; Reporting lines and accountabilities between the board, its subcommittees and the executive team	There was a lack of clarity regarding the relationships between Board Committees and management groups.	The terms of reference for all Board Committees have been reviewed in year and upward reporting for assurance to the Board from the Board committees has been formalised. Membership of the committees has been rationalised. An Audit Committee workshop was held in October 2015 which clarified the responsibilities for the Committee and its interactions with other Board committees.
	The purpose and levels of authority of each of the groups or committees reporting to Quality & Safety Committee were not always clearly specified or well understood and in particular there was a risk that serious concerns might be identified but not escalated appropriately	A template for reporting upwards from the Quality & Safety Committee subgroups has been introduced during the year, which standardised the reporting of key risks, highlights and activities of the groups. The workplan of the Quality & Safety Committee was revised to introduce clarity around which groups are to report and when a Clinical Quality Committee has been established to review the work of a number of clinical subgroups and provides upwards assurance to the Quality & Safety Committee.

AREA	PRINCIPAL RISKS	ACTIONS IDENTIFIED TO MITIGATE THESE RISKS
The submission of timely and accurate information to assess risks to compliance with the trust's licence; and	There was no clear clinical audit process across the Trust and no testing of clinical audit processes by the Audit Committee	A clinical audit programme has been created and is delivered under the remit of the Head of Knowledge Management. In year, a Clinical Audit & Effectiveness Committee has been established with a remit to monitor the delivery of the audit programme. Clinical audit is a key inclusion of the internal audit plan for 2016/17.
	Policies were out of date	In year, a Policy for the Development, Approval and Management of policies has been launched, which simplifies the template for policies and streamlines the processes for policy approval. The Clinical Quality Committee takes responsibility for reviewing clinical policies prior to consideration by the Trust Management Committee, which is now the sole forum for gaining approval of new and substantially revised policies The Quality & Safety Committee receives a quarterly update on policy governance.
	There was no systematic assessment of NICE guidance published for relevance to the Trust	An initial review of a backlog of NICE guidance published has occurred, where relevance to the Trust was assessed and actions to ensure compliance will be worked through following a further review of the guidance by the Clinical Audit & Effectiveness Committee. The Clinical Audit & Effectiveness Committee includes consideration of NICE guidance within its routine matters of business
The degree and rigour of oversight the board has over the Trust's performance	The BAF did not accurately reflect key strategic and corporate risks.	The Board Assurance Framework has been remodelled to provide a clearer view of the Trust's strategic and corporate risks
	There was not adequate detailed Board oversight of financial and operational performance and risks	A Finance & Performance Committee was established in February 2016 to provide oversight of initially financial and activity recovery, with this remit expanding to cover more routine oversight from summer 2016 onwards

How the Trust is able to assure itself of the validity of its Corporate Governance Statement

The role of the Quality & Safety Committee, Finance & Performance Committee, the Audit Committee, and the Transformation Committee in providing assurance regarding Corporate Governance has been described earlier in this Statement. In addition, the Board itself considers the quarterly Corporate Governance Statement during the year and reviews ways in which underpinning assurance required can be strengthened. In October 2015 an Audit Committee workshop was held which considered ways in which assurance could be better provided to the Board, an event which was supported by the Trust's internal auditors. The outputs informed a refresh of the Board Assurance Framework and the revised terms of reference for the Audit Committee.

Prior to the submission of the annual Corporate Governance Statement to Monitor a Board paper is created with input from the whole of the executive team summarising evidence for the validity of each element of the Corporate Governance Statement.

How risk management is embedded in the activity of the Trust

The Trust's risk management processes are embedded within all aspects of service planning, delivery and redesign as a means of prioritising and decision making. These key elements, processes and priorities for the management of risk are required to be applied locally to all wards, areas, departments and operational management/ Service units.

Divisions receive localised risk register reports which are discussed as part of monthly Divisional Governance Board meetings.

The Trust Management Committee, which is attended by Executive Directors, Divisional General Managers and key senior leaders, considers a monthly report authored by the Associate Director of Governance & Company Secretary, which presents the Corporate Risk Register and shows progress with delivery of key mitigating actions to address the organisation's key risks.

The Board Assurance Framework (BAF) provides a framework for reporting key information to the Board. It identifies which of the Trust's objectives are at risk because of inadequacies in the operation of controls and at the same time it provides structured assurances about where risks are being managed effectively and objectives are being delivered. The BAF draws together the key corporate risks from the Corporate Risk Register and strategic risks identified by the Board itself and is considered by the Trust Board and Audit Committee during the year to ensure a bottom up and top down approach to capturing key corporate risks. Each reported risk has a lead executive, summary treatment plan and an indication of further actions planned to reduce the severity and/or likelihood of the risk.

As an example of risk management activity below the level of the BAF and potentially feeding into it, reporting of potential risk situations, adverse incidents, 'near-misses', accidents and concerns is a vital part of managing and controlling risks. The Trust has a unified system for the reporting of both clinical and non-clinical incidents. This is an electronic system called 'Ulysses'. This system enables members of staff to report incidents in a timely fashion and allows managers and other relevant individuals to receive real time notification of incidents. This system also allows managers to complete an electronic management review of incidents. All managers are expected to encourage an incident reporting culture and support their staff in utilising the incident reporting system. Ulysses is currently being upgraded and updated to reflect the new structure of the organisation as well as to develop detailed reports in order to provide Divisions and wards with detailed, appropriate and accurate information. To support the strengthened process of incident reporting, the Serious Incident policy has been refreshed and approved. This will standardise the process and ensure effective and accurate reporting of incidents. Incidents are now being reviewed on a daily basis by the Governance Department to ensure timely escalation of any patient safety queries that may arise as well as to quality check the data inputted.

Information on all incidents requiring an investigation and any clinical negligence claims is shared with key staff.

The executive considers a weekly report on serious incidents, including those that are new and those which have been returned from the Clinical Commissioning Group for the Trust to strengthen the action plan created to prevent a reoccurrence of the incident. The Quality & Safety Committee reviews incidents monthly as part of the routine Quality & Patient Safety report. Through the Clinical Quality Review forum, the clinical performance and risk information is shared with lead commissioners and scrutinised as part of the contract review process.

How public stakeholders are involved in managing risks which impact on them.

The Trust is committed to involving stakeholders as appropriate in all areas of the Trust's risk management activities. This includes informing and consulting on the management of any significant risks. Key stakeholders include the Trust's Council of Governors, NHS Improvement, CQC, NHS England, Commissioners, Subcontractors, Voluntary Groups, Patient Groups, Patient and Carers' Forum, patients and the local community.

Compliance with the registration requirements of the Care Quality Commission.

The Trust has not been placed under any special measures or conditions.

Following the re-inspection of the Trust in July 2015, the CQC inspection report was released in December 2015 and specified the compliance actions the Trust must take relating to regulated activities.

The Trust received a range of actions from the CQC that were described under the headings of; Requirement Notices; Must Do and Should Do.

The Key actions under the heading of Requirement Notices needed within the CQC report by the Trust were around:

Outpatients

- The flow of patients through our outpatient department; and
- Inadequate number of staff had undertaken safeguarding training for adults and children at the correct level.

Critical Care

- Children were being cared for on an adult HDU which did not have the facilities or space required to meet their needs;
- HDU required paediatric registered nurses to care for children for the full length of their stay; and
- The arrangements in place were not adequate regarding the medical cover for the deteriorating child by not having a paediatric doctor on the premises.

Additionally, there were some 14 'Must Do' and 'Should Do' recommendations.

Good progress had been made against the delivery of the actions that were due for completion by February 2016. Whilst there has been slippage in delivery of a Learning Disability Strategy, a recovery plan is in place with there being no anticipated risks to delivery. The recruitment of paediatric nurses remains an ongoing challenge for the Trust and discussion about the provision of alternative models of care continues.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. 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.

Equality and Diversity

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 Adaptation Reporting requirements are complied with.

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

The Trust robustly reviews performance throughout the organisation to ensure that resources are used economically, efficiently and effectively. There is a robust budget setting and financial management control system which includes activity related budgets, monthly budget manager meetings, Divisional performance meetings and regular reports to the Trust Management Committee and the Trust Board. The budgetary control system is complemented by a clear scheme of delegation and financial approval limits. This process enables regular review of financial performance by highlighting areas of concern via variance analysis.

The Trust is structured into four principal operational Divisions, a model which has been introduced and embedded during the year. Additionally, other departments are led by Directors. Figure 3 overleaf presents this structure:

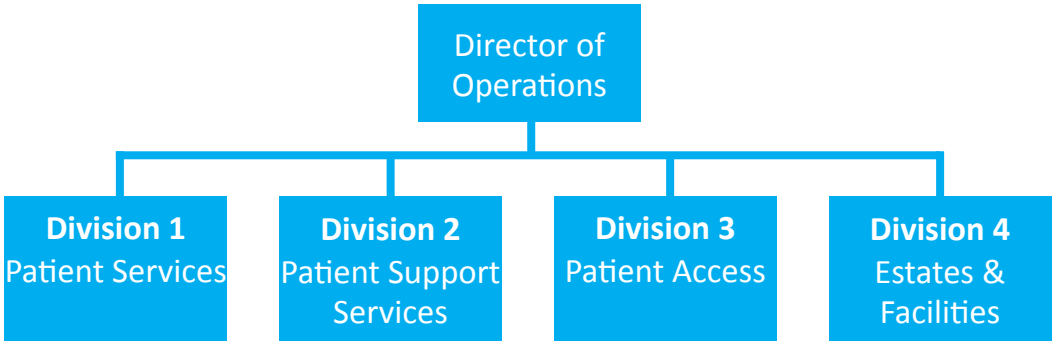


Figure 3: Operational management structure

This structure has streamlined the previous clinical directorate model and created a robust structure of accountability for the key elements of the Trust's business. Each Division meets monthly for a management board, the agenda for which is divided into a section to review performance & operations, with the second part primarily concerned with clinical governance and risk and is supported by members of the Trust's clinical governance team. Each Division is subject to formal quarterly reviews with Executive Directors. These reviews combine outcomes with efficiency, effectiveness, use of resources, quality and governance to ensure a holistic view of performance is taken.

The Trust has developed, within its Corporate Performance Report, a scorecard which monitors both national and local targets together with efficiency indicators which are reported on a monthly basis. There are plans to refine this report further in 2016/17 to provide additional granularity on performance and encompass some of the material being considered in depth by the Finance & Performance Committee.

A component of the Trust's financial planning is the implementation and delivery of a Cost Improvement Programme. Performance against the Trust's Cost Improvement Programme, both in terms of financial delivery and quality impact, is monitored on a monthly basis by the Trust Management Committee and Finance & Performance Committee.

The Trust regularly benchmarks its reference costs with national tariffs to highlight the areas of potential inefficiency and compares its use of resources with other specialist orthopaedic centres. As a member of the National Orthopaedic Alliance vanguard, there is an opportunity to review and benchmark services across a number of partner providers.

The Trust benefits from the data produced by the Patient Level Information and Costing System, which has enabled the Trust to increase the understanding of where efficiencies can be targeted and has focused discussions with the Department of Health around issues with the national Payment by Results tariff system. Information from the Patient Level Information and Costing System is being used to develop Service Line Reporting.

The Board receives regular updates from its Audit Committee on the reviews carried out by both Internal Audit and External Audit. They receive and consider the Internal Auditor's opinion and the Annual Management Letter by the External Auditor which comments on the economy, efficiency and effectiveness of the use of resources. The Audit Committee considers the recommendations from all audits carried out and oversee, by appropriate monitoring of actions taken by responsible officers any required corrective action needed. The Audit Committee receives regular technical updates from the Trust's external auditor, a number of which have related to a changing external context and the drive for greater efficiency and transformational practice. The Director's report provides further information regarding the Committee structure, attendance records and coverage of each of the Committees' work.

The Finance & Performance Committee workplan includes the Trust's response to the review undertaken by Lord Carter of Coles, 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' and the Monitor 'Getting a Grip' guidance which sets out a series of prompts, developed by Monitor from their work with a number of Trusts, to enable Trust management to self-assess against a set of possible actions, which could reduce expenditure, increase income or improve liquidity. A self-assessment has been undertaken which indicates that there is further work the Trust could do around procurement, stock management and e-rostering, the latter two being the subject of business cases being considered by the Board at present.

The Council of Governors review and challenge planned and actual corporate performance throughout the year as part of the regular presentations by the Non Executive Directors and consideration of the complaints and Corporate Performance Report.

In 2015/16, Monitor's measure of financial performance and sustainability changed from the Continuity of Services Rating to the Financial Sustainability Risk Rating (FSRR). The Trust achieved a full year FSRR of 2 for 2015/16. This was reflective of a strong liquidity position, which continues to receive the highest rating under Monitor's risk assessment

framework, and an underperformance with regard to the Trust's overall Income and Expenditure position. The Trust delivered a year end deficit, excluding the impact of capital to revenue transfers, valuation impairments, and charitable funds consolidation of £6.76m. This drove down the ratings received for the other three components of the FSRR; I&E margin, I&E margin vs plan and capital service cover.

The Trust has a formal governance rating of "Under Review" from Monitor as at 31st March 2016. As defined in Monitor's risk assessment framework, this represents "potential material concerns with the Trust's governance", and is the second of three potential ratings that Monitor can issue (the other two being green and red). The rating of "under review" relates to the Trusts financial position, with Monitor's latest governance feedback stating that they are "requesting further information following a financial sustainability risk rating of 2, before deciding next steps". The Operating Plan for 2016/17 presents a further challenge with an ambitious control total of £3.2m having been set.

The management of our highly specialized paediatric spinal deformity patients within national waiting time targets continues to be a major challenge. As at 31 March 2016, 38 patients had been waiting over 52 weeks for treatment; the Trust continues to work with NHE England's specialist commissioning team and other provider partners to find both short-term and strategic solutions to this ongoing issue. Additional capacity has been funded in 2016/17 to support the reduction in waiting times in this service, with further capacity promised form 2017/18. All other Monitor healthcare targets and indicators were achieved in 2015/16, with the exception of an underperformance against the 62 day cancer waiting time target in Quarter 1. This performance (77% against a target of 85%) was impacted by late tertiary referrals and the very low number of patients that are applicable to that target, meaning that even a small number of breaches can have a material impact on the overall performance. The target has been achieved in all other quarters and for the full year as a whole.

Information Governance

During the year the Trust had six serious incidents relating to Information Governance. None of these incidents were reportable to the Information Commissioner. The majority of serious incidents related to information that was disclosed to individuals in error, such as a patient receiving another patient's appointment letter as well as their own or a GP receiving the wrong patient letter. The Trust's Information Governance Manager investigates all serious incidents, and learning from these is shared at the IG Group and with the individual stakeholders involved.

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 Director of Nursing and Governance has executive responsibility for the completion of the Annual Quality Report and Account. This process involves significant input from a range of stakeholders including staff, patients and the Council of Governors. The views of our commissioners and the Birmingham Healthwatch are directly incorporated into the Annual Quality Report and Account and offer a balanced view of the Trust's performance.

Performance against the metrics included within the Annual Quality Report and Account are regularly reported to the Trust Board within the monthly Corporate Performance Reports and through a quarterly update to the Quality & Safety Committee.

Consultation on the quality indicators for 2016/17 took place with the Quality & Safety Committee, The Trust Board and the Council of Governors prior to the completion of the Annual Quality Report and Account.

The Trust has a large number of policies and plans which are in place to ensure the quality of care provided. These include the 'Policy on the Development, Approval and Management of Policies', which ensures consistency of approach when developing, monitoring and auditing policies and which was reviewed and refreshed during the year. Much work has continued during 2015/16 to ensure that the collection of policies having passed their review date were updated, both for clinical and non-clinical policies.

The Trust also has a number of methods of both collecting and reporting quality data. Collection systems are at both a local level and Trust level, and monitoring is performed through a number of key committees within the Trust. Examples include the Quality metrics which are included monthly within the Trust's Corporate Performance Report and the Quality & Patient Safety Report; these reports are received and reviewed by Trust Management Committee, Quality & Safety Committee and the Trust Board, in addition to being shared with the Trust's commissioners. Other examples of outcome specific data that are reviewed and shared include Patient Reported Outcome Measures (PROMs) and NJR (National Joint Registry), which is reported principally to the Quality & Safety Committee, the Clinical Quality Committee and the

Clinical Audit & Effectiveness Committee.

Professional leads provide some of the data for the quality report; these are experts in their fields. This is done in conjunction with the informatics team.

In response to Board and regulator concern over the Trust's performance against the activity trajectory set out in the annual plan and the associated deterioration in the financial position, a number of additional controls and actions were put into place during the second half of the year to provide additional scrutiny over the information being monitored by the Trust in relation to this, which are summarised as follows:

- Introduction of daily huddles – daily review of the theatre lists planned for that day to ensure that operating theatres are used efficiently by filling all sessions available. This sets the forward framework for managing the business on a day to day basis and is not just a transient arrangement while the recovery plan is progressing.
- Transformation into Action – a process supported by the Transformation Team which led a rapid process for handling some of the blockages and opportunities for improving the efficiency of the patient pathway, largely identified through the daily huddles
- Creation of an activity rectification plan – a themed plan which Monitor required to provide assurance that the shortfall position was being addressed.
- A Turnaround Project lead was identified to oversee the work and work with the Operations and Transformation teams to deliver the improvements.
- Creation of improved Board oversight of the position through the establishment of the Finance & Performance Committee

The integrity of waiting time information is undertaken via a monthly validation of patients who are reported to have breached national waiting time standards. Although a formal external review of waiting time information has not been conducted during the year, the Trusts' internal auditors were commissioned to undertake a waiting times management review for the early part of 2016/17, which will encompass a review of Data Quality tools used. The introduction of a new data warehouse which is managed by the Information department has strengthened the reporting of waiting time information.

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 attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other 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, and its committees, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I can place reliance on the Head of Internal Audit Opinion for 2015/16, which states that *'the organisation has an adequate and effective framework for risk management, governance & internal control. However our work has identified further enhancements to the framework of risk management, governance & internal control to ensure it remains adequate and effective'.* The opinion notes in particular four reviews which have provided no assurance (equipment training; local income collection arrangements; patient consent; and NICE guidance & safety alerts) and some small specific internal control compliance weaknesses in some clinical and corporate areas which are being addressed through actions already in progress, the majority of which are described within this Statement.

The effectiveness of our systems has also been considered during 2015/16 through a range of external reviews including a formal CQC visit and visits by our commissioning partners. Our CQC visit provided a range of learning opportunities building on the initial inspection in June 2014, and actions have been taken to address the key findings relating to services provided by our outpatient facility, with further work ongoing to support the improvements required to our High Dependency Unit.

Other steps taken during 2015/16 to maintain and review the Trust's systems of internal control include:

- The Audit Committee receiving regular reports on reviews undertaken by the Internal and External Auditors, and follow up any recommendations to ensure that the management team are implementing the agreed improvements to internal control processes within the agreed timeframe or that there are reasonable explanations for variances.

- The Audit Committee held a workshop at which a range of measures for improving the effectiveness of the Committee, relationships with other Committees and the means by which more robust assurance might be sought and provided to the Board

- An additional Board Committee has been established during the year to provide oversight of operational and financial performance and risks to achievement of the Trust's operating plan

- The action plan arising from the diagnostic work undertaken by the Good Governance Institute continues to be reviewed and shows good progress has been made around enhancing the risk management framework, development of the Board Assurance Framework, strengthening policy governance and making the process by which Serious Incidents are reported and managed more robust

- The terms of reference for all Board Committees have been reviewed and refreshed during the year

- The annual work plan for the Board and its committees have been revised and made more comprehensive

- A series of Quality & Patient Safety walkabouts has been established by the Deputy Director of Nursing & Clinical Governance

- Trust Business and Learning Days continue to share good practice, learn from experience and improving local clinical governance processes, ensuring there is protected time for teams to come together on a regular basis to review the quality of care provided.

- A new operational management structure has been introduced, supported by a strong governance framework to ensure that there are clear lines of accountability and risk management & clinical governance discussions are given significant focus

- A weekly Executive Team business meeting was introduced in year, which escalated formal reporting of activity against plan, serious incidents (in Duty of Candour threshold) and complaints to strengthen operational oversight and enable early intervention in response to negative indicators.

During the year the following areas of weakness in internal control have been highlighted:

- The CQC reinspection in July 2015, made a series of recommendations to address areas where the Trust was not fully compliant with standards to which the Trust should adhere in order to deliver its regulated activities. These requirements are being addressed through the delivery of the Trust's CQC Improvement Plan.

- Some remedial work was identified to address a backlog of NICE guidance that had not been assessed for relevance to the Trust. The guidance has been reviewed initially by the Director of Nursing & Clinical Governance. The guidance is currently being reviewed in further detail by the members of the Clinical Audit & Effectiveness Committee who will ensure that necessary actions to ensure that the Trust is compliant with the guidance are delivered. The review of NICE guidance has been included within the remit of a subgroup reporting up to the Quality & Safety Committee and this is a subject included within the internal audit plan for 2016/17.

- Action needed to be undertaken to rectify a void in the reporting of incidents to the National Reporting and Learning System (NRLS). A backlog upload has been completed and routine reporting will be undertaken as a key responsibility of the governance team.

- A need to strengthen controls around some aspects of operational management and performance reporting was identified during the year. Of particular concern was a discrepancy on stock valuation which was identified as the Trust prepared to submit its end of year draft accounts. An urgent review was commissioned from Internal Audit and much work was undertaken to verify the position, through into the new financial year ahead of the submission of the audited accounts to NHS Improvement at the end of May 2016; this review has led to new controls and policies being developed in addition to existing plans to procure an electronic stock system. To address oversight of the controls around operational performance, a Board-level Finance & Performance Committee was established during the year and a suite of enhanced reporting & arrangements by the executive was put in place, alongside the introduction of a daily operational performance review.

Conclusion

Whilst acknowledging the issues identified, I am assured by the advice I have received about the effective operation of controls across the Trust during the year as confirmed by internal audit, managers, committees of the board, the quality account and external audit opinion, and on balance I am able to take sufficient assurance that overall the Trust has a sound system of internal control.

The Trust is committed over 2016/17 to the continued development of our governance and control system building on the progress and learning undertaken in 2015/16.

Mrs Jo Chambers
Chief Executive
27th May 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

QUALITY ACCOUNT & REPORT 2015/16

CONTENTS

PART ONE

1.1
STATEMENT FROM THE CEO

The Quality Account 2015/16 provides evidence of the Trust's commitment to the delivery of safe and effective services for all our patients and service users. During 2015/16 we have continued to work towards our goal of becoming 'First choice for orthopaedic services' by embedding the principles of good governance and driving forward improvements in all aspects of care.

In July 2015 the Trust underwent a re-inspection of its Critical Care and Out Patient services. I am pleased that the CQC found the services to be good in the category 'caring' and that the improvements in our HDU and outpatients environments made during 2014/15 were noted by the inspectors. However, the Trust retained its overall rating as 'requires improvement' as a result of new concerns and has developed a detailed action plan in order to respond to the recommendations made within the report.

Of particular focus for 2016/17 are:

- The development of our High Dependency Children's services, including the creation of a ' stand- alone' children's section within HDU which will provide much better parent accommodation and afford all children greater privacy
- The recruitment of additional paediatric nurses to our HDU department.
- The implementation of new ways of working in our outpatients clinics in order to reduce waits and improve the patient journey
- Continued work to address the quality of our estate on the 'Woodlands' site including work to redevelop HDU and the theatre areas.
- Increased focus on the patient journey, reducing avoidable delays to surgery and avoidable delay in discharge from hospital.
- Reduction in waiting times in our clinics

We have demonstrated significant progress in delivering our Quality Priorities for 2015/16, which included achieving consistent compliance with WHO Surgical checklist, developing a robust programme of Quality Assurance visits, improving our compliance with NJR standards of consent and reporting and reducing the length of time patients are starved before surgery. Those priorities not achieved in 2015/16 have been taken forward to 2016/17 as part of our continued commitment to excellent patient care.

The Trust continues to work hard to sustain these improvements and we are committed to continue our improvement journey for the coming year. To this end The Trust has identified eight improvement priorities for 2016/17 which are detailed below:

QUALITY PRIORITIES 2016/17

1. Reducing the number of incidences of consent on day
2. Reducing the number of avoidable pressure ulcers
3. Reducing the number of avoidable VTE events
4. Ensuring that learning identified from serious incidents and complaints are embedded in practice
5. Reducing waiting times in clinic
6. Reducing cancellations on the day of surgery (Governors Priority)
7. Delivering the commitments outlined in the first year of the Dementia Strategy
8. Improving patient reported experience of pain

Throughout 2015/16 we have continued to proactively seek the views and opinions from our patients on the quality of care they receive including further developing the Friends and Family Test across our services. The feedback we have received on patient experience is consistently positive which evidences the commitment and clinical expertise of our teams. For 2015/16, 95 % of patients who responded to the question on adult inpatient wards said that they would recommend the hospital to their friends and family.

The Trust has also performed very highly in the national survey of adult inpatients (2014), scoring within the top 20% of Trusts in the survey for areas including being offered a choice of food, not being bothered by noise at night and involvement in discharge planning. The Trust remains committed to continuing to provide an excellent patient experience together with excellent quality and safety of its services.

This will be enhanced by our work as part of the National Orthopaedic Alliance (NOA) which will provide a framework for improving quality in orthopaedic care in England. The NOA will support us to create tools, including a membership model, to enable us to consistently achieve quality and efficiency, and will provide a clear benchmarking system. In addition, the NOA will support us to develop flexible contracting mechanisms to ensure that our local commissioners can adopt the quality assured model of care

2016/17 will be a challenging year for the Trust as we focus on providing the best possible clinical outcomes for our patients whilst managing demand for our services in an increasing financially challenged environment. The Trust will continue to work with other organisations and commissioners to develop new models of care delivery and ensure the provision of high quality care.

The Trust has a number of different processes in place for the collection and interpretation of data and not all of these are subject to external audit and review. With this caveat, I confirm to the best of my knowledge that the information contained in this report is accurate.

Jo Chambers
Chief Executive Officer
The Royal Orthopaedic Hospital

27th May 2016

1.2
ABOUT THE TRUST

The Royal Orthopaedic Hospital NHS Foundation Trust is a single specialty orthopaedic hospital offering both elective and specialist services to the people of the Midlands, North of England and Wales. It has the ambition to be "First Choice for Orthopaedic Care' for these communities by ensuring delivery of world class outcomes and excellent patient experience.

The Trust works closely with local partners including Birmingham Children's Hospital and University Hospitals Birmingham and in doing so ensures that best orthopaedic practice is shared across the local health community. Our patients benefit from a team of highly specialist surgeons, many of whom are nationally and internationally recognised for their expertise. Our links with other local hospitals ensures that we can draw on their expertise if our patients require it.

We are proud of our commitment to teaching, learning and innovation here at ROH and during 2015/16 have developed our local "Knowledge Hub" to drive this important agenda forward. The Knowledge Hub brings together three key components: research and development, education and learning and audit and outcomes in order to enable greater partnership working and drive innovation and quality improvement at every level across the Trust.

The Trust strategic intentions were outlined in the Trust Five Year Strategic Plan (2014-2019) and are detailed below:

1. Delivering exceptional patient experience and world class outcomes.
2. Developing services to meet changing needs, through partnership where appropriate.
3. At the cutting edge of knowledge, education, research and innovation.
4. With safe, efficient processes that are patient centred.
5. Delivered by highly motivated, skilled and inspiring colleagues.

A detailed delivery plan has been developed shown in Table 1 opposite:

TABLE 1: STRATEGIC PLAN

OUR VISION: 'TO BE FIRST CHOICE FOR ORTHOPEADIC CARE'

OUR VALUES: the aim of the Trust's values is to create a culture of excellent patient care by ensuring that we all:

- Respect and listen to everyone
- Have compassion for all
- Work together and deliver excellence
- Have pride in and contribute fully to patient care
- Work together and deliver excellence
- Have pride in and contribute fully to patient care
- Be open, honest and challenged ourselves to deliver the best
- Learn innovate and improve to continually develop orthopaedic care.

STRATEGIC INTENTIONS

- Delivering exceptional patient experiences and world class outcomes.
- Developing services to meet changing needs, through partnership where appropriate.
- At the cutting edge of knowledge, education, research and innovation.
- With safe, efficient processes that are patient centred.
- Delivered by highly motivated, skilled and inspiring colleagues.

STRATEGIC TRANSFORMATIONAL INITIATIVES

TRANSFORMATIONAL PRIORITIES

1. CREATING A CULTURE OF EXCELLENCE, INNOVATIONA AND SERVICE: Agreed clinical culture and associated behaviours; organisational development to support change; clinical leadership development; clinical outcomes strategy; strong partnerships (clinical, local, business and international); innovation pipeline

2. EXCEPTIONAL PATIENT EXPERIENCE, EVERY STEP OF THE WAY: setting standards and expectations; new outcome collection measures; patient access review programme; access to diagnostic service review; patient support and information

TRANSACTIONAL CHANGE PRIORITIES

3. SAFE AND EFFICIENT PROCESSES
- 7 day working
- Productive theatres
- Electronic prescribing
- RTT- 18 weeks
- Standards and protocols i.e.care of the deterioirating patient and emergency admissions.
- Enhanced recovery
- Expert and guidence (to GPs)
- Standardised clinical practice

4. FULLY ENGAGED PATIENTS AND STAFF
- New communications and engagment strategy
- New communications skills website, intranet and use of social media
- Staff, patient and GP engagment
- Branding
- Communications effectiveness measures

5. DEVELOPING CLINICAL SERVICES
- General surgery expansion including revisions
- Paediatric surgery
- Spinal and deformity surgery
- Oncology
- MSK Wellbeing, advice, diagnostics
- Bone Infection Unit and services
- Clinical partnerships and orthopaedic network

6. INFORMATION FOR EXCELLENCE
- Electronic patient record development
- Outcome measurment and comparison
- Clinical decision support
- Audit and monitoring
- IT infrastructure improvment
- Mobile devices
- Patient administration

7. ROH THE KNOWLEDGE LEADER
- Integrated audit, teachinbg research and development evaluation
- Innovation strategy
- Acedemic strategy
- International Partnerships

EXAMPLE STRATEGIC OUTCOMES

- Top decile clinical outcomes
- World class patient experience
- Track record of innovative service delivery
- Consistant application of agreed protocols
- Flow and capasity optimised
- Low waiting times
- Low infection rates
- High staff satisfaction and retention
- Strong and enduring partnerships

Support by **Trust Enabling Strategies**: Quality and Safety, Clinical Outcomes Strategy, Communication and Engagment, Organisational Development, Research, Evaluation and Innovation, Estates, People, IM&T, Finance, Programme and Change Managment, Governance, Business Continuity Planning

Underpinned by **Strong Risk Management.** Key risks (with migration): Changed commisioner intentions (work closly with them); Failure to deliver cost and activity assumptions (excellent planning and execution); Resistance to change and change capability (invest and develop); Major incident (business continuity planning)

Each of the 7 strategic work streams has an executive sponsor (SRO – senior responsible officer) and each project has a nominated project lead who reports by exception on a monthly basis. SROs attend the bi-monthly Transformation Committee which is a formal committee of the board. The Transformation Committee is chaired by the Trust's Deputy Chairman and the membership of the committee includes the Chairman and Chief Executive.

SROs present a work stream update to the committee to highlight progress, risks and planned actions. At each committee, a different project is scrutinised and challenged to ensure the delivery of the project benefits are still on track. If there have been any new strategic initiatives which impact on a project, they are debated and agreed at the committee.

The Trust strategy will be delivered through the hard work and commitment of our colleagues and underpinned by the Trust values which guide us in delivering high standards of patient care and experience and help us understand the importance of developing relationships with and supporting each other.

TABLE 2: TRUST VALUES

Value	We expect to see these behaviours
Respect Respect and listen to everyone	• Courtesy at all times • Listen without interrupting, sensitive to others views, show patience • Acknowledge and empathise with others, irrespective of their needs, views and beliefs • Politeness in person, by email and on telephone • Greet each patient with 'hello my name is..' and where care is to be provided, explain this clearly before commencing delivery of care • Recognise the right of each individual to be treated with dignity at all times • Value the contribution of all colleagues, irrespective of their role • Thank colleagues for their contribution • Maintain strong personal discipline with meetings, respects time as a resource for self and others
Compassion Have compassion for all	• Focus on the needs of others • Demonstrate care and concern for the physical comfort and mental wellbeing of patients and colleagues • Accept that others will have different priorities, needs and values, and seek to understand them • Develop and deliver working practices and plans which are centred on patient needs • Make time for patients and colleagues when they need it • Demonstrate kindness and humanity while respecting rules, guidelines and frameworks • Deliver difficult messages with warmth, concern and empathy
Excellence Work together and deliver excellence	• Establish clear standards, reporting lines, accountability/objectives • Collaborate with colleagues, patients and other care providers to plan and deliver high quality care for patients • Set and maintain consistent high standards for own work, accept responsibility and critically review own performance • Deliver improvement and fulfil promises made to others • Seek to maximise own contribution to the team and build team relationships • Actively seek to understand other areas of work. Seek feedback from other teams, use to resolve problems & improve collaborative working • Actively participate in Trust-wide events to build shared understanding • Undertake effective handover at change of shift / annual leave / other absence to ensure continuity of care/service

Pride Have pride in and contribute fully to patient care	• Show pride in own work and strive to deliver the best within available resources • Utilise all knowledge, skills and experience for the benefit of patients and the Trust • Take responsibility for own work • Overcome obstacles and adopt a 'can do' approach • Set and maintain high standards of personal conduct for self and colleagues • Take responsibility for independent audit or self – audit of work • Celebrate and share successes of Trust, own team and other teams • Acknowledge shortfalls in standards/performance and take steps to correct them
Openness Be open honest and challenge ourselves to deliver the best	• Recognise and acknowledge when things don't go to plan, truthful and transparent with patients and colleagues when explaining what happened. • Support colleagues and promote learning & improvement by seeking and giving balanced, honest and timely feedback • Communicate in a way that is clear and concise • Courageous in challenging unsafe practice and inappropriate behaviour • Raise concerns appropriately when things are not right • Understand and fulfil the 'Duty of Candour'
Innovation Learn innovate and improve to continually develop orthopaedic care	• Embrace new ideas and challenges self and others to adopt new ways of working/ alternative approaches • Network with others within and outside ROH to maintain good practice • Lead on developing and effectively sharing good practice • Seek new and better ways of caring for patients for today and for the future • Demonstrate active ownership of ongoing learning and development for self, both mandatory and optional • Learn from own and others experience • Seek to learn from incidents/shortfalls in standards/performance • Maintain knowledge of NHS structures and strategies outside ROH, ensure innovations fit the wider environment • Prefers 'support and challenge' management style

1.3
ABOUT THE QUALITY ACCOUNT 2015/16

1.3.1. WHAT IS A QUALITY ACCOUNT?

A Quality Account is a report about the quality of services by an NHS provider and each year all NHS providers are required to publish a Quality Account. The report is an important way for local services to publish information on the quality of care it provides and to demonstrate improvements and developments in its services. The report enables local communities and stakeholders to review the progress that the Trust is making in delivering its quality priorities and to hold the provider to account.

ROH is committed to continuously improve the services it provides to patients and their families. Within the Quality account we aim to make the following information available to stakeholders, patients and the public.

- Our quality priorities for the year 2016/17
- Our progress against delivery of the quality priorities we outlined in 2015/16
- How we have performed against national quality indicators for patient safety, patient experience and clinical effectiveness.
- How we have performed against local quality measures as agreed with our commissioners
- How we will ensure that ROH maintains continuous quality improvement

1.3.2 WHO HAS BEEN INVOLVED IN PRODUCING THE QUALITY ACCOUNT?

The Quality Account has been developed by the Trust with input and the help of a range of stakeholders including:

- Consultation with staff through the Trust Intranet site , seeking views on the proposed priorities
- Presentation of the Quality Account and priorities at the Trust Patient and Carers Forum and Trust wide Clinical Quality Group
- Discussion of Quality Account priorities through the local Contract Quality Review Group
- Sharing of Quality Priorities and draft Quality Account with local Healthwatch
- Sharing of Quality Priorities and draft Quality Account with lead commissioner BCC CCG

PART TWO

PRIORITIES FOR IMPROVEMENT 2016/17 AND STATEMENT OF ASSURANCE FROM THE BOARD

2.1 QUALITY PRIORITIES

The quality priorities set by the Trust for 2016/17 focus on some key areas of improvement which have been informed by discussion with staff, patients and the public. During 2015/16 the Trust identified a total of 13 improvement priorities, 9 in the Quality Account published in 2014/15 and a further four which were added through the year in response to quality initiatives identified through the Clinical Quality Group. Table 3 below shows a summary of achievement against those priorities. Greater detail about each of these priorities is provided in Section 3 of this report.

TABLE 3: ACHIEVEMENT OF QUALITY PRIORITIES 2015/16

Achievement of Quality Priorities 2015/16	
Improve medicine safety awareness through incident reporting of harm/potential risk	Staff feeling able to raise concerns
Improve the standard of incident investigation	Ensure actions from Serious Incidents are demonstrated within Clinical Practice
Ensure more than 95% of patients are assessed for risk of Venous Thrombolytic Event	To be compliant with National Joint Registry standards of consent and reporting
To achieve consistent compliance with the WHO checklist	To ensure a robust and regular schedule of Quality Assurance visits
Increase results for staff doing everything they can to control patients pain	To ensure patients get enough help to eat their meals
To reduce the length of time patients are starved before surgery to less than 10 hours	To reduce the length of time patients wait in outpatients clinics to less than 60 minutes
To ensure patients wait no longer than 60mins to transfer from recovery to the ward	

The Trust has made good progress on 10 of the priorities outlined above and considers this sufficient to conclude that the priorities have been achieved. However there has been limited progress on the remaining three and for this reason the Quality and Safety Committee have supported continuing with these three priorities into 2016/17.

Table 4 below summarises the areas of focus for 2016/17 and their alignment to the 3 domains of quality.

TABLE 4: QUALITY PRIORITIES 2016/17

Quality Priorities 2016/17	Clinical effectiveness	Patient safety	Patient experience	2015/16	2016/17
Reduce number of incidences of consent on day	✔	✔	✔		✔
Reduce the number of avoidable pressure ulcers		✔	✔		✔
Reduce the number of avoidable VTE events	✔	✔	✔		✔
Ensure that learning identified from serious incidents and complaints are embedded in practice	✔	✔		✔	✔
Reduction in waiting times in clinic	✔		✔	✔	✔
Reduction in cancellation on day of surgery (Governors Priority)	✔		✔		✔
Deliver the commitments outlined in the first year of the Dementia Strategy		✔	✔		✔
Improve patient reported experience of pain			✔	✔	✔

Priority 1: Reduce the number of incidences of consent on the day to zero by end March 2017

Why?

The consent process has two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage. Good practice guidance recommends that patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process

How we will monitor this?

During 2015/16 we undertook an audit of compliance and found that 60% of our patients were consented on the day of surgery. This finding was shared with the medical body at Clinical Audit meetings by the Medical Director.

As a result the Consent Policy has been rewritten and will be launched in Quarter 2 2016/17 with a workshop planned for a Clinical Audit meeting at this time. Re-audit will take place through Quarter 3 and 4 of 2016/17.

Priority 2: Reduce the number of avoidable Hospital Acquired Pressure Ulcers due to poor documentation or unavailability of equipment to zero (0) by end March 2017.

Why?

Pressure ulcers, which are often preventable, have a significant impact on patients and their families and may lead to long periods of treatment either on the hospital or community. They cause unnecessary pain and distress for the patients involved.

How will we monitor this?

A detailed action plan has been developed in order to respond to this priority which is overseen by the Trust Clinical Quality Group. Measuring will take place through monthly audit in each clinical area and review of Safety Thermometer data. The results will be reported and monitored through the monthly Quality Report received by the Trust Board.

Priority 3: Reduce the number of avoidable VTE events due to documentation errors and non- compliance with ROH policy to zero (0) by end March 2017.

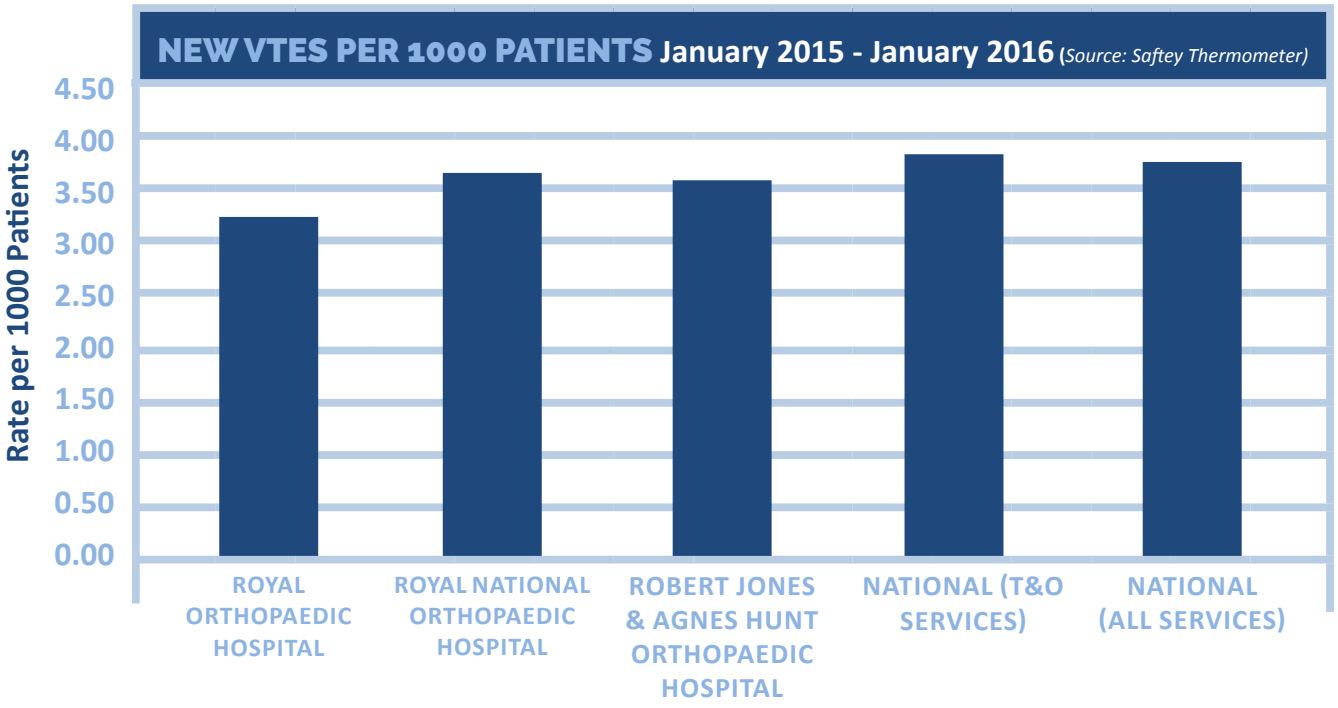
Why?

An estimated 25,000 people in the UK die every year from preventable hospital acquired VTE. Non-fatal VTE is important because it can cause significant longer-term complications to patients, such as post-thrombotic syndrome and chronic thromboembolic pulmonary hypertension which may impact on quality of life.

How will we monitor this?

Safety Thermometer provides benchmarking data against peer organisations (Table 5 below) and the VTE Advisory Group facilitated a themed review of all VTEs which occurred during 2015/16 in partnership with the local CCG.

TABLE 5: VTE SAFETY THERMOMETER DATA



It is a commissioner requirement that a Root Cause Analysis (RCA's) is undertaken on all positive VTEs. RCAs completed to date identify that the vast majority of VTEs are deemed avoidable due to non-compliance with expected documentation requirements. As a result a number of key actions will be put into place through 2016/17 including:

- The local physiotherapy electronic records (TIARA) will be further developed to support the recording of compliance with VTE best practice.
- Review of the VTE care planning documentation is underway and will include more comprehensive use of when support devices are used and when anti embolic stockings are removed/reapplied together with the rationale for the decision.
- Process for undertaking the 24hour risk assessment will be reviewed, in order to identify and implement ways of increasing compliance.

All actions will be monitored to completion by the VTE Advisory Group, which reports directly to the Clinical Quality Group.

Priority 4: Ensure that learning from Serious Incident Reports is embedded into practice.

Why?

ROH is committed to becoming the safest provider of Orthopaedic services in the UK. In order to do this effectively it is imperative that we learn from incidents where harm has occurred to patients. This learning is essential if we are to improve our care processes and the safety of the care we give to patients.

How will we monitor this?

We will benchmark the number of serious incidents in comparable peer Trusts and aim to reduce the number of Serious incidences that occur at ROH to below this number by March 2017.

We will develop an ' action tracker' against every recommendation made following a Serious incident report and ensure that this is shared widely across the Trust through both corporate and Divisional Structures

Priority 5: Reduction in waiting times in clinic. No patient will wait more than 30 minutes for their appointment by end March 2017

Why?

Patients tell us via the local Friends and Family test that they are sometimes frustrated by the length of time they have to wait when attending for clinic appointments and diagnostic tests.

How will we monitor this?

We will implement a Standard Operating Procedure (SOP) for clinic waits across all clinics and services within Out Patients Department (OPD).

We will ensure that the newly implemented electronic monitoring system, 'In Touch', enables production of weekly 'waiting times reports'

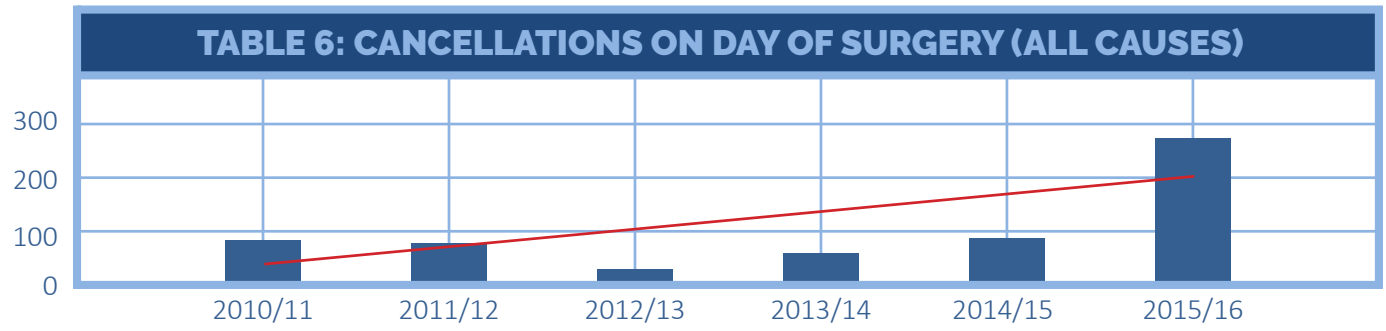
The Division 1 Governance Board will take responsibility for monitoring waiting times and for developing action plans to respond to 'off track' reports. A monthly upward progress report will be provided to the Clinical Quality Group (CQG

Priority 6: Reduce the number of hospital cancellations on day of surgery for non- clinical reasons to zero (0) by end March 2017

Why?

The number of on the day cancellation at ROH has risen substantially through 2015/16 (Table 6). Cancellation on the day of surgery is both distressing for patients and their families and wasteful of NHS resources. Better planning and organisation of theatre lists and capacity will reduce the number of on the day cancellations for non-clinical reasons through 2016/17.

TABLE 6: CANCELLATIONS ON DAY OF SURGERY (ALL CAUSES)



How will we monitor this?

This is already an NHS wide quality standard and is reported internally and externally on a monthly basis. The national requirement is to treat those patients canceled on the day of surgery within 28 days. We will provide the current and future performance of this standard at the Finance and Performance Committee to monitor its improvement.

Priority 7: Deliver the commitments outlined in the first year of the Dementia Strategy.

Why?

The Trust's Dementia Strategy was launched in 2015/16in order to improve dementia care and patient experience at ROH. Launched in response to the Prime Minister's challenge and the Dementia Action Alliance (DAA) Call to Action,

it has been developed in consultation with local stakeholders and patient feedback and is based on best practice advocated by the National Institute for Clinical Excellence (NICE), the Royal College of Psychiatrists (RCP) and the DAA.

How will we monitor this?

The newly formed Dementia Steering Group have developed a work/action plan with clearly defined milestones to deliver the Strategy. The Dementia Steering group reports into and is monitored via the Clinical Quality Group via a bi-monthly report. During 2016/17, we will deliver the first year commitments as detailed below:

Develop a Skilled and Effective Workforce:

- 100% of all staff and volunteers will have received level one face to face dementia awareness training.
- We will identify a dedicated skilled dementia champion in each adult department and service.

Dementia Friendly Environment:

- We will use the EHE (Kings Fund Enhancing the Healing Environment) tool within our wards and departments to have a clear assessment to support delivery of the strategy.
- Promote familiarity with personal and self-care items, photographs and memory boxes.
- Ensure all developments, refurbishments and redecorations of clinical areas are scrutinised and 'signed off' as appropriate for people with dementia.

Dementia Pathway, Delivering Individualised Care:

- We will champion and relaunch 'This is me'
- Implement the dementia care bundle.
- The responsibility for diagnosis and screening for dementia becomes part of everybody's business and rests with all members of the multi-disciplinary team providing care.
- Ensure the assessment of cognition is culturally relevant for all patients, using the best available tools.

Engagement:

- Carer presence and input into the Dementia Steering group.
- All wards that care for patients with dementia will have the option of open visiting for these patients.
- Formal discharge planning to involve carers and relatives at the point of admission/Pre-operative Assessment.

Priority 8: Improve patient reported experience of pain management post-surgery.

Why?

The experience of some pain is an inevitable consequence of surgery. However there are many effective medications and regimes that help keep pain under control. In order to achieve our ambition to become ' First Choice for Orthopaedic Care", it is essential that patients pain is well controlled and that patient's believe that every effort will be made to keep them pain free.

Review of the findings in our most recent National In patient survey suggests that 14 % of our patients report inadequate pain control post-surgery and this figure has showed no improvement for the past three years.

How will we monitor this?

The Trust has agreed a local CQUINN with Birmingham Cross City Clinical Commissioning Group to improve the management of pain in patients post-surgery during 2016/17.

We will undertake a monthly survey of patient perception of pain control on every in- patient and day case areas using the questions from the National In patient survey and present the findings from this as part of the monthly Divisional Governance reports.

In addition we will review the use of a pain assessment tool across the Trust to enable patients to self-report their pain. We will report progress against the introduction of a tool through the Clinical Quality Group.

STATEMENT OF ASSURANCE FROM THE TRUST BOARD

2.2.1 PROVISION OF SERVICES BY THE TRUST

During 2015/16, the ROH provided 14 NHS services. ROH has reviewed all the data available to them on the quality of the services provided. The 14 services provided by the Trust are listed below.

- Anaesthesia
- Bone infection Unit
- Functional Restoration
- Imaging
- Large Joints
- Small Joints
- Spinal surgery
- Paediatric Orthopaedics
- Pain Management
- Orthopaedic cancer
- Orthotics
- Podiatry
- ROCs
- Therapy Services

2.2.2 PERCENTAGE OF INCOME GENERATED BY TRUST SERVICES

The income generated by the relevant Health services reviewed in 2015/16 represents 98.82% of the total income generated from the provision of relevant services by The Royal Orthopaedic NHS Foundation Trust for the reporting period 2015/16.

2.2.3 PARTICIPATION IN CLINICAL AUDIT

From April 2015 – March 2016, six national clinical audits including one national confidential enquiry covered relevant health services that The Royal Orthopaedic Hospital provides.

During that period The Royal Orthopaedic Hospital NHS Foundation Trust participated in all six national clinical audits (100%) and one national confidential enquiry (100%) of the national clinical audits and confidential enquiries of which it was eligible to participate in. Listed below these are:

1. Elective Surgery (National PROMs Programme Elective Surgery (National PROMs Programme)
2. Emergency use of oxygen
3. Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
4. National Cardiac Arrest Audit (NCAA)
5. National Comparative Audit of Blood Transfusion Programme
6. National Joint Registry (NJR)

The national clinical audits and national confidential enquiries that The Royal Orthopaedic Hospital NHS Foundation Trust participated in, and for which data collection was completed during April 2015 – March 2016, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

TABLE 7: PARTICIPATION IN CLINICAL AUDIT

Audit	Participation	% Cases submitted
PROMS	Yes	91.3% (2015/16)
Emergency use of oxygen	Yes	Closed
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Sepsis published Nov 2015 by NCEPOD. Report available at www.ncepod.org.uk/2015sepsis_org.html
National Cardiac Arrest Audit (NCAA)	Yes	All required cases submitted (100%)
National Comparative Audit of Blood Transfusion Programme	Yes	Minimum number of cases required were submitted- full data completeness (100%)
National Joint Registry (NJR)		86% (estimated fig Apr 2015- Mar 2016)

The reports of six national clinical audits that were reviewed by the provider in April 2015-March 2016 and The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The level of compliance with the NJR and PROMS continues to attain high levels throughout the year. NJR data is being reported monthly to the Trust's Clinical Audit and Effectiveness Committee.
- PROMS data has been reviewed at Clinical Audit and Effectiveness Committee and has provided assurances regarding the quality of outcomes in hip and knee replacement.
- PROMS reports have shown that for 2015/16 the Trust is above the national average in all hip primary and revision arthroplasty. With reference to knees, the figures show that during the period, although the Trust has improved its position for primary knee arthroplasty we do continue to be slightly below the national average for EQ5D.
- The NJR process has undergone a full review and there have been many changes to the way consent is collected and compliance is monitored, which will help increase the compliance figures.
- The Trust has improved the processes around collecting national audit data by using innovative IT solutions to increase efficiency.

In addition to the national audits, 15 local clinical audits were completed during April 2015- March 2016 and The Royal Orthopaedic Hospital Foundation Trust intends to take the following actions to improve the quality of healthcare provided as detailed in Table 8 opposite:

TABLE 8: LOCAL AUDIT OUTCOMES

Audit	Committee Reviewed/ Monitored	Description of Actions Taken
SSI surveillance	Quality & Safety Committee	In 2015, a total of 25 Surgical Site Infections for Primary Hip and Knee replacements were reported. 2015 has seen the lowest rates of infections in Primary Hip and Knee Replacements at 30 days since surveillance began in 2009. There has been a significant reduction in SSI's for Primary Hip Replacements where rates have fallen from 2.7% (CI: 1.9 to 3.9) in 2009 to 0.9% (CI: 0.5 – 1.7) in 2015, which equates to a reduction of 65.5% over a seven year period. In Primary Knee Replacements rates have fallen from 7.4% (CI: 5.8 – 9.4) in 2009 to 1.7% (CI: 1.0 – 2.8) in 2015, which equates to a reduction of 75.8% over a seven year period. However, overall there are still a higher number of SSIs for Primary Knee Replacements when compared to Primary Hip Replacements.
Safety Thermometer	Quality & Safety Committee	Our compliance has been above 95% for the whole year [2015/16]. The Trust also achieved 100% for March16. We have managed to avoid New UTI & catheter harms for the full year and old UTI and catheters since July15. Our lowest compliance of the year was in june15which was largely due to old pressure ulcers thus out of our control." The Trust has launched a new SOP for Safety Thermometer in February this year. The SOP makes data collection processes more robust as recommended by the HSCIC, carry out a 'snap shot' view at 2pm on audit day to avoid duplication and use national collection tools with descriptors on to facilitate completion. The Trust has also launched the CYPST (children and young person's safety thermometer) which again is a national tool and will be used on ward 11 and children in HDU to better capture the findings for this patient group.

<table>
<tr><th>Audit</th><th>Committee Reviewed/ Monitored</th><th>Description of Actions Taken</th></tr>
<tr><td>Infection Control indicators</td><td>Quality & Safety Committee</td><td>Mandatory Surveillance of Healthcare Associated Infections (HCAI)

The Infection Prevention and Control Team (IPCT) at the ROHFT are required to report on a number of different Healthcare Associated Infections (HCAI) through a number of mandatory surveillance schemes which includes monitoring of Methicillin-Resistant Staphylococcus Aureus (MRSA) and Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemias as well as Clostridium Difficile, E.coli and Glycopeptide-Resistant Enterococcus (GRE).

MRSA: There have been no MRSA bacteraemias at ROHFT since May 2008. This is against a national picture of a continual year on year reduction of MRSA bacteraemia cases across England. In 2014-15, there were just 320 cases of MRSA bacteraemia reported in England.

MSSA: There was 1 pre 48 hour MSSA bacteraemia reported in May 2015. This was investigated and avoidability was difficult to determine due to some gaps in documentation at a ward level.

E.coli: There were 3 E.coli bacteraemias reported at ROH this year, 2 cases (May and October) were deemed avoidable due to gaps in documentation at a ward level and a further unavoidable case occurred in March 2016.

GRE: There were no cases of GRE reported at ROH this year.

In 2015-16, all targets were achieved for mandatory surveillance once avoidability had been agreed by the lead commissioners for the Trust (Birmingham Cross City Clinical Commissioning Group).</td></tr>
<tr><td>Falls risk assessment Quality Indicators</td><td>Clinical Quality Group</td><td>Quarterly falls documentation results 2015-16

Our monthly audits of practice in falls risk assessment and subsequent care planning have demonstarted that we have achieved (other the four quarters) the expectation of 91% compliance.

<table><tr><th></th><th>Qu 1</th><th>Qu 2</th><th>Qu 3</th><th>Qu 4</th><th>Overall performance over 12 months</th></tr><tr><td>Q1: Has the falls assessment been completed within 6 hours of admission?</td><td>97%</td><td>96%</td><td>98%</td><td>98%</td><td>97.3%</td></tr><tr><td>Q2: If the patient is identified as high risk, is there a care plan in place?</td><td>93%</td><td>93%</td><td>97%</td><td>93%</td><td>94%</td></tr></table></td></tr>
</table>

Audit	Committee Reviewed/ Monitored	Description of Actions Taken
Notes Audit	Health Records Group	Two clinical notes audits were carried out during 2015/16 in July 2015 and January 2016. The aim is to improve the quality and consistency of record keeping in accordance with Trust document core standards which are based on the Royal Medical College standards (2013). Findings are presented to Clinical Audit Committee. The notes were generally in good order and in sequence. Abbreviation list has been updated to avoid use of non-standard abbreviations. Further guidance issued to staff on signing and dating changes and using 24 hour clock.
From patches to patchwork embedding an Advanced Nurse Practitioner service in a specialist orthopaedic hospital	Nursing Strategy Group	The audit results were presented at RCN Orthopaedic Conference in September 2015 by two of our senior nurses The ROH strategic goals were fundamental to crafting "patchwork" & embedding the service into the clinical aspect of the organisation. Learning: The Trust has applied the principles outlined in this paper to local practice & share the tools/ techniques for crafting a successful "patchwork".
Back pain clinic patient satisfaction questionnaire	Clinical quality Group	The questionnaire was developed using the NHS Patient Experience Framework Principles of Patient-Centred Care. Actions following the audit:- 1. Reviewed patient letters regarding information about likely waiting times and the clinician that the patient will be seeing. 2. Developed a leaflet to be included with appointment letter for ESP clinics explaining the role of the extended scope physiotherapist. 3. Feed back to staff and management.
Early onset scoliosis questionnaire (EOSQ)	Division 1 Governance Board	This audit which validated the EOSQ has become an accepted patient outcome score for EOS in the ROH.
Handwritten operative notes audit	Health Records Group	ACTIONS FOLLOWING AUDIT: Appropriate Printed/Electronic proforma might be better for capturing important data. Printed proforma would be clearer than hand written one Re-audit our operative notes after applying the new proforma.

Audit	Committee Reviewed/ Monitored	Description of Actions Taken
Paediatric Spine Infections- an audit cycle	Infection Control Committee	The paediatric audit found the use of topical vancomycin reduces deep wound infection. Findings, why is "all causes" important? Procedures, Patient co-morbidites, practice review vs expert consensus, practice review + changes made, re-audit & conclusions were discussed as part of the presentation. To be re-audited in 6 months. (June 2016)
Mechanical thromboprophylaxis in adult patients undergoing spinal surgery	VTE Steering Group	Action plan Positive feedback to all involved parties Spinal MDT meeting for surgeons Theatre teams, Ward MDT meeting. Reminder to junior doctors re need to complete VTE form at the time of admission
Gap Analysis for VTE prevention	VTE Steering Group	Recommendations following audit: Apply ERP, with shorter starvation times to encourage early mobilisation VTE committee to clarify appropriate duration of TEDs Improve assessment of patients at admission & 24 hours for VTE risk. All TKR and THRs should be consented for the risk of a VTE including the risk of death
Audit of Anaesthetic Record keeping	Theatre Operational Group	Findings: Compliance was good – almost 100%. There were no clinical incidents in this sample. Critical incidents – no tick box for this – hence no records. Discussion: Presence of tick boxes in the anaesthetic charts – will be useful. Absence of tick box for critical incident needs to be addressed.

2.2.4 PARTICIPATION IN CLINICAL RESEARCH

The Trust has a long history of conducting very important and influential research, which has helped the way orthopaedic injuries and conditions are treated today. Research is recognised as a key priority for the Trust and we aspire to become a leader in this field.

The number of patients receiving relevant health services provided or sub-contracted by The Royal Orthopaedic Hospital NHS Trust in April 2015- March 2016 that were recruited during that period to participate in research approved by a research ethics committee was 593.

The Royal Orthopaedic Hospital NHS Foundation Trust was involved in setting up and conducting 101 clinical research studies in orthopaedics during 2015/16. The improvement in patient health outcomes in The Royal Orthopaedic Hospital NHS Foundation Trust demonstrates that a commitment to clinical research leads to better treatments for patients.

There was 59 clinical staff participating in research approved by a Research Ethics Committee at The Royal Orthopaedic Hospital NHS Foundation Trust during 2014/15. These staff participated in research covering seven sub-specialties.

"This year has seen a slight reduction in the number of patients entering into clinical research. However, we have been successful in acquiring new research funding including a prestigious grant from the European Union to commence new research studies in the coming year. We have also seen an increase in the number of clinicians undertaking research. This will enable more of our patients to benefit from being involved in cutting edge orthopaedic research."

Professor Edward Davis, Director of Research and Development.

2.2.5 USE OF THE CQUIN PAYMENT FRAMEWORK

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to NHS Trusts based on delivery of improvement work. A proportion of The Royal Orthopaedic Hospital NHS Foundation Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between The Royal Orthopaedic Hospital NHS Foundation Trust 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. For 2015/16 this figure was £1.566 million. Table 9 below shows the Trusts CQUIN schemes for this period, together with the financial value attached to them.

TABLE 9 : CQUIN SCHEMES 2015/16

CQUIN	Value (£000)	Objectives	Met/not met
Patient Shadowing Project	470	Improving services using patients experience as a driver for change	Achieved
Improving the Care and Management of the Deteriorating patient	399	To reduce incidents of avoidable harm to patients by improved early detection and escalation of deteriorating patient conditions	Achieved
Improving Discharge processes	404	Ensure that potential barriers to facilitating early or planned discharges are reduced and that patient understanding and participation in the processes are maximised	Achieved
Highly Specialised PMBTS workshop	42	Annual multicentre presentation of outcomes/ audit	Achieved
Non-Invasive Spinal Rods	251	100% use of non-invasive lengthening spinal rods	Achieved
TOTAL	1566		

During 2014/15 the total amount of income conditional upon achieving CQUIN goals was 1.561 million. The payment made was 1.536 million which represents 98.4% of the total value of the 2014/15 CQUIN scheme.

Further details of the agreed goals for 2016/17 are available on request from the ROH Head of Clinical Commissioning, Gareth Hyland (garethhyland@nhs.net).

2.2.6 USE OF THE CQUIN PAYMENT FRAMEWORK

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for Quality and Innovation payment Framework. For 2015/16 this figure was £1.566 million .Table 8 below shows the Trusts CQUIN schemes for this period , together with the financial value attached to them.

2.2.7 CARE QUALITY COMMISSION (CQC) REGISTRATION AND COMPLIANCE

The CQC monitors, inspects and regulates services to make sure that they meet fundamental standards of quality and safety. They ask five key questions of all service providers which are:

- Are they safe?
- Are they effective?
- Are they responsive?
- Are they well–led?
- Are they caring?

All NHS hospitals are required to register with the CQC in order to provide services and are required to show that they are compliant with CQC standards in order to maintain their registration. The Royal Orthopaedic Hospital is required to register with the CQC and its current registration status is 'without conditions'. The ROH has not participated in any special reviews or investigations by the CQC during this period nor has there been any enforcement action against ROH by the CQC during this reporting period.

ROH was first inspected, under the new regulations, by the CQC in June 2014 and received a rating of ' Requires Improvement' In July 2015 a focused follow-up inspection was completed. At that inspection the core services of Critical Care (HDU) and Outpatients Department (OPD) were reviewed. Both had an inadequate rating in one domain following the inspection completed in 2014.. This was within Safe for HDU and Responsive for OPD. The CQC revised the inadequate rating for OPD during their inspection in July 2015 to requires improvement but maintained the inadequate rating for safety in HDU. Both services were rated as 'Requires Improvement' overall.

The overall status for the Trust therefore remains as 'Requires Improvement'. Individual ratings for each of the domains are shown in Table 10 opposite:

TABLE 10 OVERALL RATING FOR ROH

	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Good	Good	Good	Requires improvement	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Intensive/critical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children & young people	Good	Outstanding ☆	Good	Good	Good	Good
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement

The key findings of the follow up review were as follows:

- Staffing of HDU with regards to children was not suitable. The CQC found that children were being cared for within the unit but not always by a paediatric trained member of staff, nor were the facilities suitable for children.
- Within both core services the CQC found that infection control practices were well embedded, and staff followed trust policy and procedures.
- The CQC found that although the trust and its staff worked to the essence of the regulations of the Duty of Candour, in being open and transparent when things went wrong, they did not meet all of the requirements of that regulation.
- Multi-disciplinary working was effective in improving patient experience within the hospital.
- 100% of staff in both core services had received their appraisals, which was higher than the hospital's overall rate.

The CQC noted several areas of outstanding practice including:

- The unit manager had ensured that staff were both aware and understood the values of the trust. A post box had been put on the unit to enable staff to identify what the values meant to them in their work on HDU. Staff views on the values displayed on a noticeboard and had also been discussed during staff meetings.
- Within Outpatients the CQC observed that some clinicians were dictating letters to GP's and other services onto an electronic system for same day delivery, in the presence of the patient before the patient left the clinic.
- These findings have been communicated widely across the Trust to ensure that good practice is shared.

The Trust has developed a detailed action plan in order to respond to the findings of the CQC report which

includes the following:

- Improving Safeguarding training compliance for both adults and children in OPD
- Ensuring that the HDU
- HDU information for the Intensive Care National Audit & Research Centre was uploaded so that it can be benchmarked against other similar trusts.
- Addressing the layout and design of the HDU to ensure that adequate toilet and bathroom facilities were provided for all patients.
- Addressing the layout of HDU in order to ensure that children are always cared for in an appropriate environment.
- Developing management reports in OPD to monitor clinic wait times and cancellations. There must to be an agreed process which all staff followed in the event of a clinic being canceled
- To improve medical and nursing cover must be improved on HDU when children are accommodated.
- Improving local leaders' understanding of the processes involved in exercising the duty of Candour, in particular what they should expect beyond ward level and at a practical level, including record keeping.

The Trust is making good progress towards delivery of the actions to address the issues identified within the CQC report with the major achievements and outcomes at end of 2015/16 as follows:

- All staff in OPD have been trained to the appropriate level of Safeguarding training. A trust wide review of Safeguarding training across the organisation has been completed.
- The systems and processes required to ensure that information can be uploaded to the Intensive Care National Audit & Research Centre (ICNARC) have been put into place and the first upload will be completed at end of Quarter 1 2016/17.
- The capital plan for 2016/17 includes development of HDU to meet the required accommodation standards for both children and adults with work planned to commence in Quarter 1 2016/17.
- A review of paediatric services by the Royal College of paediatrics was completed in March 2016.
- There has been an uplift in the paediatric nurse establishment in HDU from 4 to 7 WTE and recruitment is continuing through 2016/17.
- A new electronic information system 'In touch' has been employed into the OPD and will enable better management information about waiting times and clinic cancellations.
- A new Duty of Candour Policy has been approved by the Trust and Duty of Candour training has been added to the timetable at local induction and mandatory training days.

2.2.8 DATA QUALITY AND INFORMATION GOVERNANCE

NHS Number and General Medical Practice Code Validity

The Royal Orthopaedic Hospital NHS Foundation Trust submitted records during 2015/2016 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are published in the Data Quality Dashboard from HSCIC. The percentage of records in the published data which included the patients' valid NHS Number was:

- 99.4% for admitted patient care
- 94.7% for outpatient care
- The percentage of records which included the patient's valid General Medical Practice Code was
- 100% for admitted patient care

- 99.6% for outpatient care

The percentage of records reported in the published data is shown in Table 11 opposite:

TABLE 11 PERCENTAGE OF RECORDS

	Total with NHS number	Total Records	Percentage
In- Patients April 2015 to February 2016	13924	13994	99.5%
Out Patients April 2015 to February 2016	124435	131755	94.4%

2.2.9 INFORMATION GOVERNANCE ASSESSMENT REPORT

Information Governance (IG) assesses the way in which an organisation handles and processes the information that is available to it. It covers both personal (e.g. patient records, complaints) and corporate (e.g. financial records) information. 45 standards are assessed and the Trust must score at level 2 or above against each of these standards to achieve compliance

The Royal Orthopaedic Hospital Foundation Trust Information Governance Assessment Toolkit overall score for 2015/2016 was 77% and graded as green (satisfactory).

2.2.10 PAYMENT BY RESULTS CLINICAL CODING AUDITS

The Royal Orthopaedic Hospital Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/2016 by the Audit Commission, Department of Health or Monitor

2.2.11 IMPROVEMENT OF DATA QUALITY

The Royal Orthopaedic Hospital NHS Foundation Trust takes the following actions to monitor and improve data quality:-

- Regular data quality review undertaken by the Director of Operations with support from the finance, informatics and clinical teams.
- Addressing concerns identified through this regular review by sharing learning through the Trust Management Committee monthly meeting

2.3 REPORTING CORE INDICATORS

All data reported in this section has been taken from internal Trust systems unless otherwise specified.

2.3.1 VTE

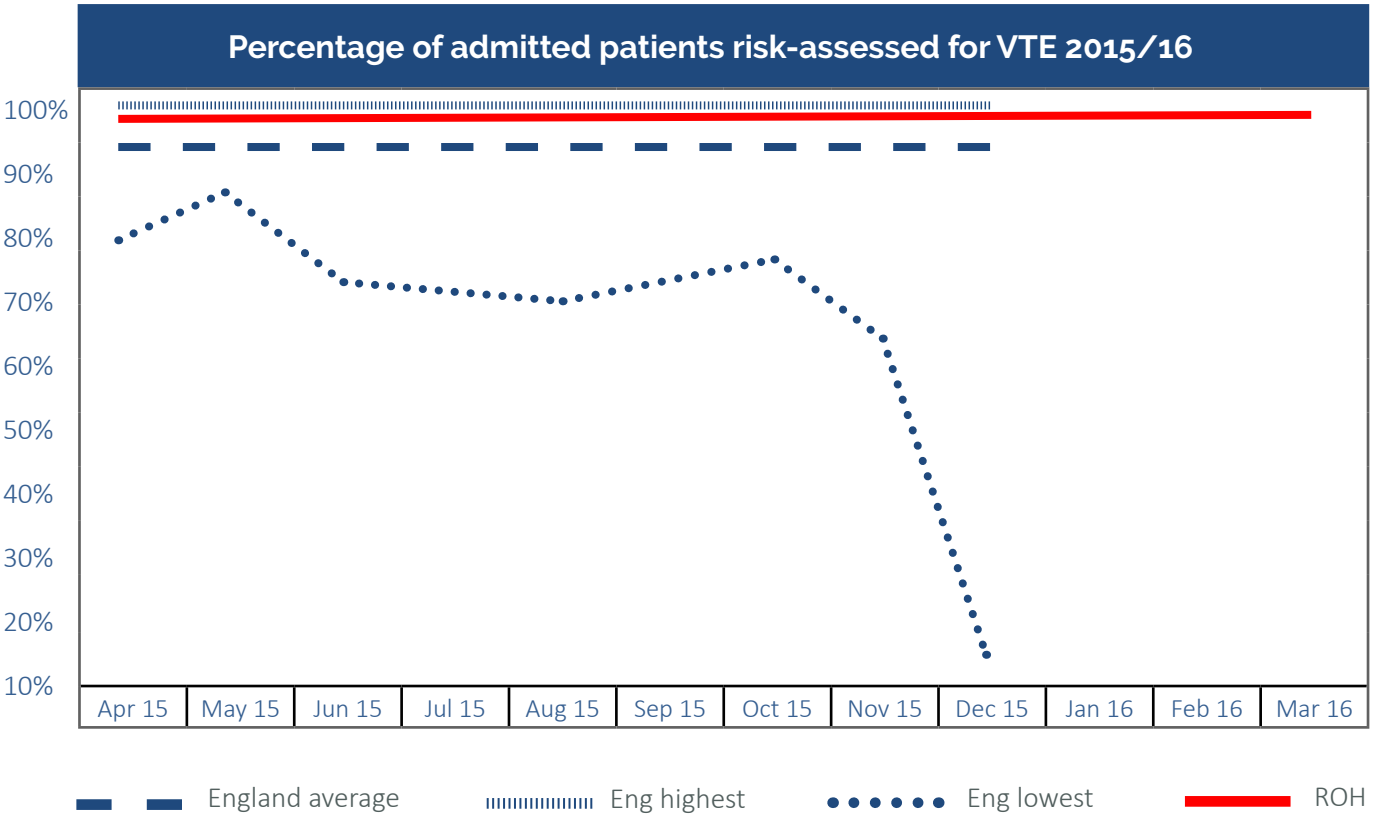
The work of the VTE Steering Group has been described previously in this report together with evidence that the Trust is compliant with the national standard to ensure that > 95% of all patients admitted to the hospital are risk assessed for VTE. Table 12 below shows the percentage of patients who were risk assessed for VTE against the numbers admitted to hospital in this time frame, whilst Table 13 provides benchmarking data.

TABLE 12: RISK ASSESSMENTS BY MONTH 2015/16

Month	No Assessed	No Admitted	Percentage (%)
Apr-15	978	986	99.2
May-15	953	962	99.1

Month	No Assessed	No Admitted	Percentage (%)
Jun-15	1003	1020	98.3
Jul-15	1070	1086	98.5
Aug-15	932	940	99.1
Sep-15	1058	1065	99.3
Oct-15	1107	1120	98.8
Nov-15	1001	1008	99.3
Dec-15	1013	1027	98.6
Jan-16	1010	1021	98.9
Feb-16	999	1016	98.3
Mar-16	1017	1025	99.2

TABLE 13 VTE RISK ASSESSMENT OVER TIME VS NATIONAL AVERAGE



It can be seen that ROH is consistently reporting rates of VTE risk assessment that are greater than the national average.

The Royal Orthopaedic Hospital considers that this data is as described for the following reasons:

- The Trust has maintained focus and support on the areas previously identified as failing the required target.
- New local systems have been put into place and embedded into practice thus delivering good compliance against the required target and most importantly ensuring patient safety.

The Royal Orthopaedic Hospital intends to take the following actions to improve the specific VTE indicators and so the quality of its services.

- For 2016/17 the Trust has a CQUIN to improve the managements of patients who present with a

VTE within 90 days of discharge and to achieve exemplar site status. In addition we have set a Quality Standard to reduce the number of avoidable VTE's.

- This will enable the Trust to continually improve with regard to the prevention of VTE and reduction in patient harm. In addition in will promote the good work that already takes place across the Trust in this area.
- The above will be monitored via existing reporting and monitoring methods and led the VTE lead and VTE chair. This will undergo review by the VTE Advisory Group which in turn reports quarterly to Clinical Quality Committee.

2.3.1 CLOSTRIDIUM DIFFICILE INFECTION (C-DIFFICILE)

The Royal Orthopaedic Hospital NHS Foundation Trust considers that the rate of C-Difficile infection per 1000 bed days shown in Table 14 below is as described for the following reasons:

- The control of infection is of paramount importance for our patients and the Trust has continued to meet its objective of zero (0) avoidable cases of Clostridium difficile during this reporting period..
- The Trust is compliant with Department of Health Guidance against which C- Difficile is reported and is subject to external scrutiny of its data for audit purposes.

In addition the Trust remains committed to the prevention of Infection by:

- Maintaining rigorous attention to good infection control practices through education and audit of practice.
- Undertaking regular ward rounds as part of the Bone infection Unit in order to ensure that antibiotic therapy is correctly and appropriately prescribed.
- Taking action to improve practice when concerns are identified through audit and review.
- Reporting and monitoring of actions through the Trust Infection Control, Committee with upward reporting to the Quality and Safety Committee.

TABLE 14: RATES OF C. DIFFICILE INFECTION (PATIENTS AGED 2 YEARS AND OVER): TRUST APPORTIONED CASES ONLY

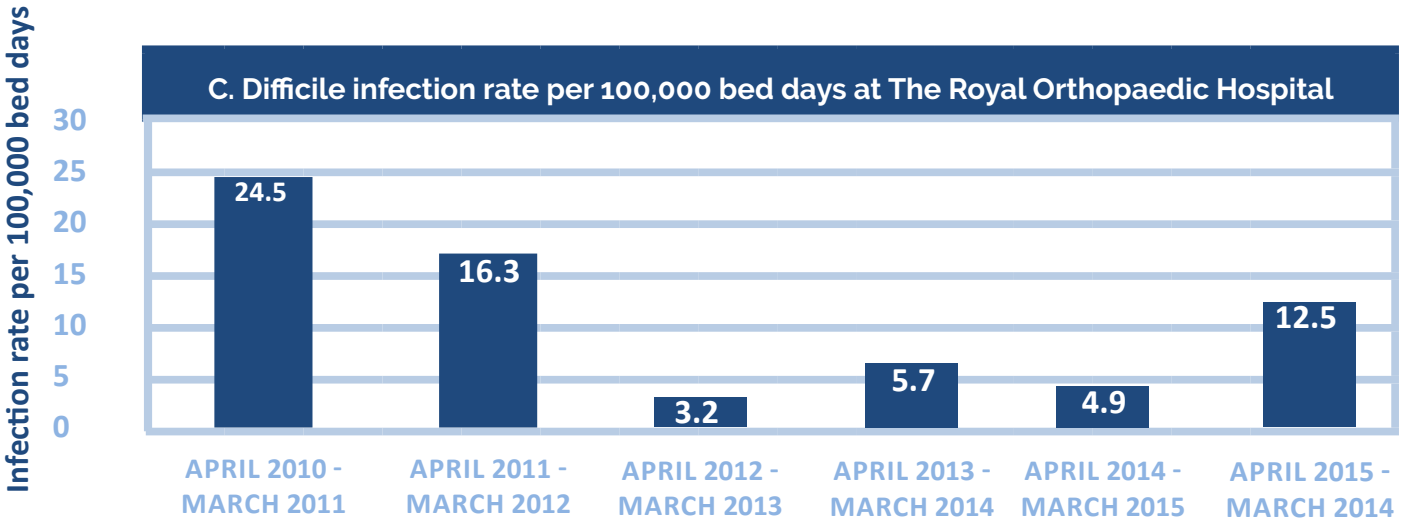


TABLE 15: TRUST APPORTIONED CASES AS A PROPORTION OF NATIONAL AVERAGE

RATES OF C.DIFFICILE INFECTION (PATIENTS AGED 2 YEARS AND OLDER) - TRUST APPORTIONED CASES ONLY						
	April 2010 - March 2011	April 2011 - March 2012	April 2012 - March 2013	April 2013 - March 2014	April 2014 - March 2015	April 2015 - March 2016
Royal Orthopaedic Hospital	24.5	16.3	3.2	5.7	4.9	12.5
All England rate	29.6	21.8	17.3	14.7	15.1	Data has not yet been published
Lowest England rate	0	0	0	0	0	
Highest England Rate	71.8	51.7	30.8	37.1	62.2	

Six cases have occurred during this time frame. All were subject to investigation and agreed as unavoidable with local commissioners for the following reasons.

- 4 cases were patients who were under the care of the Bone Infection Unit and targeted antibiotic therapy was required for all of these patients in order to treat prosthetic joint infections. A balance of risk is required as both Clostridium difficile and deep infection can pose a risk to the patient's life. All patients were treated according to Trust protocol and recovered from their Clostridium difficile infection.
- 3 cases were oncology patients: 1 patient had an infected massive endoprosthesis and required essential treatment of this infection under the care of the BIU (therefore this patient is included in both sections of this report). This case was also a recurrence within 30 days of a CDI case identified at another Trust prior to the patient's transfer to ROH. The second case was an oncology patient who was admitted from another provider where the patient and the family had a history of diarrhoea prior to admission. The third oncology case was admitted to our Trust at the beginning of March, the patient had a four day inpatient stay at another provider prior to admission to the ROH. In all cases appropriate antibiotic prophylaxis was prescribed following surgery and the treatment pathway was followed correctly for all patients who were suspected of having a C.Difficile infection. All patients were isolated and samples taken and sent to Microbiology within appropriate time frames.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions t in order to ensure that it continues to report zero avoidable cases for 2016/17 and so improve the quality of its services:

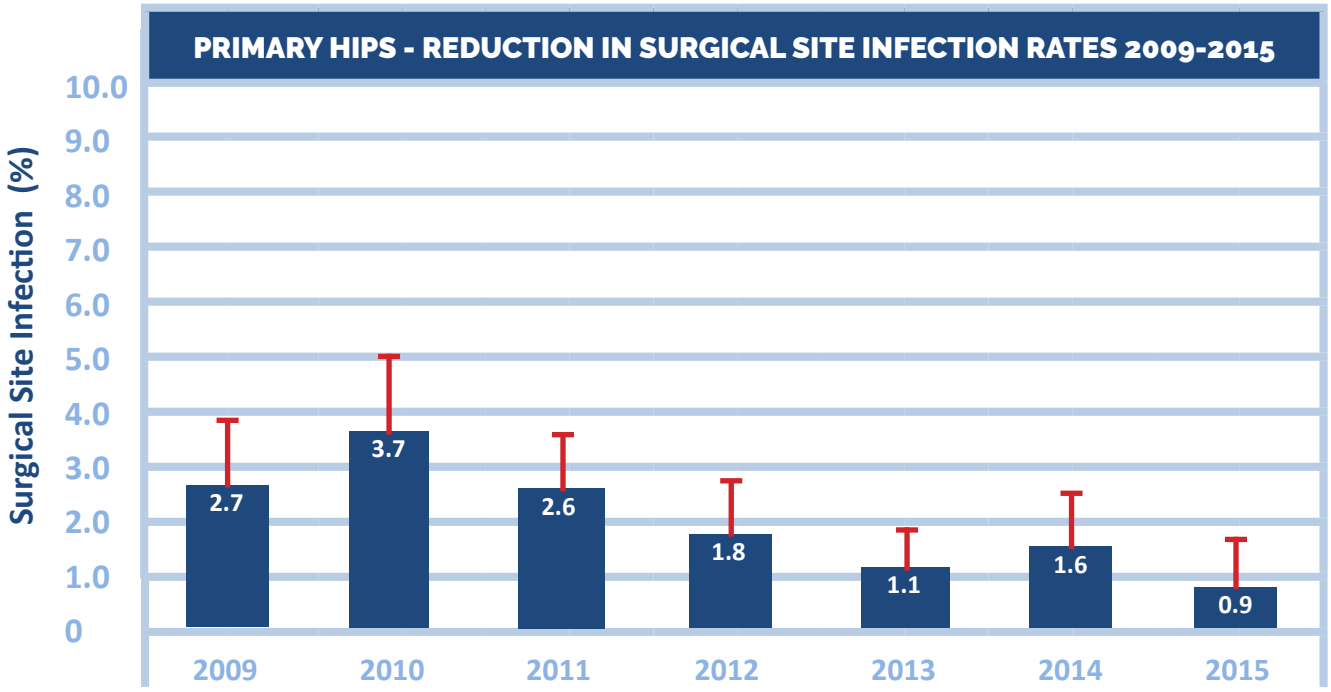
- We will maintain our focus on Infection Prevention and Control, so that exemplary standards of hand hygiene and use of personal protective equipment is maintained.
- We will review our Uniform and Dress Code Policy to ensure that all staff adhere to the principles of bare below the elbows in clinical areas
- We will develop a business case to support creation of a stand- alone bone infection unit which will maximise effectiveness of ward rounds and ensure that best practice is upheld in respect of antibiotic prescribing.

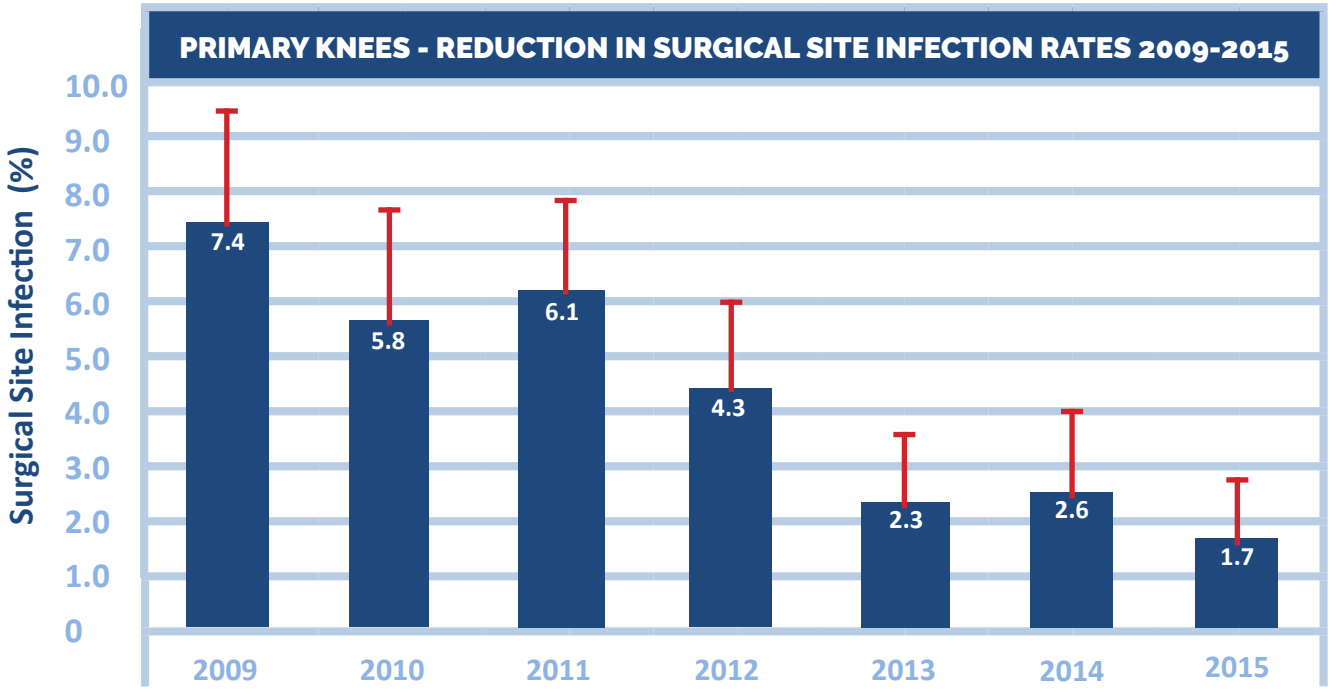
2.3.2 SURGICAL SITE INFECTION

The Royal Orthopaedic Hospital considers that the number of patient safety incidents reported and the number and percentage of such incidents that resulted in severe harm or patient death are as described for the following reasons:

- In 2015, a total of 25 Surgical Site Infections for Primary Hip and Knee replacements were reported. 2015 has seen the lowest rates of infections in Primary Hip and Knee Replacements at 30 days since surveillance began in 2009.

TABLE 16 ROH SURGICAL SITE INFECTION: PRIMARY HIP AND KNEE REPLACEMENTS ONLY – 30 DAY RATE





There has been a significant reduction in SSI's for Primary Hip Replacements where rates have fallen from 2.7% (CI: 1.9 to 3.9) in 2009 to 0.9% (CI: 0.5 – 1.7) in 2015, which equates to a reduction of 65.5% over a seven year period. In Primary Knee Replacements rates have fallen from 7.4% (CI: 5.8 – 9.4) in 2009 to 1.7% (CI: 1.0 – 2.8) in 2015, which equates to a reduction of 75.8% over a seven year period. However, overall there are still a higher number of SSIs for Primary Knee Replacements when compared to Primary Hip Replacements.

In line with NICE and DH guidance a range of measures were introduced at different times over the past 5 years to reduce the rate of SSI at the ROHFT. This included the introduction of antimicrobial sutures, 2% chlorhexidine, antimicrobial ioban incise drapes and Aquacell dressings, introduction of Wound Care Helpline, as well as providing training and education to all clinical staff to raise awareness of SSI prevention in conjunction with an improvement in monitoring and surveillance of SSIs would have contributed towards the reduction in SSI rates. Active surveillance is undertaken for all primary arthroplasty patients for a period of 12 months post operatively, with the data being reported to Public Health England according to their protocol.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions in order to ensure that it continues to report zero avoidable cases for 2016/17.

- The team feel that the reduction in SSIs is reaching an irreducible minimum based on the multitude of interventions that have been put in place as recommended in national guidance.
- The focus this financial year is to look continue improving standards in Theatres and to review practice to improve SSI rates further.

2.3.4 PATIENT SAFETY INCIDENTS

The Royal Orthopaedic Hospital considers that the number of patient safety incidents reported and the number and percentage of such incidents that resulted in severe harm or patient death are as described for the following reasons:

- The Trust actively promotes a culture of incident reporting so that issues can be identified, actions initiated and lessons learned.
- The Trust categorises incidence from no harm to severe harm and uses the definitions provided by the National Reporting and Learning System (NRLS) to categorise the level of harm
- All reported incidents are subject to review by a member of the governance team at ROH who will seek clarity on level of harm from clinical staff where necessary and amend the initial categorisation if required.
- The Trust submits patient safety incidents to the NRLS which enables benchmarking against other similar organisation in respect of numbers and types of patient safety incidents.

The ROH has taken the following actions in order to ensure learning from incidences is shared and embedded across the organisation:

- Continues to actively encourage reporting of incidents
- Delivery of Root Cause Analysis Training to 41 members of senior staff who undertake investigations
- A review of the way actions from incidents are tracked and shared across the organisation, including the development of action trackers that are used to monitor progress against action at Divisional Governance Meetings.

Table 17 below shows the trend of number of incidences over the past three years.

TABLE 17 : INCIDENT DATA OVER PAST THREE YEARS.

Indicator	2013/14	2014/15	2015/16
Number of Patient safety Incidents reported	883[1]	897	1113[2] (subject to internal validation)
Rate of Patient safety Incident per 1000 bed days (NB this indicator changed in 2014/15 from rate of incidences per 100 admissions)	14.77 per 100 Admissions (this indicator changed in the reporting period 2014/15) [1]	34.72[1]	36.3 1] (April 2015 to Sept 2015)
Number of patient Safety Incidents with Severe harm/ death	11[1]	8[1]	12[2]
% of patient safety incidences that resulted in severe harm/death	1.1 %[1]	0.9[1]	1.0[2]

[1] Data taken from NRLS [2] Data taken from Trust Source

The Trust has seen a significant increase in the number of patient safety incidents reported over the three year period represented above which reflects the focus through the year on encouraging staff to actively report incidents of concern.

There have been no themes identified from the severe harm incidents recorded during 2015/16, which included harm as a result of pressure ulcer formation, patient falls and delay in diagnosis. Learning from review of these incidents has been widely shared across the Trust at clinical audit meetings and through the Clinical Quality Group.

During 2015/16 ROH reported zero (0) never events against two which were reported in the same period 2014/15.

The Trust recognises that it has work to do to improve the standard of incident reporting and to ensure that feedback from incidents is regularly provided to the incident reporter. The ROH intends to take the following action to improve the standard of incident reporting and engage staff in feedback and sharing lessons from incidents and so improve the quality of its services:

- Deliver a series of training seminars to arrange of staff during Quarter 1 2016/17 outlining the key principles of the Incident Reporting and Investigation Policy.
- Continue to actively encourage the reporting of incidents by actively reviewing our feedback mechanism through our incident reporting system Ulysses.

2.3.5 NUTRITION ASSESSMENTS

Nutritional assessments are used to monitor for the risk of malnutrition, in this case as defined by the NICE Quality Standard 24 'Quality Standard for Nutritional Support in Adults'. At ROH, we use the nationally recognised MUST/ STAMP tool to undertake these assessments. The Royal Orthopaedic Hospital NHS Trust considers that the nutritional assessment data is as described for the following reason:

- The completion of this assessment is audited on all wards by their nutrition link nurses on a quarterly basis, below is the compliance data from the ROH over the last year (Table 18)

TABLE 18: COMPLIANCE WITH MUST/STAMP ASSESSMENT 2015/16

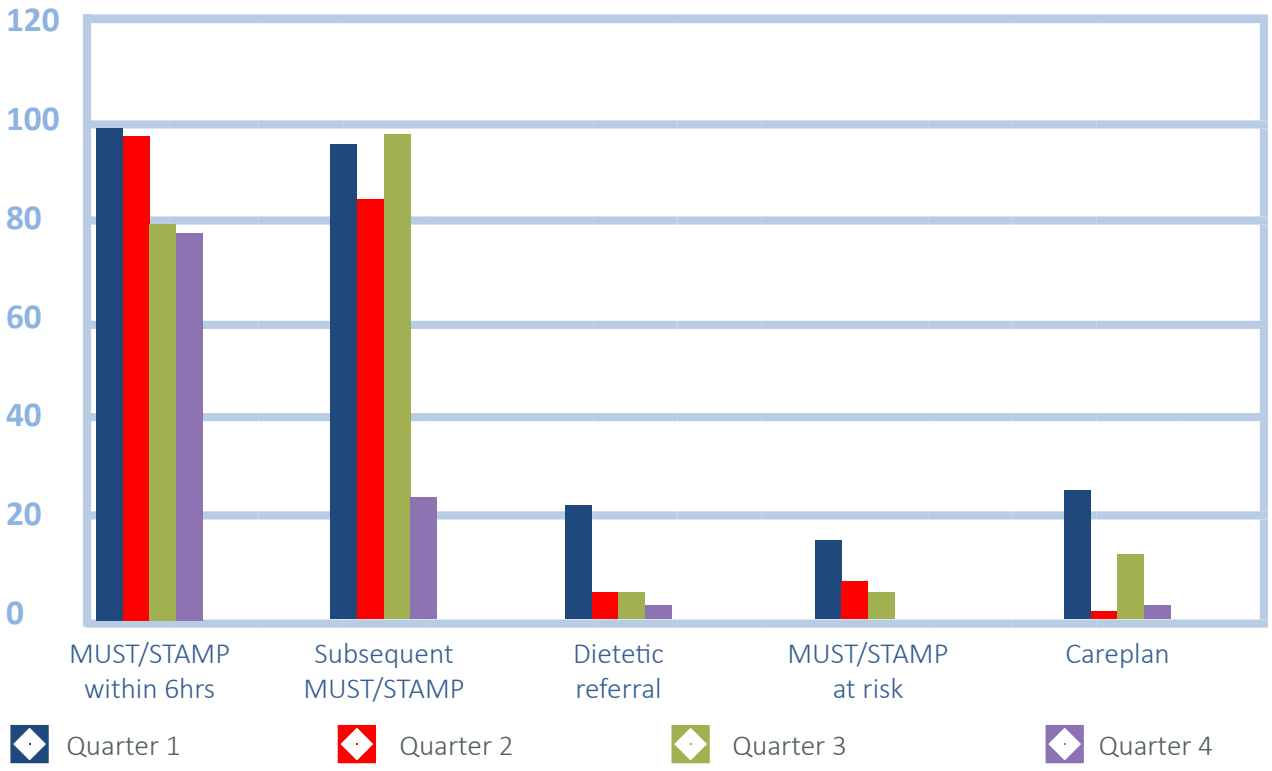
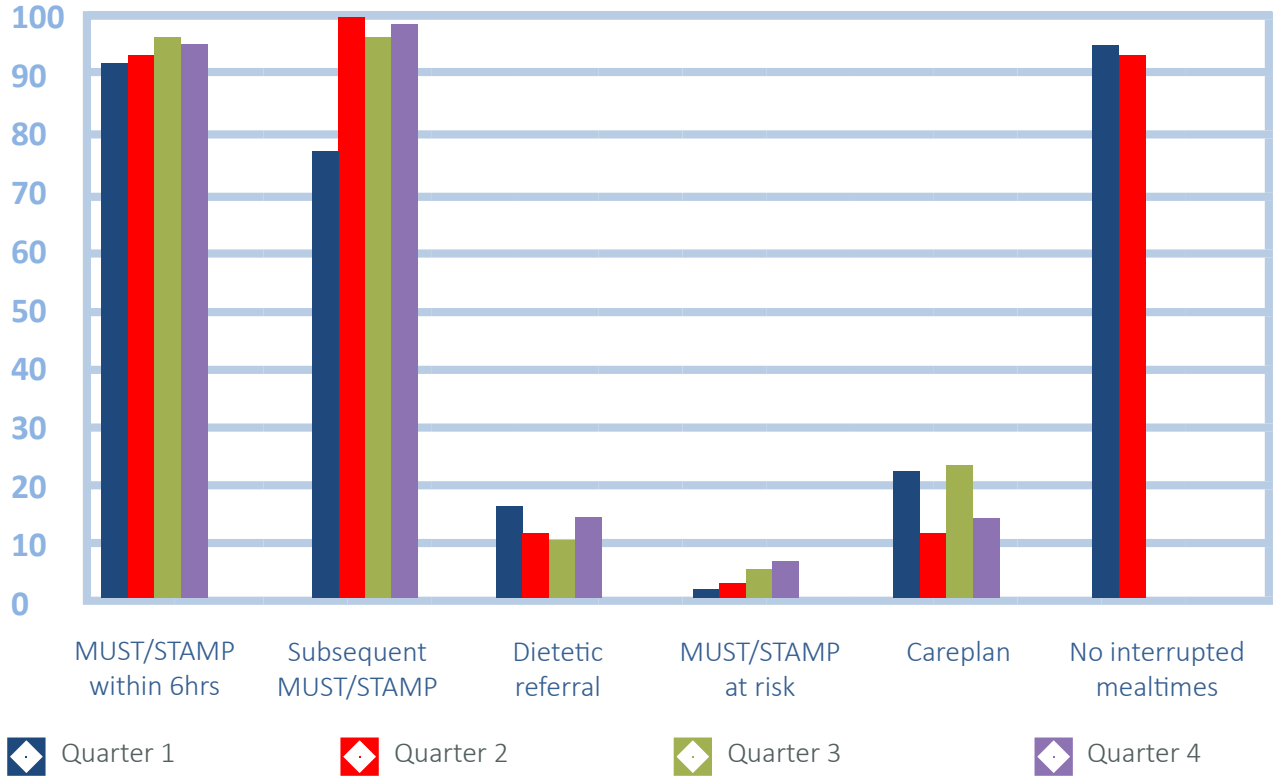


Table 19 overleaf shows the compliance rate for nutritional assessments for 2014/15.

TABLE 19: COMPLIANCE WITH MUST ASSESSMENT 2014/15



The overall data for 2015/16 shows an average of MUST/STAMP initial assessment and completion at 89%. This is a decrease in compliance, however, it is of note that the last quarter of 2015/16 has a statistical skew as a ward failed to complete the audit tool.

Since Quarter 2 2015/16, the Trust has included HDU within the trust wide nutritional audit in order to improve the standard of nutritional support provided to this patent group. In addition there has been new training emphasis on STAMP/MUST assessments with the Train the Trainer training completed at end of Q4 with the availability of the Nutritional Assessment Policy.

The percentage of patients who needed a subsequent assessment had remained high in Q1-3. When analyzed further in Q4 one ward did not return any data and this will have affected the overall percentage but Ward 2 had a low number of patients needing re-assessment and would account for the dramatic dip.

Good practice has continued with the use of care-plans and dietetic referrals based on clinical judgment for patients that are not assessed as nutritionally at risk from the MUST tool but put in place for other concerns, for example; patients with wound healing requirements, dementia.

The Royal Orthopaedic Hospital NHS Trust has taken the following actions in order to improve compliance with nutritional risk assessment and so the quality of its services:

- Quarterly audit of compliance with the MUST risk assessment tool will be included in the Ward sister monthly meeting to ensure that awareness is raised and actions highlighted where gaps in assessment are noted.
- The Trust is currently developing the Red Tray" system to highlight those in need of support with feeding and has reviewed and relaunched its policy on protected meal times.
- In addition the newly launched Dementia Strategy introduces John's campaign to the trust to support carers and families to stay with patients with dementia

2.3.5: SUMMARY HOSPITAL MORTALITY INDEX (SHMI)

The measure for SHMI is not applicable to this Trust.

2.3.6 PATIENT REPORTED OUTCOME MEASURES (PROMS)

Patient Reported Outcome Measures (PROMs) provide information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. Patients complete a questionnaire before the operation and six months after the operation.

The EQ5D Index asks patients 5 questions regarding their general health (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression).

The Oxford Hip/Knee Score comprise of 12 questions relating to the patient's experience of pain, ease of joint movement and ease of undertaking normal domestic activities such as walking or climbing stairs.

The adjusted average health gain is used for comparison between providers and the England average; (this is adjusted for case-mix- age, sex, co-morbidity etc.).

This data is the latest available and is for the period April 2013 – March 2014.

The percentage of cases submitted is 91.3% (Apr 15-Mar 16).

TABLE 20: ADJUSTED AVERAGE HEALTH GAIN

Procedure Type	Measure	England Average	England Highest	England Lowest	ROH	Position
Hip Replacement Primary	EQ-5D Index	0.437	0.524	0.331	0.455	Significantly above national average (99.8% control limit)
Hip Replacement Primary	Oxford Hip Score	21.44	24.65	16.29	22.49	Significantly above national average (99.8% control limit)
Hip Replacement Revision	EQ-5D Index	0.278	0.376	0.186	0.34	Above Average
Hip Replacement Revision	Oxford Hip Score	12.76	15.88	8.81	15.88	Above Average
Knee Replacement Primary	EQ-5D Index	0.315	0.418	0.204	0.306	Above Average
Knee Replacement Primary	Oxford Knee Score	16.15	19.49	11.48	16.22	Above Average
Knee Replacement Revision	EQ-5D Index	There are too few revision knee replacements with completed data in 2014/15 for comparison with the England average. The unadjusted change in EQ5d score has improved from 0.1 in 2013/14 to 0.25 in 2014/15. The unadjusted change in Oxford Score has improved from 7.75 in 2013/14 to 11.96 in 2014/15.				

The Royal Orthopaedic Hospital considers that this data is as described for the following reasons; PROMS reports have shown that for 2015/16 the Trust is above the national average in all hip primary and revision arthroplasty. With reference to knees, the figures show that during the period, although the Trust has improved its position for primary knee arthroplasty we do continue to be slightly below the national average for EQ5D.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following action to improve PROMS scores and so the quality of its services:

- We will maintain a high focus on submitted cases and continue to monitor submitted case totals

and EQ5D and Oxford score data through the Clinical Audit and Effectiveness Committee.

Data available from The Health and Social Care Information Centre at www.hscic.gov.uk/catalogue/PUB19823

2.3.7 EMERGENCY READMISSIONS WITHIN 28 DAYS OF DISCHARGE

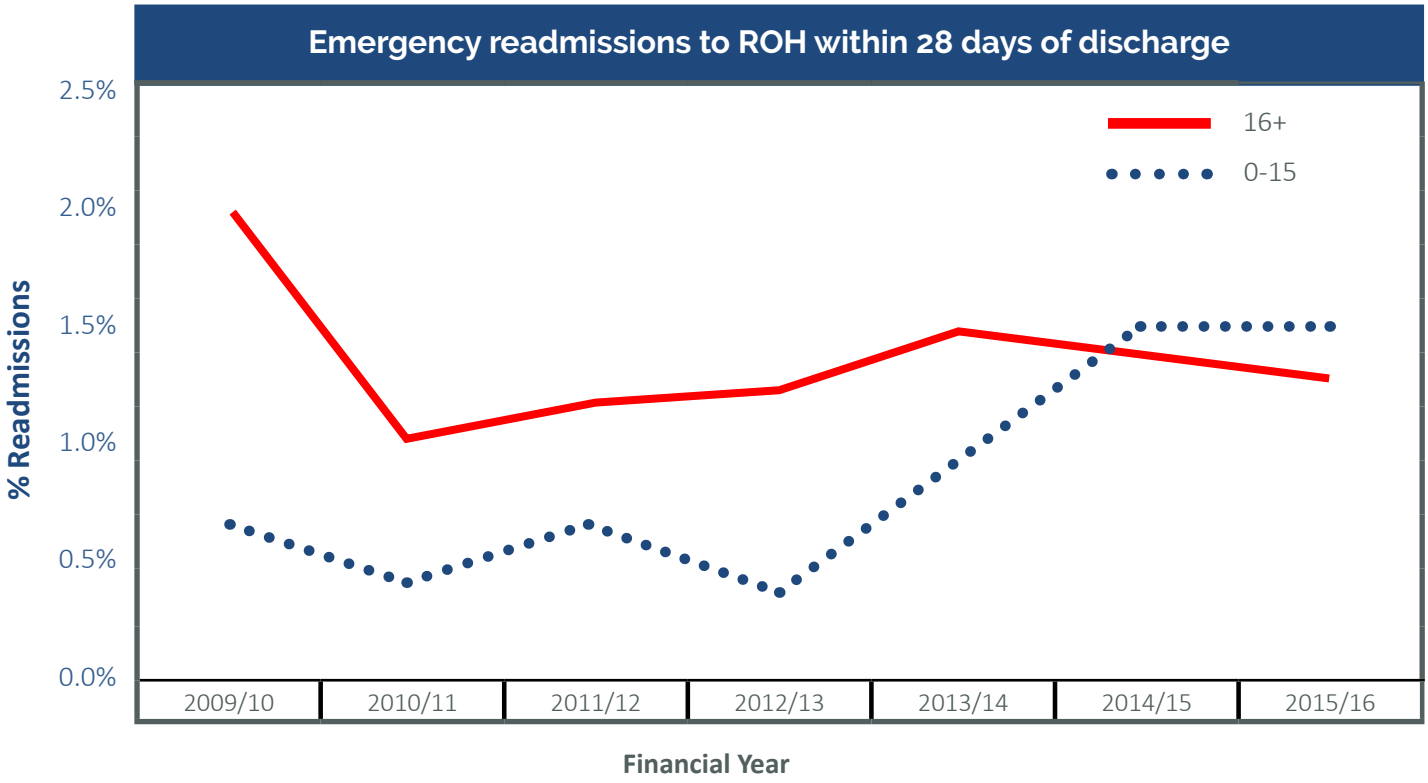
The percentage of patients aged:

(i) 0 to 15 and

(ii) 16 or over

who are readmitted to a hospital which forms part of the trust within 28 days of being discharged during the reporting period as shown in Table 21 below:

TABLE 21: EMERGENCY ADMISSIONS WITHIN 28 DAYS OF DISCHARGE

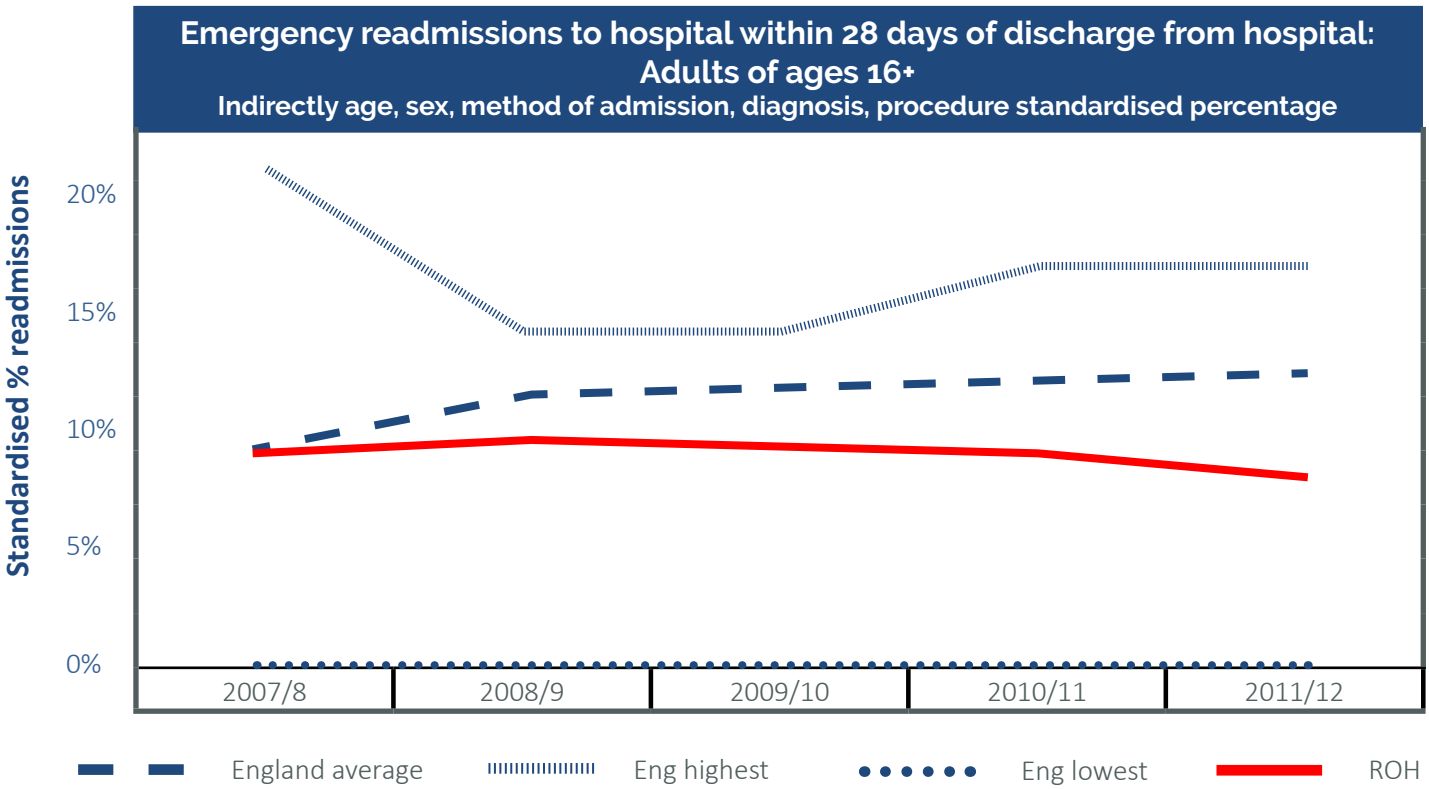


Number of Emergency Readmissions to ROH within 28 days of discharge							
	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
0-15	4	3	5	3	6	9	9
16+	111	62	69	65	86	74	75

The 28 day readmissions as defined by Monitor for the Quality Accounts is a local indicator and therefore cannot be benchmarked or compared to a national average.

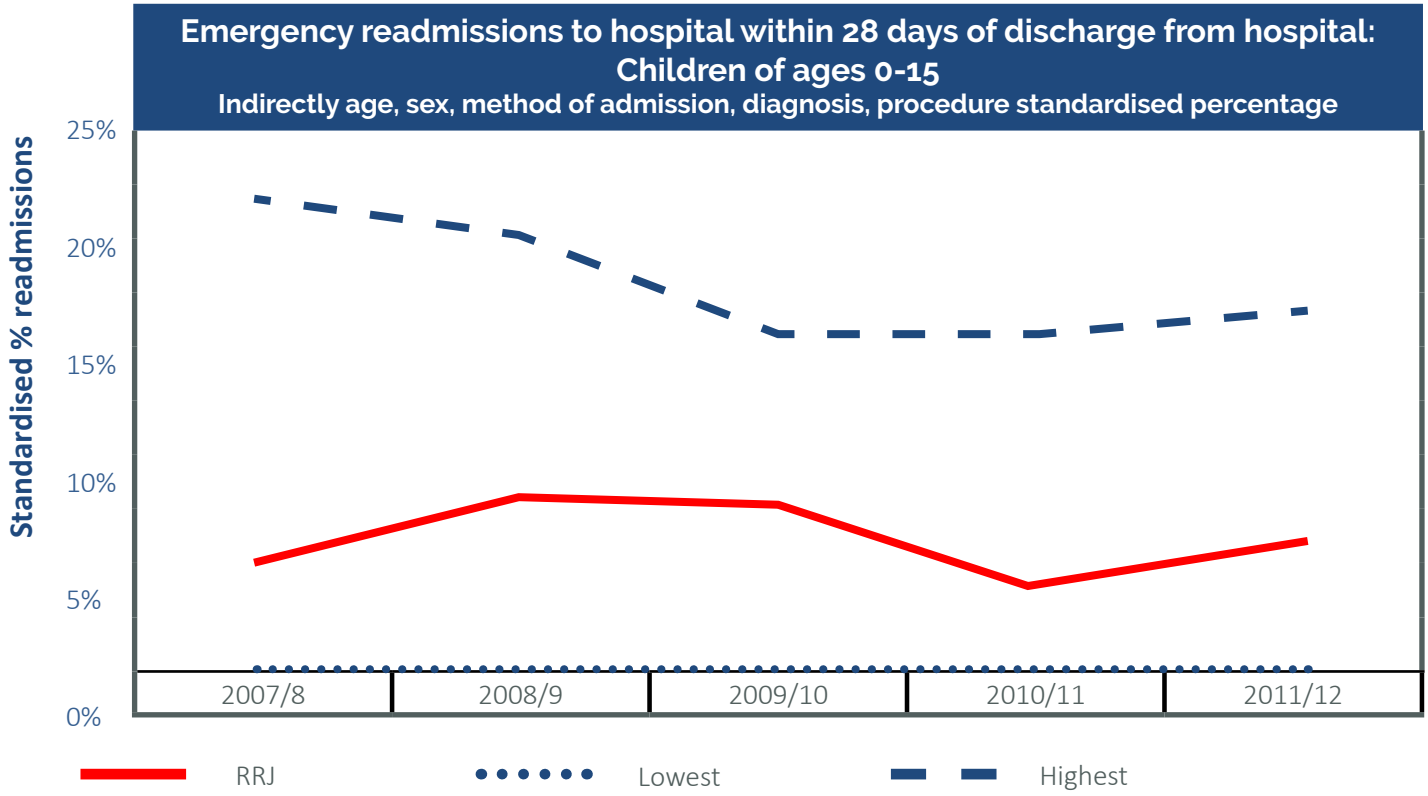
However a further readmissions indicator identified in the quality accounts data dictionary is able to be benchmarked nationally. This is produced by the Health & Social Care Information Centre and has national data-the latest available is 2011/12. For the purposes of the Quality Accounts this has been included, there is no England value available for readmissions for patients aged 0-15. Table 22 below describes emergency readmissions to hospital within 28 days of discharge from hospital: adults aged 16+.

TABLE 22: EMERGENCY READMISSIONS (<28 DAYS) FOR ALL OVER 16 YEARS



Our standardised emergency readmissions figure for adults aged 16+ is significantly better than the England average. The latest period this data is available for is 2011/12 as shown in Table 23 below:

TABLE 23: EMERGENCY READMISSIONS TO HOSPITAL WITHIN 28 DAYS OF DISCHARGE FROM HOSPITAL: CHILDREN AGED 0-15



Our standardised emergency readmissions figure for children aged 0-15 is within the expected range of the England average. The England average figure is not available on the published data. The latest period this data is available for is 2011/12.

The Royal Orthopaedic Hospital considers that this data is as described for the following reasons:

The Royal Orthopaedic Hospital intends to take the following actions to improve the specific readmission indicators and so the quality of its services

- The trust is currently reviewing its data including the area, specialism and reason behind readmission.
- Dependant on the data analysis further focused actions will be taken to reduce readmissions if and where possible.

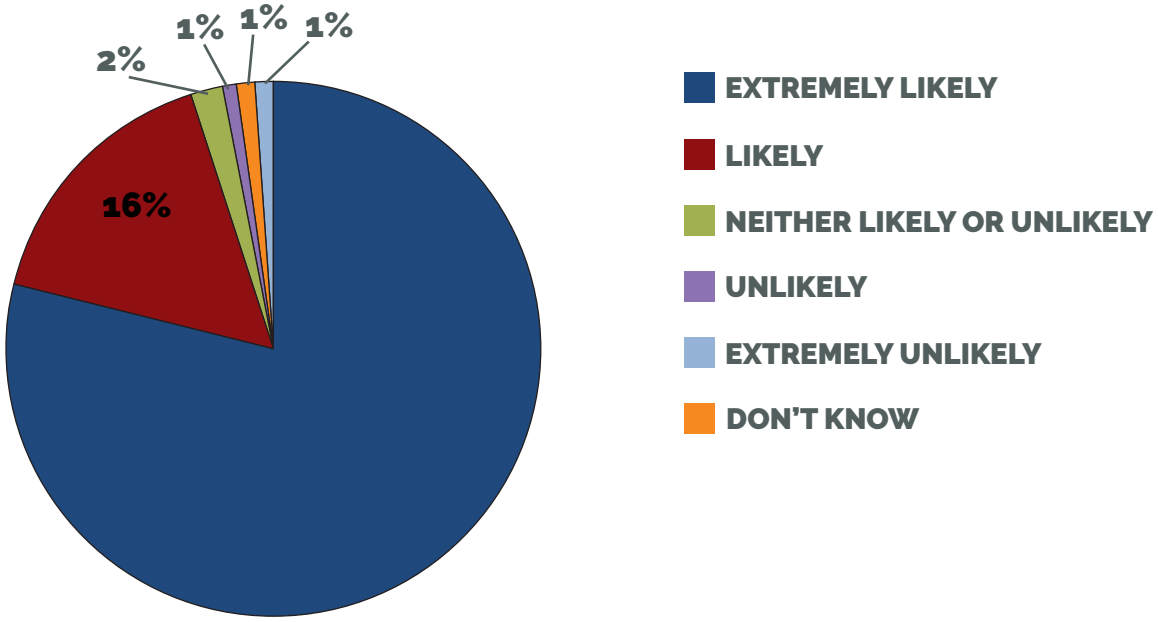
2.2.8 THE FRIENDS AND FAMILY TEST AT ROH

The Friends and Family question is a single question used across the NHS to establish whether patients and service users are happy with the standard of care that they receive. The Royal Orthopaedic Hospital NHS Trust considers that the data is presented as described for the following reasons;

- We have rolled out the FFT to outpatient and paediatric areas
- We have continued to promote FFT with patients and service users through 2015/16

Table 24 below shows the results of the FFT across all adult inpatient wards and day case areas for the year 2015/16

TABLE 24: HOW LIKELY ARE YOU TO RECOMMEND OUR SERVICE TO FRIENDS AND FAMILY?



It can be seen that the overwhelming majority of our patients (95%) would recommend our services to their Friends and Family. The results and feedback from the Friends and Family Test are shared with all wards and departments. During 2015/16 The Trust Developed 'Patient Experience' Posters that are displayed in all public areas so that feedback can also be shared with patients and their families.

A sample of comments from FFT is included below in Table 25 below:

TABLE 25: COMMENTS

Staff all levels very efficient and caring. The major issue in my case is lack of effective communication between shift changes, in connection with prompt pain relief
I experienced much good practice. Everyone was very caring, accommodating and friendly. I was always treated with respect and dignity as was my partner. I felt I matter and staff were happy to invest in my care. Pain relief seemed readily available. Good atmosphere on ward. Lovely clean room. Seemed like an integrated service.
Excellent in all aspects. Based on other hospitals this is the best I have visited. Exceptional technical skills and staff attitude great.
Not always easy to get out of ward if there are no members of staff to open doors for you. Sometimes it can take a minute or two to get in to ward also.
A better outline of what's going to be going on when and what we were waiting for e.g., X-ray/see doctor etc. Daily schedule for first time patients would be good: drug rounds washing etc.

The Royal Orthopaedic Hospital NHS Trust intends take the following action in order to improve the way in which information gained from the Friends and Family Test is used through the organisation and so improve the quality of its services:

- A Task and Finish Group has been set up with specific remit to review the way Friends and Family data is collected and shared across the organisation.
- The forms used to gather the response to the question have been revised to include more detailed demographic information to enable better monitoring and review of responses.
- The forms used for collecting data from Children's services will be revised so that they are more child- friendly and enable children to communicate in a range of ways.
- A review of the work undertaken by the Patient Experience volunteers at the Trust will be

completed by the end of Quarter 1.

- The Trust is considering securing the services of an external company to enable more real time collection and response to patient feedback.

2.3.9: FINDINGS FROM THE STAFF SURVEY/STAFF FRIENDS AND FAMILY TEST 2015/16

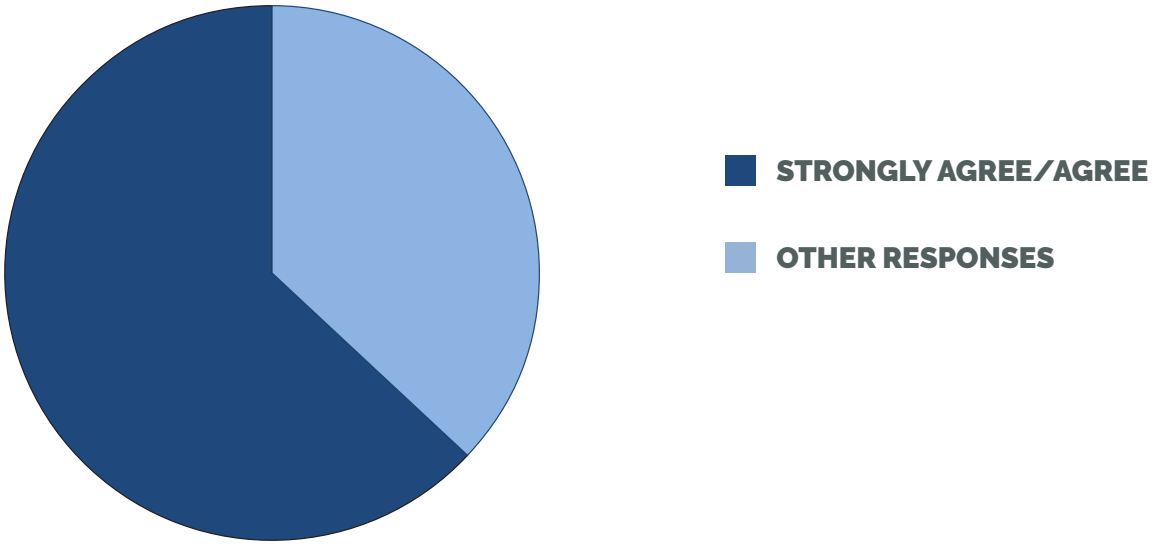
This section presents the findings from the annual staff survey in respect of indicators K 1, K21 and K27 together with a summary of the findings of the staff Friends and Family test through 2015/16.

The Royal Orthopaedic Hospital considers that this data is as described for the following reasons:

- Each year the Trust participates in the annual staff survey and shares the findings across an range of Trust boards and committees
- In addition the Trust takes part in the Staff Friends and Family test which asks the question 'How likely are you to recommend ROH' as a place to work'? All staff are invited to take part in this survey which is made available through the Trust's intranet site.

Table 26 below presents the results from the 2015 staff survey whilst Table 27 provides the findings of the Staff Friends and Family test for 2015/16.

TABLE 26: STAFF SURVEY RESULTS KEY INDICATOR 1 ' I WOULD RECOMMEND MY ORGANISATION AS A PLACE TO WORK ' 2015.



In 2014, a sample of staff were invited to take part in the annual National Staff Survey. 52% (n=286) responded, and 67% would recommend the Trust as a place to work.

However in 2015, all staff were invited to take part in the National Staff Survey. 55 % of staff (n=505) responded, and 63% confirmed that they would recommend the organisation as a place to work.

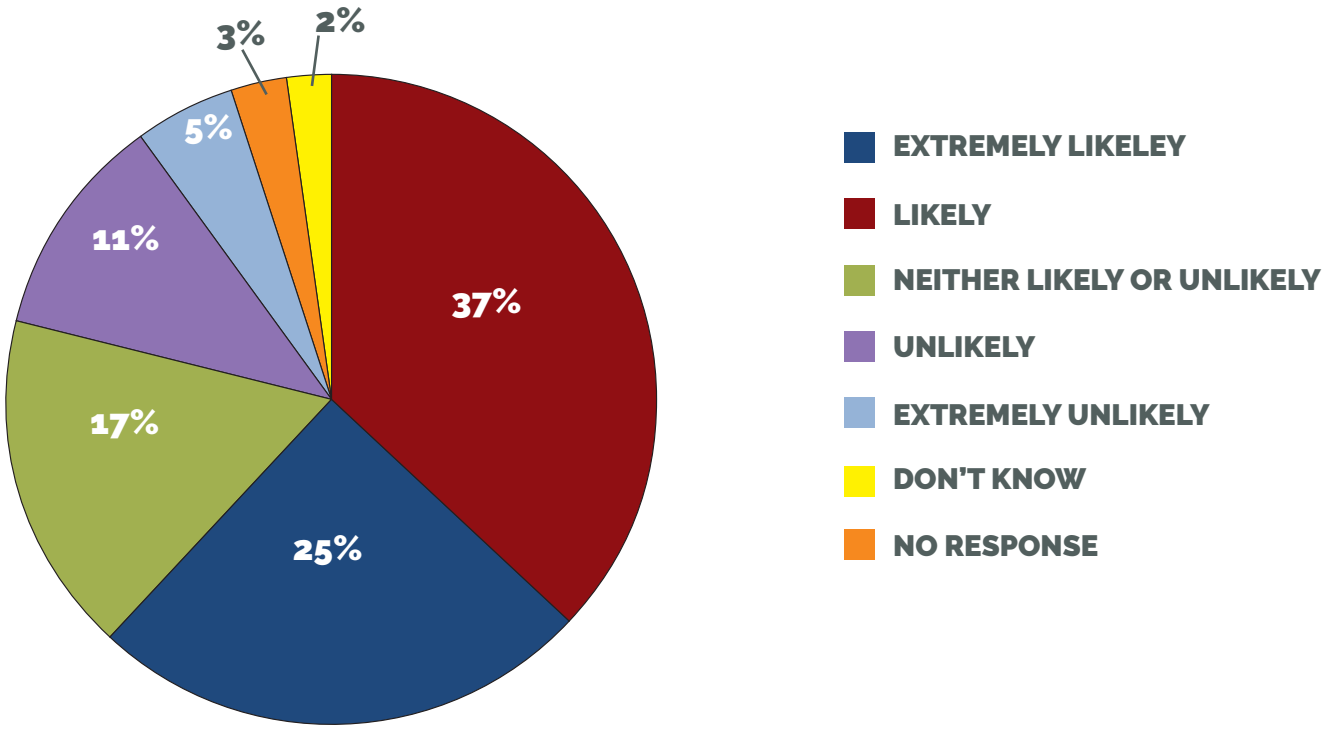
This shows a deterioration of 4%, this decrease is not however considered statistically significant, as it is 'unweighted' data.

The results of the Staff Friends and Family Test for 2014/15 are presented in Table 27 below.

In 2015/16 545 staff responded to this survey with 62% of those indicating that they would recommend the Trust as a place to work.

This represents a decrease on the percentage reported in 2014/15 of 68 %, however this was based on only 216 responses.

TABLE 27: RESULTS FROM STAFF FRIENDS AND FAMILY TEST 2015/16 (545 RESPONSES)



The Royal Orthopaedic NHS Foundation Trust considers that the data is as described for the following reasons:

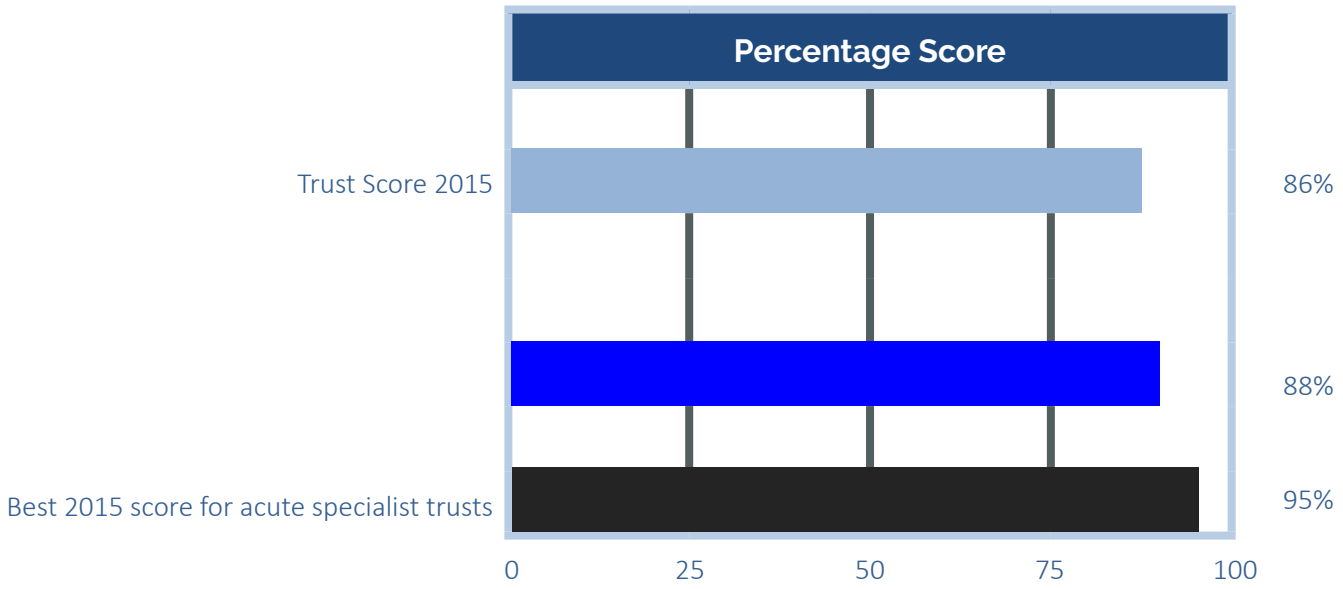
- The Trust has undergone a significant period of reorganisation with the development of new Divisional teams and management restructure.
- The Trust has increased its focus on performance management across all teams.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following action to improve the response to the annual staff survey indicator, and the staff Friends and Family test results:

- During early 2015/16 the Trust embarked on a series of staff engagement events (New Beginnings) that provided a wealth of information on which the Staff Engagement Strategy is based. Newly launched, this strategy sets out the way the Trust will build relationships with staff over the next three years
- We have invested in line managers to build their capability
- We are delivering more job-related training.
- Through 2016/17 work will be completed to raise awareness of this measure with all staff groups and to enable more members of the team to take part.
- A detailed review of the comments completed by staff will be undertaken in Q1 2016/17 in order to identify themes which will be used to inform the next steps in developing the Staff Engagement Strategy

In addition to this key finding the Trust are expected to report on Key Indicators 21 and 27 and the findings from both indicators are presented in Tables 28 and 29.

TABLE 28: INDICATOR 21 - PERCENTAGE OF STAFF BELIEVING THAT THE ORGANISATION PROVIDES EQUAL OPPORTUNITIES FOR CAREER PROGRESSION OR PROMOTION (THE HIGHER THE SCORE THE BETTER)



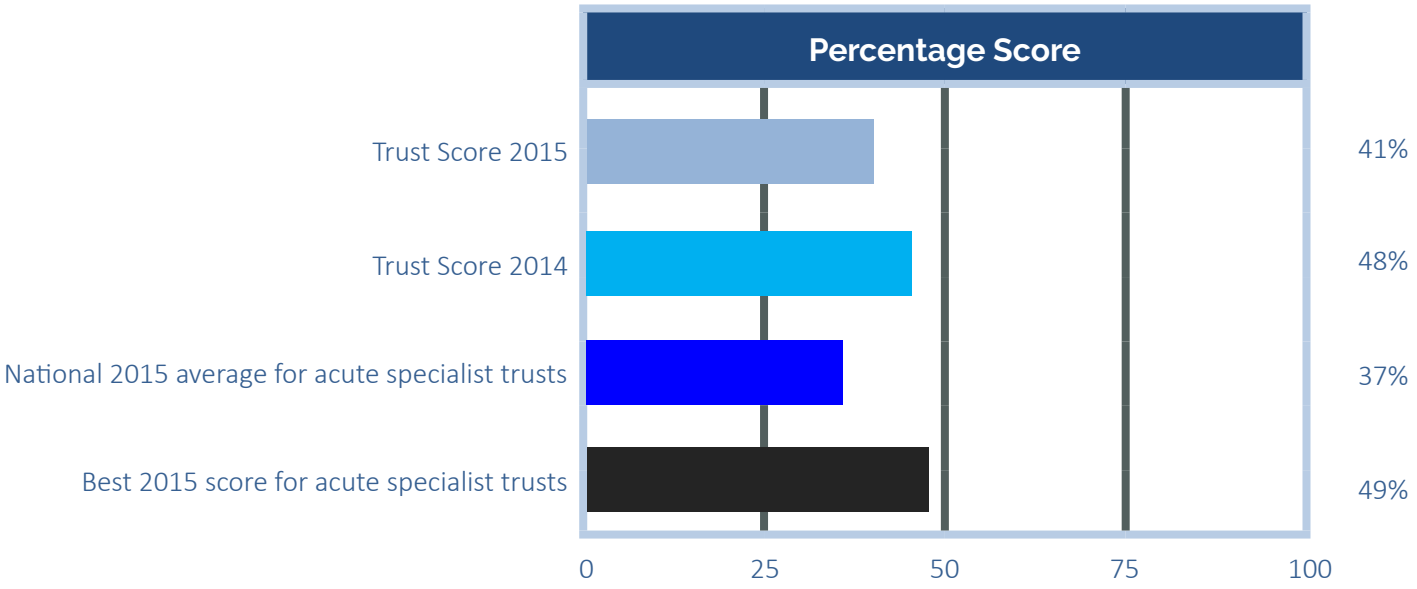
The Royal Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The lower than average score has been consistent at 86% over a number of years and insufficient action has been taken to actively respond to this finding.

The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following action to improve the staff response to this indicator and so the quality of its services:

- The Trust has completed the Equality Delivery System assessment and the relevant report will be published shortly.
- The Trust Board has instructed that a formal plan is developed to address the potential improvements identified in the report. As a first step, the Trust will introduce a new Work Experience policy which will encourage applicants from across the wider community.
- Robust adherence to inclusive recruitment and selection processes will help us in the medium and longer term.

TABLE 29: INDICATOR 27 - PERCENTAGE OF STAFF/COLLEAGUES REPORTING MOST RECENT EXPERIENCE OF HARASSMENT, BULLYING OR ABUSE



This indicator provides the Trust with a positive finding and is better than average. The 2015 Trust score is 41% (out of a possible 100) which is just higher than the National 2015 average for acute specialist trusts at 37% but lower than the 49% score for the best 2015 score for acute specialist trusts. This key finding links the staff pledge 3 which is to provide support and opportunities for staff to maintain their health, well-being and safety.

The Royal Orthopaedic Hospital NHS Trust considers that the data is as described for the following reasons:

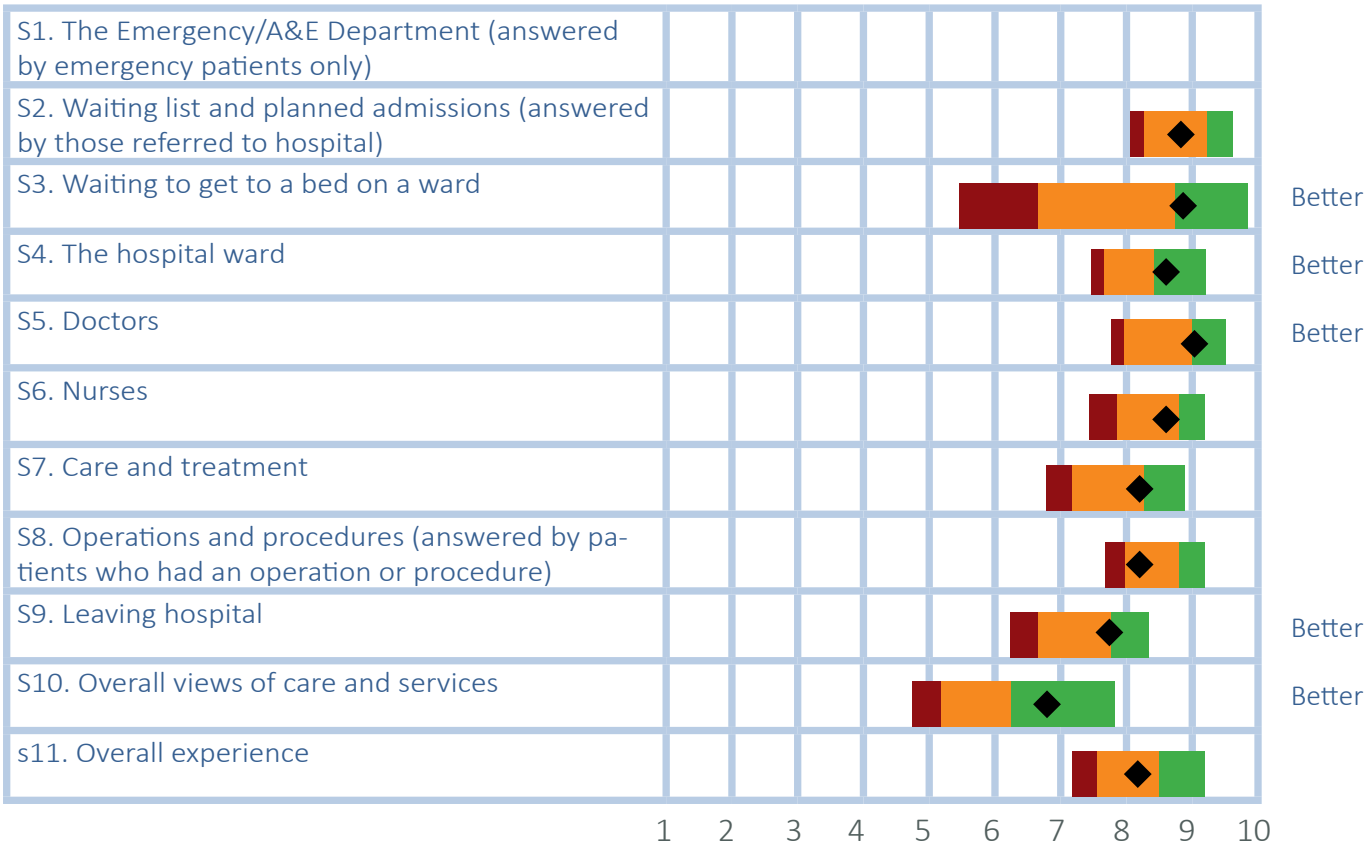
- There has been a lot of work done with staff by the Learning, Development and Equalities Manager in raising the importance of reporting incidents of harassment, bullying or abuse, and the types of actions that constitute these behaviours.
- Receive presentations on joining at Trust Induction, during the Core Mandatory Training day and as standalone sessions during the year.

The Royal Orthopaedic Hospital NHS Trust intends to take the following action to improve the staff response to key findings 19 and 27:

- Staff Work is continuing through recommendations made in the Trusts 2015 Equality Delivery System Report, the addition of "Inclusion" training sessions in the Trust Core Mandatory Training Programme and as standalone sessions.
- Access to health improvement projects have been sourced through arrangements with local Occupational Health providers
- The Trust has signed up to the NHS Employers Health and Well -being Forum and will undertake a review of its Health and Wellbeing Strategy through 2016/17

2.3.10 RESPONSIVENESS TO PERSONAL NEEDS

The data presented below is based on the 2014 National In-Patient survey. The 2015 survey has not yet been released. The Royal Orthopaedic Hospital considers that the mean score for responsiveness to personal needs is described as follows for the following reason:



- Each year the Royal orthopaedic Hospital takes part in the National In patient survey whereby random samples of 850 patients are sent a questionnaire to complete. The results of the survey are analysed independently by Patient Perspective. In 2014, a total of 525 returns received giving a percentage return of 62% which compares very favourably to the national return rate of 47%.
- The Trust (2014), scored within the top 20% of Trusts in 5 out of the 9 domain areas, with no areas scoring in the bottom 20% of all Trusts. Table 30 opposite shows the summary of the section scores that ROH received.

TABLE 30: SUMMARY OF SECTION SCORES 2014 IN PATIENT SURVEY

The Royal Orthopaedic Hospital intends to take the following action to improve responsiveness to personal needs and so the quality of its services by:

- Implementing intentional rounding across all in patient areas
- Improving access to discharge medications
- Improving the way we communicate with our patients about admission to hospital
- Improving the quality of post discharge information.

2.4
IMPLEMENTATION OF DUTY OF CANDOUR AT ROH

During 2015/16 the Trust undertook significant work in order to respond to concerns raised by the CQC about Regulation 20: Duty of Candour, was fully embedded across the organisation. This included:

- Approval of a new Duty of Candour Policy and process
- Amendment of the Incident Reporting System to include a Duty of Candour tab to make it easier for staff to identify concerns and upload evidence of discussions with patients
- The inclusion of Duty of Candour Training at induction and mandatory training days
- The development of a Duty of Candour Action tracker to ensure that all requirements of Regulation 28 are adhered to
- Executive oversight of the Duty of Candour process at Senior management team meetings

ROH was subject to two external reviews by CCG colleagues in respect of Duty of Candour through 2015/16. Significant improvement in compliance was shown between the first audit which took place in July 2015 (25% compliance) and the second which took place in March 2016, following the implementation of the actions outlined above (100%) compliance.

The Trust considers that the improvement in compliance is evidence that good progress has been made in embedding Duty of Candour across the organisation but recognises that the good work undertaken must be sustained.

Regular bi annual audit of compliance with Duty of Candour will be included as part of the audit plan for 2016/17 in order to monitor compliance with Regulation 20.

2.5
SIGN UP TO SAFETY PLEDGES

Sign up to Safety is a national campaign which supports the mission to make the NHS the safest health system in the world.

Organisations who Sign up to Safety commit to strengthen patient safety by:

- Setting out the actions they will undertake in response to the five Sign up to Safety pledges and agree to publish this on their website for staff, patients and the public to see.
- Committing to turn their actions into a safety improvement plan (including a driver diagram) which will show how organisations intend to save lives and reduce harm for patients over the next 3 years.

During Quarter 1 2016/17, the Trust will complete the process of signing up to this national campaign and of developing its sign up to safety action plan based on the five key pledges outlined in the programme as detailed below:

1. Putting safety first. Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans
2. Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are
3. Being honest. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong
4. Collaborating. Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
5. Being supportive. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress

PART 3:

REVIEW OF QUALITY PERFORMANCE 2015/16

3.1

REVIEW OF QUALITY PRIORITIES 2015/16

During 2015/16 the Trust outlined 13 areas for improvement and successfully achieved 10 of these as summarised in Table 31 below:

TABLE 31: PROGRESS AGAINST QUALITY PRIORITIES 2015/16

Improve medicine safety awareness through increased incident reporting of harm/potential risk	Staff feeling able to raise concerns
Improve the standard of incident investigation	Ensure actions from Serious Incidents are demonstrated within Clinical Practice
Ensure more than 95% of patients are assessed for risk of Venous Thrombolytic Event	To be compliant with National Joint Registry standards of consent and reporting
To achieve consistent compliance with the WHO checklist	To ensure a robust and regular schedule of Quality Assurance visits
Increase results for staff doing everything they can to control patients pain	To ensure patients get enough help to eat their meals
To reduce the length of time patients are starved before surgery to less than 10 hours	To reduce the length of time patients wait in outpatients clinics to less than 60 minutes

To ensure patients wait no longer than 60mins to transfer from recovery to the ward	

Key

Not achieved

Achieved

The rationale to support achievement of the 2015/16 Quality Priorities is provided in detail below. All data reported in this section has been taken from internal Trust systems unless otherwise specified.

3.2

PATIENT SAFETY OBJECTIVES

3.2.1 IMPROVE MEDICINE SAFETY AWARENESS THROUGH INCREASED INCIDENT REPORTING OF HARM/ POTENTIAL RISK

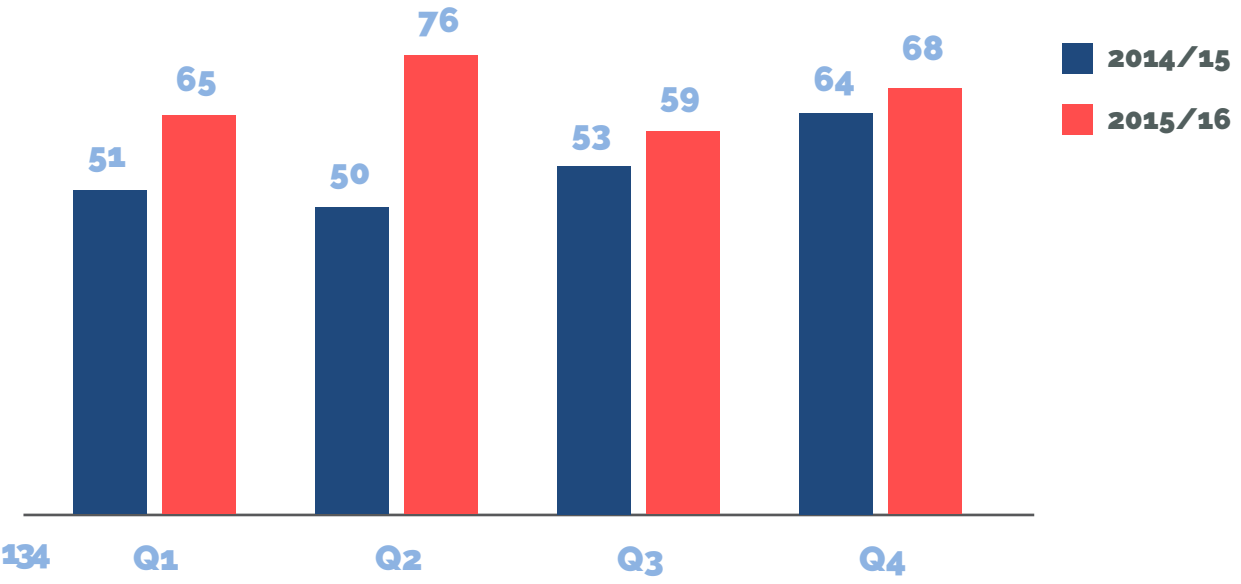
In March 2014, a national patient safety alert was issued which required providers of healthcare to take action in order to increase the number of medication incidents reported as part of a move towards improving patient safety following the publication of the Francis report (2014).

However, during 2014/15 the number of reported medicines incidents fell across the Trust and for this reason, it was identified as a Quality Improvement Priority. Through 2015/16 a number of key actions were taken to support this objective including:

- Increasing awareness of the need to report all medication incidents through senior nurse and ward meeting.
- Inclusion of Medication Safety as part of the Clinical Skills update day for all nursing staff
- Inclusion of the importance of medication safety as part of junior doctor induction
- Provision of regular reports on medication incidents to Divisional Governance groups
- Review of the Medication Safety Policy and introduction of key standards for reporting

The number of reported medication incidents has risen in 2015/16 from 218 in 2014/15 to a total of 268 as shown in Table 32 below.

TABLE 32: NUMBER OF MEDICATION INCIDENTS BY QUARTER (2014/15 AND 2015/16)



Whilst recognising that there is no room for complacency and understanding that work to improve medication safety must continue, the Trust considers that this priority is met for 2015/16.

3.2.1 IMPROVE THE STANDARD OF INCIDENT INVESTIGATION

In 2015/16 The Trust committed to delivery of training in incident investigation for those members of staff who undertake incident investigation. Training was undertaken in February 2016 and 41 members of staff attended, drawn from a range of backgrounds.

In addition much work has been completed during 2015/16 to raise the standard of reports that are submitted to the local CCG and reduce the number of reports that are open subject to requests for additional information. During the latter six months of 2015/16 The Trust has reduced the number of open Serious Incidents from 23 to 9. Whilst recognising that improvement is continuous and must be maintained, the Trust considers that it has achieved this standard for 2015/16

3.2.2 ENSURE MORE THAN 95% OF PATIENTS ARE ASSESSED FOR RISK OF VENOUS THROMBOLYTIC EVENT

VTE risk assessment prior to surgery supports identification of patients at risk and enables the implementation of an appropriate care plan to minimise the risk and support safer surgery.

The Royal Orthopaedic Hospital has a multi-disciplinary VTE Advisory Group which:

- Ensures that all policies and procedures relating to the care and management of VTE are kept up to date
- Reviews all RCAs undertaken following identification of VTE to ensure that learning is identified and actions implemented
- Ensures that the Trust follows all national guidelines for VTE
- Is responsible for setting up and delivering training to all staff groups within the hospital.

NICE recommend that all patients are risk assessed for VTE on admission to hospital. The expected national compliance level is 95%. ROH have consistently achieved this level of compliance since August 201

The Trust has consistently achieved this measure since August 2013 with > 98% of all patients receiving appropriate risk assessment during 2015/16. Table 33 provides month by month evidence of compliance with the national standard.

TABLE 33: COMPLIANCE WITH VTE ASSESSMENT 2015/16

Month	No Assessed	No Admitted	Percentage (%)
Apr-15	978	986	99.2
May-15	953	962	99.1
Jun-15	1003	1020	98.3
Jul-15	1070	1086	98.5
Aug-15	932	940	99.1
Sep-15	1058	1065	99.3
Oct-15	1107	1120	98.8
Nov-15	1001	1008	99.3
Dec-15	1013	1027	98.6
Jan-16	1010	1021	98.9
Feb-16	999	1016	98.3
Mar-16	1017	1025	99.2

Work will continue through 2016/17 to ensure that this standard is maintained and delivered in order to ensure the

best outcome for our patients. On the basis of the evidence presented, the Trust considers that this priority is met for 2015/16.

3.2.3 ENABLING STAFF TO FEEL ABLE TO RAISE CONCERNS

The importance of staff feeling able to raise concerns and feeling confident that there concerns are taken seriously and responded to has been well described in the Francis report (2014). The publication of the Freedom to Speak Up report in 2015 further emphasised the importance of enabling staff who work in NHS services to speak out when something is of concern to them.

In response to the recommendations containing within that report, , ROH held a series of 'New Beginnings' events across the organisation early in 2015/16 which provided staff with an opportunity to prioritise actions arising from the annual national Staff Survey, and identified that 'raising concerns' was the top priority. This reflected a long term issue for the Trust, in that National Staff Survey reports for the previous six years indicated that ROH staff have much less confidence in the 'fairness and effectiveness of reporting procedures' than their colleagues in other specialist Trusts.

The Trust recognises that perceptions of a lack of fairness and effectiveness relating to raising concerns have a significant impact on the wider morale of the staff. They are very likely to be reflected in other highly visible staff survey key findings, including recommendation of the Trust as a place to work or be treated, staff motivation, and staff ability to contribute to improvements at work.

On completion of the 'New Beginnings' events, the Trust agreed to use the NHS Employers 'Draw the Line' campaign as the vehicle through which to monitor progress and improvement on matters relating to 'raising concerns'.

In August 2015 a 'Draw the Line' self-assessment was completed by a group of staff from across divisions and professions, and the key findings were that improvements were needed in incident reporting and in policies related to raising concerns.

During 2015/16 the Trust has made good progress in defining the factors that limited engagement with this important indicator of staff satisfaction at work and has developed a detailed action plan in order to respond to these factors as detailed in Table 34 below. It is of note the number of incidents reported by staff has significantly increased during this period.

TABLE 34: PROGRESS AGAINST ACTION PLAN DEVELOPED FOLLOWING NEW BEGINNINGS EVENTS

Subject	Detail	Who responsible	Update to TMC
Incident reporting	A backlog of unclosed incidences was identified following review of the data base in July 2015. It is believed that this has significantly contributed to a lack of feedback to staff following reporting. An incident closure plan is in place. The Ulysses incident reporting system is being upgraded to allow the closed incident report to be sent automatically to the person who reported the event so that feedback is assured. Regular feedback sessions to consultant and other staff are now part of the monthly Clinical Audit meeting	Head of Clinical Governance	August 2016

Subject	Detail	Who responsible	Update to TMC
Policy updates	Speak up / Whistleblowing/Grievance The national Freedom to Speak Up policy published in March mandates the appointment of a Speak Up Guardian, and detailed guidance has been issued defining the requirement s of the post and relevant processes for concerns to be raised. The Grievance policy will be refreshed and adapted to take account of, and integrate with, the requirements of the national 'Freedom to Speak Up' policy.	Head of L&OD Head of L&OD	June 2016 June 2016
FTSU Guardian	Our Commissioners have advised that the policy must be adopted no later than 31 March 2017. The ROH Speak Up Guardian post is being developed and will be appointed by the end of Q2. The Trust will adopt the national role guidance in developing the post. It is envisaged that the post will be 0.4 FTE, appointed in the Governance team, to provide the required support to staff, and to have ready access to reports and trends from the incident reporting system. Appoint to post	Head of HR Head of HR Head of HR	July 2016 Sep 2016
Reassessment	Utilise 'Draw the Line' self- assessment tool, with support from colleagues across the Trust	Head of L&OD	October 16

The Trust recognises that it is some way off achieving the desired outcome that all our staff feel confident that when they raise a concern of any kind, they are listened to, their view is respected, and they receive feedback to demonstrate that appropriate learning has taken place.

Managers will need to work closely with their individual team members through 2016/17 in order to overcome the widely held perception that our reporting systems are unfair and ineffective.

However the Trust has taken significant steps in identifying the barriers and enablers that will enable staff to raise concerns with confidence and for this reason considers that it has met the quality priority to create the conditions which will enable staff to confidently raise concerns.

The engagement of staff in this important measure of service quality will be included as part of the audit that is undertaken in quarter 2 2016/17 following introduction of the revised 'Incident Reporting Policy' and delivery of associated engagement session through quarter 1 2016/17.

3.3

CLINICAL EFFECTIVENESS OBJECTIVES

3.3.1 TO ACHIEVE CONSISTENT COMPLIANCE WITH THE WHO CHECKLIST

The World Health Organisation (WHO) Checklist was developed as a Patient Safety Initiative to reduce errors in surgery

and to increase communication between surgical teams. Use of the WHO checklist has been shown to significantly reduce morbidity and mortality and it is now standard practice internationally.

The measurement of both completeness of the checklist (all items on the checklist completed) and implementation (number of checklists completed vs number of case completed) is undertaken by the theatre team and reported on a monthly basis through the Quality and safety Report to the Quality and Safety Committee. It is also reported externally to the lead CCG through the monthly Contract Quality Meeting .

In 2015/16 the Trust agreed local targets with the CCG of 100% for implementation and 99% compliance. During 2015/16 ROH made significant improvements in compliance with the WHO checklist as shown in Table 35 A and B:

TABLE 35 A WHO CHECKLIST : IMPLEMENTATION AND COMPLIANCE 2014/15

Operational Standard	APR-14	MAY-14	JUN-14	JUL-14	AUG-14	SEP-14	OCT-14	NOV-14	DEC-14	JAN-15	FEB-15	MAR-15
WHO Checklist implementation	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
WHO Checklist completion	98.69%	96.88%	97.34%	96.32%	97.69%	95.92%	97.96%	98.23%	97.81%	99.50%	98.90%	99.64%

TABLE 35 B WHO CHECKLIST: IMPLEMENTATION AND COMPLIANCE 2015/16

Operational Standard	Threshold	APR-15	MAY-15	JUN-15	JUL-15	AUG-15	SEP-15	OCT-15	NOV-15	DEC-15	JAN-16	FEB-16	MAR-16
WHO safety checklist Compliance	100%	100.00%	100.0%	100.0%	100.00%	100.0%	100.0%	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%
WHO Safety Checklist completion	98% up to February 2015 and 99% from march 2015	99.64%	97.42%	99.12%	99.15%	99.07%	99.15%	99.86%	99.16%	99.79%	98.57%	99.86%	99.80%

The Trust consistently records 100% against implementation of the checklist and has achieved the local target for compliance for 10 out of 12 months during 2015/16 as against achievement of compliance for 2 out of 12 months in the same period 2014/15.

3.3.2 TO ENSURE A ROBUST AND REGULAR SCHEDULE OF QUALITY ASSURANCE VISITS (EFFECTIVENESS)

A regular programme of Quality assurance Visits has been developed and commenced in April 2016. The teams attending the wards are drawn from a range of stakeholders including staff governors, NEDS and students.

The programme is based on the CQC key Lines of Enquiry and the findings of the programme are reported to Clinical Quality Group on a monthly basis.

The programme will be developed through 2016/17 to include members of the public and colleagues from the local CCG to ensure objective assessment takes place

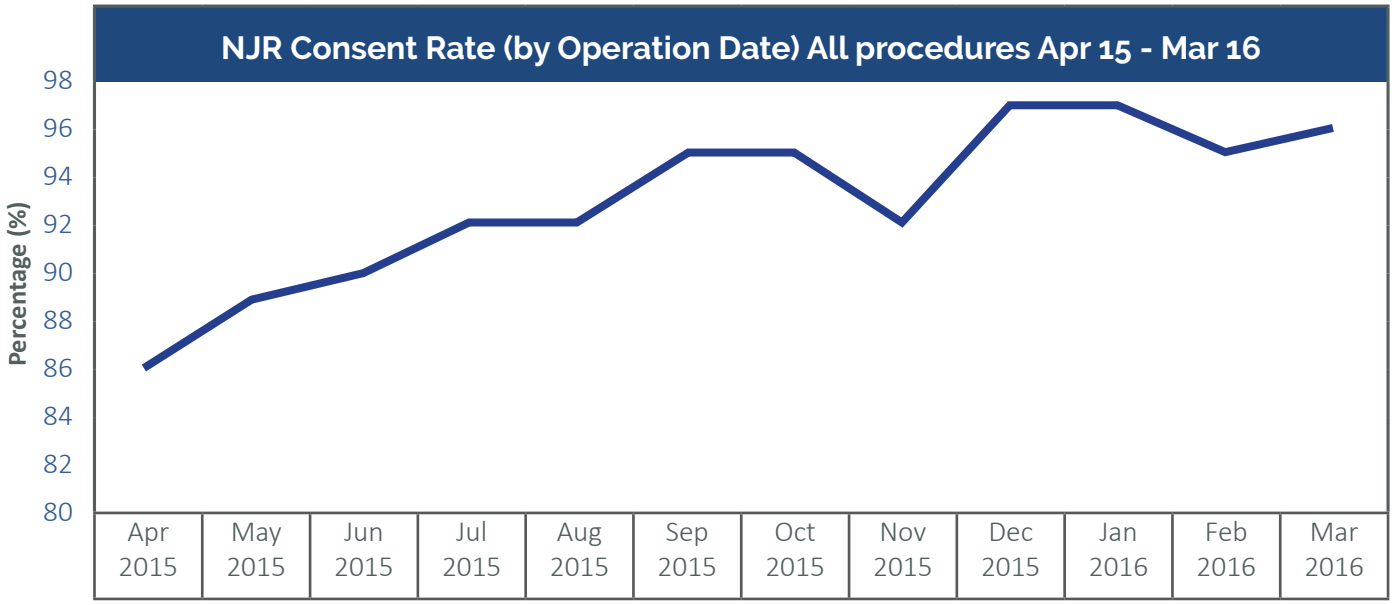
On the basis that the programme has been implemented, the Trust considers that this measure has been met.

3.2.3 TO BE COMPLIANT WITH NATIONAL JOINT REGISTRY (NJR) STANDARDS OF CONSENT AND REPORTING (EFFECTIVENESS)

The NJR consent rate is measured as the percentage of cases submitted to the NJR with patient consent confirmed. This is rated as Red if lower than 80%, Amber between 80-95% and Green if 95% or more. For the period April 2015-March 2016 the trust is rated Amber.

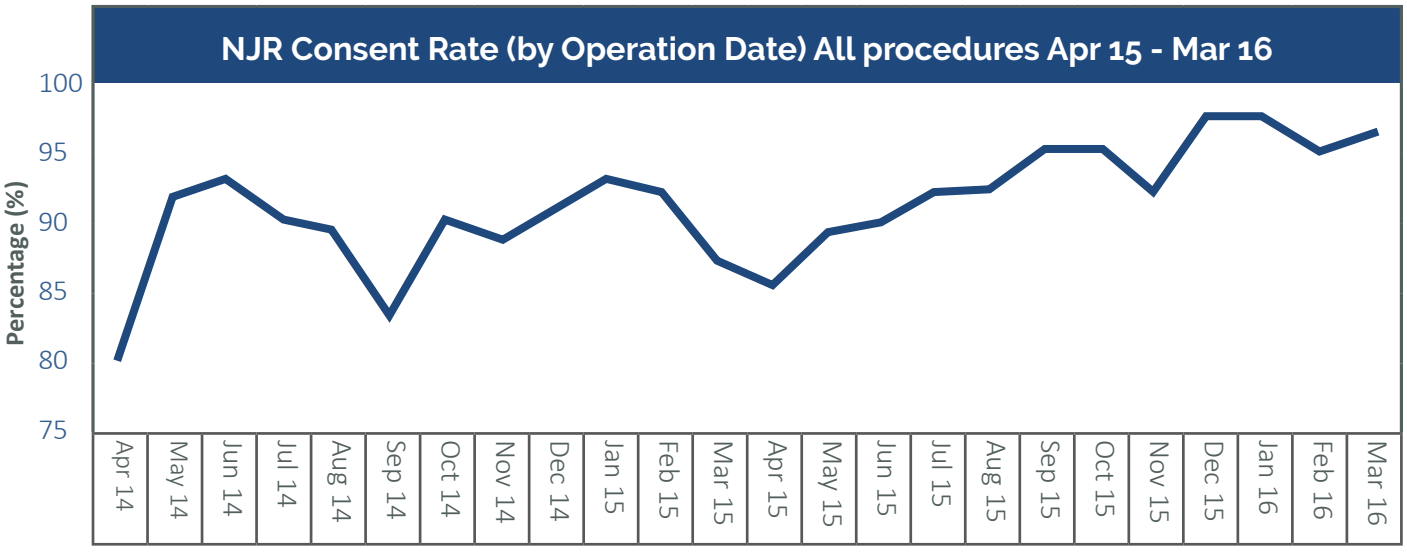
As shown below there has been improvement throughout the year in recording of consent and the trust has met the 95% (green) target in the last 4 months. There has been a significant improvement in consent rate since April 2014 as shown in tables 36 and 37 below.

TABLE 36: NJR CONSENT RATE 2015/17



Source NJR: StatsOnline

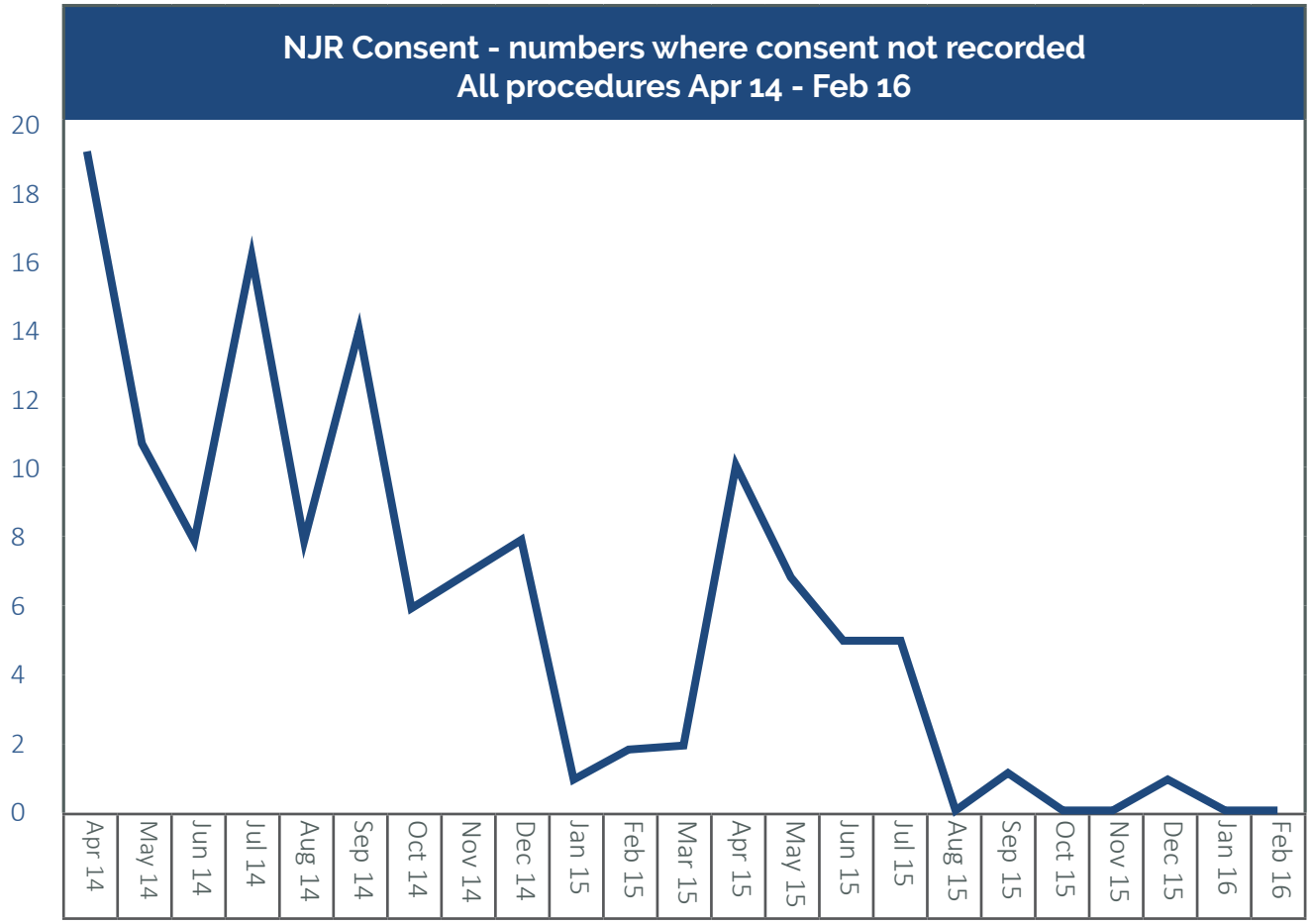
TABLE 37: NJR CONSENT RATE 2014/15



Source NJR: StatsOnline

The numbers of patients where consent is not recorded has decreased throughout 2015/16 with two patients having no record of consent since August 2015 as compared to 39 for the same period last year. Table 38 represents the reduction in the numbers of unrecorded consent over time.

TABLE 38: NUMBERS OF PATIENTS WHERE CONSENT NOT RECORDED (APRIL 2014 TO FEBRUARY 2016)



Source NJR: StatsOnline

Further improvements are being made to the process of recording consent with a view to ensuring a higher consent figure. Exception reports are being developed to identify patients who have not consented at their pre-operative assessment to enable any patients missed to be consented on admission.

Whilst recognising that improvement against this indicator must be continuous and sustained, the Trust considers that it has met the Quality Priority to increase compliance with NJR consent reporting.

3.4

PATIENT EXPERIENCE OBJECTIVES

3.4.1. TO REDUCE THE LENGTH OF TIME PATIENTS ARE STARVED BEFORE SURGERY TO LESS THAN 10 HOURS

Fasting for a long time before surgery is recognised to potential increase risk to patient and to contribute to increase incidence of:

- Dehydration
- Malnutrition
- Electrolyte imbalance
- Hypoglycaemia

For this reason the Royal College of Anaesthetists (2010) and the RCN (2005) recommends that a patient is fasting before surgery for no longer than 6 hours for solid food and for no longer than 2 hours for clear fluids (water).

During 2016/17 ROH undertook significant work in order to increase compliance with these guidelines including:

- The provision of water and water prescriptions for all patients who attend for surgery through our Admission and Day-case Unit (ADCU)
- Review of fasting times for individual patients on completion of WHO checklist and revision of fasting times if necessary
- A review of all policies and procedures led by the corporate lead for nutrition
- Annual audit of Nil by Mouth compliance
- Reporting of fasting times on a bi-monthly basis through the Nutritional steering Group with oversight of compliance through the Clinical Quality Group

3.4.2 TO ENSURE PATIENTS WAIT NO LONGER THAN 60 MINS TO TRANSFER FROM RECOVERY TO THE WARD

Delays out of recovery have a negative impact on patient experience in that they compromise the patient's privacy and dignity and reduce access to friends and family.

During 2015/16 ROH undertook local audits which demonstrated that patients often waited for more than 60 minutes once deemed fit for discharge from recovery to the ward. A number of key reasons were identified including availability of staff to facilitate discharge and bed availability.

Improvement to discharge time from recovery was identified as a priority by the operational team following the introduction of the daily patient flow 'huddle' in December 2015. Discharge times are now reviewed on a daily basis and any delays greater than 1 hour are subject to internal review in order to identify cause and reduce the likelihood of recurrence.

There are still sometimes delays in discharging patients from recovery however the measures described above have effectively reduced the number of patients experiencing long waits in recovery from a total of 78 hours in January 2016 to a total of 29 hours in March 2016; an average of three patients a day to an average of 1 patient per day. The length of time these patients wait has also reduced from an average of 3.3 hours to 2.5 hours.

Whilst recognising that there is still work to do in ensuring that the standard is consistently applied for all patients, the inclusion of this measure in the daily huddle and upward reporting of exceptions through the Divisional Teams means that the Trust considers that this measure has been met for 2015/16. The majority of our patients are transferred from recovery in a timely manner and do not experience undue delay.

3.4.3 TO ENSURE PATIENTS GET ENOUGH HELP TO EAT THEIR MEALS

The Trust considers that it has met this priority for the following reasons:

- A protected mealtimes policy has been developed and launched across the Trust.
- 24 hour Food Access Policy has been written to guide staff as to what and where food is available when the catering department is closed.
- A new Red tray/ red jug policy is currently being written to enable easier identification of patients who require help with meals
- Nutritional Assessment Policy (MUST/STAMP) has been written to give the underpinning knowledge to facilitate the nutrition and hydration needs of patients. We have trained 'train the trainers' across the Trust to in 2016 to facilitate the assessment and ensure the competency of trained staff is to required standards.
- Currently updating and developing new Food Charts for easier documentation of patients dietary intake for clearer future assessment/analysis.

3.5

COMPLAINTS AND PALS

During 2015/16 the Trust has received 113 formal complaints. This is a marginal increase compared with 2014/15 when 105 formal complaints but overall a steady decrease since 2013/14 as shown in Table 39 below. In 2015/16 , the Trust has continued to review its processes for responding to complaints and in the final quarter of 2015/16 a revised Complaints and Pals Policy was developed in order to ensure that all the recommendations of the Clywd/Hart Review (2013) and Francis (2013) report were responded to.

The Patient Experience department continues to manage incoming complaints in a pro-active manner. Time scales for investigations vary depending on the complexity of the complaint. We continue to aim for resolution in 25 working days; however local resolution meetings at an earlier stage in the complaint will be offered as routine to all service users during 2016/17 as there is evidence to support the effectiveness of this process. The Trust follows the PHSO Principles of Remedy when responding to formal complaints

- Getting it right
- Being customer focussed
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

TABLE 39: COMPLAINTS AND PALS 2013-2016

	PALS	Complaints
2013/2014	1016	146
2014/2015	1621	105
2015/2016	1094	113

Top three categories for Complaints through 2015/16 were:

- Communication
- Clinical Outcome
- Appointment delay/cancellation

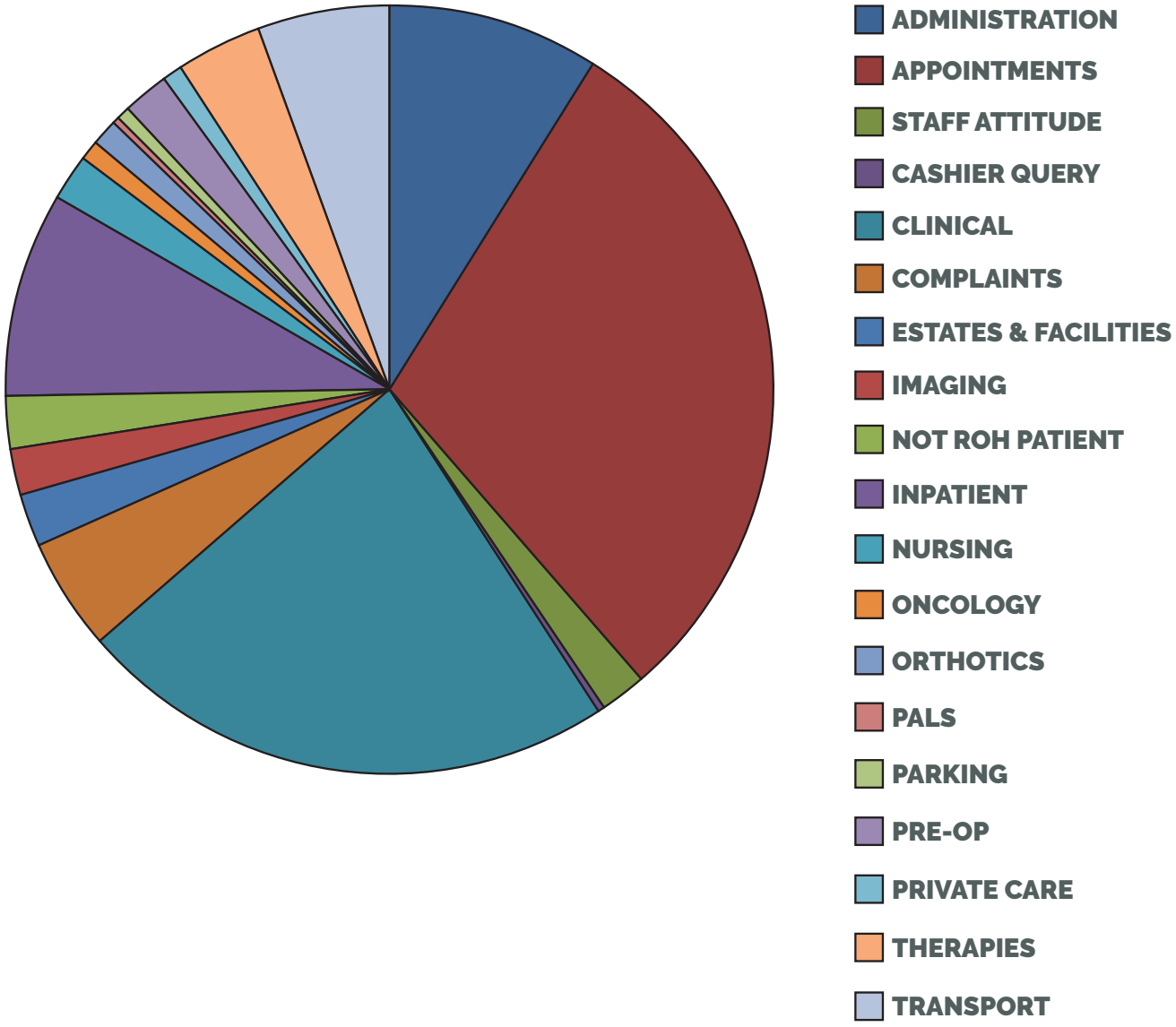
The themes have been shared with Divisional teams and action plans developed to respond to the issues raised.

3.5.1 PALS 2015/2016

The Patient Experience team have continued to work towards delivery of a responsive PALs service through 2015/16. Contacts are made through a range of sources including face to face, telephone and email. Contacts through PALS are not necessarily a concern or problem but can be an enquiry. Each contact is assessed individually and proactive measures are taken to assist as efficiently and effectively as possible.

The top 3 categories for PALs contacts are Appointments Queries, Clinical Queries and Administration Queries respectively with a detailed breakdown of activity shown in table 40 below.

TABLE 40: CATEGORIES OF PALS CONTACTS 2015/16



3.6

SAFEGUARDING ADULTS AND CHILDREN AT ROH

During 2015/16 we have further strengthened our safeguarding procedures to ensure the greater well-being and safety of our patient through the safeguarding process,. In July 2015 we published a revised Safeguarding Strategy which outlines the key objectives that we will deliver in order to safeguard the people who use our services. We will:

- Have a safe and effective workforce
- Ensure safeguarding is given high priority
- Making Safeguarding Personal – (the voice of the adult and children)
- Responsive to changes in Safeguarding Legislation requirements
- Learning and improve the care – key findings /requirements
- Work in partnership to delivery effective safeguarding externally and internally

- Effective systems for reporting, prevention, reporting, recording and learning
- Proactive in taking Learning Disabilities Care forward
- Improve awareness and practice with regard to Female Genital Mutilation (FGM)and Domestic Violence (DV)

We have made good progress through 2015/16 in delivering against these key objectives as detailed below.

3.6.1 SAFEGUARDING CHILDREN

- We have amended our pre-operative assessment practices in order to ensure that concerns are identified early
- We have reviewed our care plans and pathway for Looked after Children in line with national and local safeguarding arrangements
- We have developed better guidance about consent for use with children and their parents/ guardians
- We have undertaken a review of the training needs of all our staff to ensure that all clinically facing staff can identify and respond to concerns about Children.
- We have increased the number of train the trainers within the organisation to enable delivery of Right Service Right Time 2015 update.

3.6.2 SAFEGUARDING ADULTS

- We have developed a notification form to help staff report concerns , with a step by step approach to actions to be taken.- (this is for both child and adults SG concerns /issues)
- We have ensured that a safeguarding patient story has been shared with Trust Board on a regular basis , also with champion /link professionals to help share good practice and highlight areas for improvement and lesson learnt, to improve and protect patients. Working on ensuring the patients voice is being heard and acted upon.
- We have hosted roadshows on Domestic Violence, FGM and CSE and Mental Capacity ;through 2015/16 to engage with staff and the public in awareness raising and appropriate response
- We have undertaken a review of the training needs of all our staff to ensure that all clinically facing staff can identify and respond to concerns about adults at risk.
- We have built on Partnership working with Women's Aid , and Autism Charity to raise awareness and providing champions with update and insight into work and areas and tools to protect, promote and empower patients in their care.
- We have updated the Trust intranet updated for staff to aid in accessing information and advice ,when issues or concerns about protection and safety of a child ,young person or adult at risk.

The focus of activity through 2016/17 will be:

- The Development and Launch of a Learning Disability strategy and improving the services and access and support for patients and carers as required . which will be supported by the community health facilitation team undertake roadshow to gain patients and users feedback ideas , experience to assist in the formulation of the work plan for 16/17 service developments and areas of focus.
- The Trust will be supporting investment in training for Safeguarding Champions gaining exposure to wider safeguarding issues and concerns and feedback from local and national investigations.

For Children we will focus on:

- Partnership and joint working with CCG Named Nurse for CSE , to raise awareness and deliver staff training on assessment and referral for patients.
- Staff education and training on Domestic Abuse assessment tool and guidance on responding to disclosures with risk assessment and signposting as appropriate.
- Deliver bespoke workshops on the child's voice and having difficult conversations with families that are struggling/not engaging with services.
- The Development and implementation of a Transitional Care Policy

For Adults we will focus on :

- Working with Birmingham Community Safety Partnership and Aquarius and the Fire Service – with regard to improving referral pathways
- Developing Information so that it is easily accessible for the general public on safeguarding
- The development of "Fact sheets for staff " building upon the intranet information for staff.

3.7

MAINTAINING STANDARDS ACROSS THE BOARD: COMPLIANCE WITH NATIONAL TARGETS AND THE REGULATORY REQUIREMENTS

Table 41 overleaf shows the key indicators used to assess the overall quality of our performance during the last year. Specifically, these highlight our performance against the relevant indicators and performance thresholds as set out in Appendix A of the Risk assessment Framework.

Despite the challenges presented by referral of patients for specialist services, we have continued to achieve good compliance with the cancer targets during 2015/16. We remain challenged by the demand for spinal deformity services and as last year, have continued to develop plans in order to respond to increasing demand and complexity. This has included outsourcing our teams and services to other centres including the Cromwell Hospital and initiating discussion with commissioners and other providers to maximise potential for performing this surgery in other suitable centres.

National target	08/9	09/10	10/11	11/12	12/13	13/14	14/15	15/16	Target
MRSA	Achieved 2 cases	Achieved 0 cases	Achieved 0 cases	Achieved 0 cases	Achieved 0 cases	Achieved 0 cases	Achieved 0 cases	Achieved 0 cases	0
C diff	Achieved 7 cases	National target - achieved Local target – not achieved in 9 cases	National target – achieved Local target – not achieved in 8 cases	Achieved 6 cases	Achieved 1 case	Achieved 2 cases, both un-avoidable	Achieved 0 Avoidable cases	Achieved 0 Avoidable cases	0 Avoidable cases
31 day subsequent treatment all cancers	NA	Achieved 100%	Achieved 100%	Achieved 99%	Achieved 100%	Achieved 100%	Achieved Q1 100% Q2 97.8% Q3 100% Q4 100%	Achieved Q1 100% Q2 100% Q3 100% Q4 100%	94% standard
31 diagnosis to treatment all cancers	Achieved 100%	Achieved 100%	Achieved 99.3%	Achieved 100%	Achieved 100%	Achieved 100%	Achieved 100%	Achieved Q1 100% Q2 97.1% Q3 100% Q4 100%	96% standard
62 day referral to treatment of all cancers	Achieved 92%	Not applicable due to low number of patients	Achieved 98.3%	Achieved 94.7%	Achieved 95.3%	Qtr1 90.5% Qtr2 82.6% Qtr3 89.5% Qtr4 100%	Q1 90.48% Q2 90% Q3 85.71% Q4 87.50%	Q1 77.8% Q2 100% Q3 86.4% Q4 87.5%	85% standard
2 week cancer wait	Achieved 100%	Achieved 99%	Achieved 99.5%	Achieved 99%	Achieved 100%	Achieved 100%	Achieved Q1 100% Q2 100% Q3 99.09% Q4 100%	Achieved Q1 98.1% Q2 99.4% Q3 100% Q4 99%	93% standard
92% incomplete pathway	N/A	N/A	N/A	N/A	Not achieved full year (achieved March 2013)	Achieved 93.5%	Achieved 94.53%	Achieved 92.79%	92%
Access to healthcare for people with learning disabilities	N/A	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Not Achieved	

3.8

MAINTAINING CONTINUOUS QUALITY IMPROVEMENT AT ROH

3.8.1 CONTINUING FOCUS ON QUALITY IMPROVEMENT IN OPERATIONAL PERFORMANCE

In line with national guidance the Trust is committed to improving quality and to this end agreed a series of CQUIN schemes in conjunction with Commissioners during 2014/15.

Once agreed the schemes are cascaded down from Directors to operational and clinical leads who are responsible for the delivery of the CQUIN schemes. Progress towards achievement of the schemes is monitored quarterly at the appropriate subcommittee of the Trust Board and discussed and agreed with commissioners at monthly contract review meetings.

The Trust also has an agreed set of clinical performance indicators which form the basis of its contracts with commissioners and are monitored at monthly contract review meetings.

3.8.2 DEVELOPING A NURSING STRATEGY

The Trust will develop a new nursing strategy in 2015 that will outline the trusts ambitions for the profession through until 2018. Key stakeholders meet during Quarter 4 2015/16 to develop the outline plans with publication of the strategy expected in June 2016. Areas that are expected to feature in the strategy include:

- A focus on improving safety and experience for patients through nursing practice
- A focus on the development of clinical leadership
- A focus on recruitment and retention of nursing staff
- A focus on training and development
- A focus on delivering the objectives outlined in the Dementia strategy

3.8.3 VANGUARD

The Royal Orthopaedic Hospital is part of the National Orthopaedic Alliance vanguard which aims to create a UK-wide network of orthopaedic providers to deliver outstanding and consistent care in more areas. Also part of the National Orthopaedic Alliance Vanguard will be Robert Jones and Agnes Hunt Orthopaedic Hospital in Oswestry and Royal National Orthopaedic Hospital in Stanmore.

The vanguard partners will explore ways of formally collaborating to understand how they could extend their model more widely across the country. This work builds on our already established base of collaboration and will formalise the way organisations work together on a clinical basis as well as through processes and procurement. Only 13 proposals were taken forward by NHS England of a possible 65, so this is an excellent opportunity for ROH to strengthen collaboration, support improved outcomes and spread good practice. For patients it has the potential to help deliver higher quality care more consistently across the country.

PART FOUR

STATEMENTS OF ASSURANCE:

4.1

STATEMENT OF DIRECTORS RESPONSIBILITY IN RESPECT OF THE QUALITY REPORT.

The directors are required under the health act 2009 and the national health service (Quality Account) Regulations to prepare Quality Accounts for each financial year. Monitor (NHS I0 has issued clear guidance to NHS Trusts Boards on the form and content of the quality report and on the arrangements that the Trust Board should put in place to support the quality of data included in the report. In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

2015/16 Statement of Directors' Responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 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) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report. In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015 and Supporting Guidance
- The content of the Quality Report is not consistent with internal and external sources of information, including:

1. Board minutes and papers for the end period April 2015 to March 2016
2. Papers relating to quality reported to the board over the April 2015 to March 2016
3. Feedback from the commissioners, dated 23rd May 2016
4. Feedback from local Healthwatch organisations, dated 13th May 2016
5. The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated November 2015
6. The latest, accessible national patient survey, dated 14th May 2015
7. The latest national staff survey, dated February 2016
8. The Head of Internal Audits annual opinion over the Trust's control environment

The Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered in that:

- The performance information reported in the quality report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the quality is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to

appropriate scrutiny and review; and the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at **www.monitor.gov.uk/annualreportingmanual**) as well as the standards to support data quality for the preparation of the quality report (available at **www.monitor.gov.uk/sites/all/fckeditor/plugins/ktbrowser/openTKFile.php?id=3275**).

The directors confirm to the best of their knowledge and belief they have compiled with the above requirements in preparing the Quality Report.

By order of the board

Chair

Date: 27.05.2016

Chief Executive

Date: 27.05.2016

4.2

COMMENT FROM HEALTHWATCH BIRMINGHAM REGARDING THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST QUALITY ACCOUNT 2015/16

Dear Garry Marsh,

Thank you for sending us a draft copy of Royal Orthopaedic Hospital NHS Foundation Trust Quality Account 2015/16.

At Healthwatch Birmingham we are passionate about putting patients, public, service users and carers (PPSuC) at the heart of service improvement in health and social care in the City of Birmingham. In line with our new strategy, we are focused on helping drive continuous improvement in patient and public involvement (PPI) and patient experience. We also seek to champion health equity so that PPSuC consistently receive care that meets their individual and collective needs. We have therefore focused our comments on aspects of the Quality Account which are particularly relevant to these issues.

Quality priorities 2015/16

We note the reported measures taken to ensure patients wait no longer than 60 minutes to transfer from recovery to the ward. It is encouraging to see that discharge times are now reviewed on a daily basis, and any delays greater than one hour are subject to internal review. Unfortunately, the draft we have received does not contain information on the impact of these changes on the average discharge time from recovery (although it is implied that this information will be included in the final version). There are also no data provided on how many patients did wait over 60 minutes to transfer from recovery to the ward in 2015/16 compared with 2014/15. This makes us unable to comment on the Trust's assessment that this priority has been achieved for 2015/16.

It is disappointing to see that the Trust has not achieved the 2015/16 quality priority: 'To reduce the length of time patients wait in outpatients clinics to less than 60 minutes'. We agree that long waiting times can be frustrating for patients, and we support the intention to reduce waiting times in clinic so that no patient waits over 30 minutes for their appointment by end March 2017 (priority 5). However, we would appreciate more clarity on how the Trust has performed against this priority in 2015/16 (such as data on the proportion of patients waiting longer than 60 minutes compared with last year), the reasons why this priority has not been met, and what actions have been identified going forward to address this issue. Also, whilst we assume that one of the reasons priority 5 has been included in the 2016/17 priorities is because of the failure to meet this 2015/16 priority, this has not been made explicit. We would ask the Trust to make this clearer in the 'Priorities for improvement in 2016/17' section of the Quality Account.

We are pleased to see that the Trust has been working to ensure patients get enough help to eat their meals. However, we would advise that the Trust seeks patient feedback to ensure this goal has been met. There is no evidence that patient feedback has been sought on this issue in the draft we have been given, so it is not possible for us to comment on the Trust's assessment that this goal has been met.

Quality priorities 2016/17

We are pleased to see that the Trust has used patient feedback/ surveys to identify some of its priorities. For example, the Trust has used findings for the most recent National Inpatient Survey to identify Priority 8: improve patient reported experience of pain management post-surgery. We also appreciate that a number of the Trust's 2016/17 quality priorities have the potential to improve the experience of PPSuC, including the aim to reduce the number of incidences of consent on the day to zero, and reducing waiting times and cancellations.

It is also encouraging that delivering the commitments outlined in the first year of the Dementia Strategy is a priority for the Trust in 2016/17 (priority 7). The plans outlined in the Quality Account have the potential to help improve patient and carer experience, reduce health inequities and increase patient and carer involvement in the development and delivery of services. We therefore look forward to seeing the progress delivered against this action plan reported in next year's Quality Account.

Patient feedback

We note that 95 per cent of patients surveyed as part of the Friends and Family Test (FFT) during 2015/16 said they were either 'likely' or 'extremely likely' to recommend the Trust's services to friends or family. We also appreciate the sample of comments from the FFT included in the Quality Account. We would find it useful to know whether these comments are representative of the general themes received through this feedback. If not, we would appreciate an overview of these themes to be included in the Quality Account. We would also value information on how the Trust has performed in responding to formal complaints this year, and the key learning taken from these complaints.

We are happy that the Trust intends to include evidence from the 2015 National Patient Experience Survey in the Quality Account. Unfortunately this data has not been included in the draft we have received, but we understand this will be provided in the final version.

CQUIN and CQC

It is positive to see that the Trust has achieved the CQUIN scheme 2015/16 'Patent Shadowing Project', subject to Q4 evidence. We support attempts by the Trust to improve services by using patient experience as a driver for change, and would be very interested to learn more about the key findings and achievements of this project when more information is available.

We note that, following on from a follow-up inspection by the CQC in July 2015, the overall status of the Trust remains 'Requires Improvement'. We also note the action plan provided in the Quality Account, and the progress the Trust is making to deliver this action plan. We look forward to seeing further progress reported in next year's Quality Account.

Thank you again for giving us the opportunity to review the Trust's Quality Account.

Yours Sincerely

Jane Upton PhD

Head of Evidence

4.3

STATEMENT OF ASSURANCE FROM BIRMINGHAM CROSSCITY CCG MAY 2016

1.1

As coordinating commissioner Birmingham CrossCity Clinical Commissioning Group (BCC CCG) has welcomed the opportunity to provide this statement for the Royal Orthopaedic Hospital's (ROH) Quality Account for 2015/16. The review of this Quality Account has been undertaken in accordance with the Department of Health guidance and Monitor's requirements, and the statement of assurance has been developed in consultation with neighbouring CCGs, NHS England (West Midlands) and the Birmingham CrossCity CCG People's Health Panel.

1.2

In the version of the Quality Account we viewed there were some gaps in data which we have not been able to validate, we assume, however, that the Trust will be populating these gaps in the final published edition of this document.

1.3

The review of progress made against the 2015/16 is clearly presented and the CCG is pleased to see that priorities that have not been achieved are being carried forward to 2016/17. However, it is felt that if the original targets for 2015/16 and attainment data were displayed it would better illustrate the progress and the achievements made by the Trust. It would also be useful to draw to the attention of the reader that this is reported in more detail later in the document.

1.4

There is a good mix of priorities for 2016/17and these are clearly set out with a rationale for why they have been highlighted. It may be useful to clarify what is meant by some of the comments such as "poor documentation" to make this clearer for the public.

1.5

It is especially pleasing to note that the Dementia strategy is having such a focus and commitment within the Trust, and the pledge to ensure that 100% of staff are trained and have an understanding of how to manage this particularly vulnerable patient group. It is also positive to note that the Trust is looking forward at the point of admission to ensure a safe and timely discharge.

1.6

Apart from the Dementia strategy, and in response to the Care Quality Commission (CQC) Registration and Compliance, there is no reference to safeguarding in the quality account and this is a fundamental omission. Safeguarding arrangements are integral to the wider quality, patient safety and experience agendas and are also a statutory responsibility for the Trust in relation to Adults and Children. We are aware that over the past year the Trust has expanded its safeguarding resource and has been active in developing its safeguarding arrangements, but this is not reflected in the account.

1.7

It is extremely positive to note the participation in national audits and confidential enquiries and the evidence of a strong and cultural participation in research; this is evidenced by the number of research projects completed and the number of staff participating.

1.8

Table 9 within the document shows the achievement of 2015/16 CQUINS, however it would be useful to have some explanation regarding the reasons why one was only seen to be partially achieved.

1.9

It is pleasing to see the detailed action plan responding to the Care Quality Commission (CQC) Registration and Compliance comments following their visit in July 2015, in particular it is excellent that areas of outstanding practice are celebrated. Further clarity would be useful to encourage the reader how these practices were going to be extended to ensure that this is taken up across the whole of the Trust. Whilst it is acknowledged that there has been recruitment of Paediatric nurses it would be useful to understand what the desired projection of Paediatric nurse

recruitment is for 2016/17.

1.10

It is noted that table 15 and table 22 are duplicates, but labeled slightly differently which is confusing for the reader.

1.11

It is encouraging to see the importance that infection control plays within the Trust. It would be positive to consider including the length of time that there have been no cases of MRSA as this is currently omitted. The review of cases brings to life the issues that are emerging; it would be useful for the reader to be more informed about the Bone Infection Unit, as would a more readable format for this section to enable the public to have a clear understanding of the role of the bone unit and also the impact of the issues on patients. One case is reported as a ribotype 027; clarification is required as to why this is particularly stated. It is also not clear whether it is an infected massive endoprosthesis; or a massive infection. This needs further explanation to clarify the meaning, or re-wording. It may also be useful to mention that oncology patients are at increased risk of C-difficile.

1.12

Whilst it is pleasing to see that Friend and Family Test (FFT) data and Staff survey data is included within the quality account, it was felt that this data is not well presented as it does not show clear comparisons with previous years or other Trusts. Staff survey results do not clearly state the question asked (graph 27 page 49); also staff survey results for table 26 show data combined into 'other responses'. It would have been useful to have seen the overall response rate for both staff and patient FFT surveys benchmarked against national average and the trend over the last 2 or 3 years.

1.13

There is no mention within the document of the national "Sign up to Safety" initiative and how the Trust is responding to the 5 national pledges.

1.14

Readers of the quality account might find it useful to have a glossary explaining technical terms and abbreviations; and where terms specific to the Trust are used an explanation should be included.

1.15

The quality account would have been enhanced and made a more interesting read with some positive patient stories, staff achievements or awards mentioned, and more reader friendly graphics/pictures/visuals etc.

Barbara King

Accountable Officer

Birmingham CrossCity Clinical Commissioning Group

Safeguarding Adults and Children at ROH

Independent auditor's report to the Council of Governors of The Royal Orthopaedic Hospital NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of The Royal Orthopaedic Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of The Royal Orthopaedic Hospital NHS Foundation Trust's quality report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of The Royal Orthopaedic Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Royal Orthopaedic Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Royal Orthopaedic Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 92% incomplete pathway (18 week Referral to Treatment); and
- 62 day referral to treatment of all cancers.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified below:
    - board minutes for the period April 2015 to March 2016;
    - papers relating to quality reported to the board over the period April 2015 to March 2016;
    - feedback from the Commissioners dated 23 May 2016;
    - feedback from local Healthwatch organisations, dated 13 May 2016;
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated November 2015;
    - the latest national patient survey dated May 2015;
    - the latest national staff survey, dated February 2016;

    - the Head of Internal Audit's annual opinion over the Trust's control environment; and
    - any other information included in our review.
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual', and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the documents listed above and specified in the detailed guidance for external assurance on Quality Reports (collectively the 'documents').

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the documents. Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

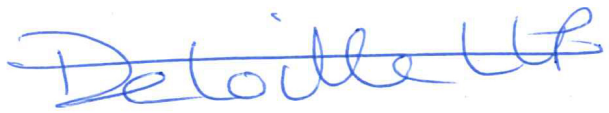
The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the Monitor 2015/16 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual'.



Deloitte LLP
Chartered Accountants
Birmingham
United Kingdom
27 May 2016


Outpatients
THE ROYAL ORTHOPAEDIC HOSPITAL BIRMINGHAM

The Royal Orthopaedic Hospital NHS Foundation Trust

Consolidated Accounts for the year ended 31 March 2016

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Opinion on financial statements of The Royal Orthopaedic Hospital NHS Foundation Trust

In our opinion the financial statements:

- **give a true and fair view of the state of the Group's and Trust's affairs as at 31 March 2016 and of the Group's and Trust's income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

The financial statements comprise the Consolidated Statement of Comprehensive Income, the Consolidated and Trust Statement of Financial Position, the Consolidated and Trust Statement of Changes in Taxpayers' Equity, the Consolidated and Trust Statement of Cash Flows and the related notes 1 to 28. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Going concern

We have reviewed the Accounting Officer's statement contained within the Annual Report that the Group is a going concern. We confirm that

- we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified any material uncertainties that may cast significant doubt on the Group's ability to continue as a going concern.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Group's ability to continue as a going concern.

Independence

We are required to comply with the Financial Reporting Council's Ethical Standards for Auditors and we confirm that we are independent of the Group and we have fulfilled our other ethical responsibilities in accordance with those standards. We also confirm we have not provided any of the prohibited non-audit services referred to in those standards.

Our assessment of risks of material misstatement	The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team.

Risk	How the scope of our audit responded to the risk
Recognition of NHS revenue and provisions There are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners, as detailed in note 1.2 due to: • the complexity of the Payment by Results regime, in particular in determining the level of overperformance and Commissioning for Quality and Innovation revenue to recognise; and • the judgemental nature of provisions for disputes and activity performance not yet settled, including in respect of outstanding overperformance income for quarters 3 and 4. The Group earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position. This risk refers to revenue from patient care activities of £74m (2014/15 £73m) as shown in note 3 to the financial statements.	We evaluated the design and implementation of controls over recognition of Payment by Results income. We performed detailed substantive testing on a sample basis of the recoverability of overperformance income and adequacy of provision for underperformance through the year, and evaluated the results of the agreement of balances exercise. We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners. We reviewed the contract setting process for 2016/17 contracts, and considered whether, for material contracts, taken together with the settlement of current year disputes, there were any indicators of inappropriate adjustments in revenue recognised between periods.
Property valuations The Group holds property assets within Property, Plant and Equipment at a modern equivalent use valuation as set out in notes 1.5. The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value. As at 31 March 2016 these assets, being land, buildings and dwellings, are valued at £35m (2014/15 £38m) and are included in note 12.1.	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Group to the Valuer. We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Group's properties, including through benchmarking against revaluations performed by other Groups at 31 March 2016. We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the

Risk	How the scope of our audit responded to the risk
	Income Statement or in Other Comprehensive Income.
Financial sustainability The Trust operates in an increasingly financially constrained environment, with significant ongoing cost pressures from Cost Improvement Programme (CIP) requirements. The Trust is reporting a deficit for the year of £6.4m for 2015/16 (2014/15 £1.4m surplus).	We reviewed the Trust's financial performance during the year and outturn position and challenged management's assessment of going concern. We reviewed documentation including board papers and the Trust's Board Assurance Framework to identify whether a robust diagnosis of the key issues has been made by the Trust. We reviewed the Trust's plans to recover the 2015/16 deficit, understanding and challenging management's arrangements to implement and govern the financial recovery plan.

Our report includes an additional risk, financial sustainability, which was not included in our report last year. This has been identified as a new risk in 2015/16, as a result of the deterioration in underlying financial performance and the recognition that the environment the Trust is operating in is becoming increasingly challenging.

The description of risks above should be read in conjunction with the significant issues considered by the Audit Committee discussed on page 6.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

We determined materiality for the Group to be £1.6m (2014/15: £0.9m), which is 2% of revenue (2014/15 0.8% of revenue). Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements. This is an increase compared to 2015 due to the increased revenue for the year and increased benchmark to 2%.

A lower materiality level was used for the testing of each component of the group. We determined materiality for the Trust to be £1.5m (2014/15: £0.9m).

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £79,300 (2014/15 £46,200), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our group audit was scoped by obtaining an understanding of the Group and its environment, including group-wide controls, and assessing the risks of material misstatement at the Group level.

The focus of our audit work was on the Trust, with work performed at the Trust's offices in Birmingham directly by the audit engagement team, led by the audit partner.

We performed specified audit procedures on the Trust's subsidiary, The Royal Orthopaedic Hospital NHS Charity, where the extent of our testing was based on our assessment of the risks of material misstatement and the materiality of the subsidiaries to the Group.

Our audit covered all of the entities within the Group, which account for 100% of the Group's net assets, revenue and surplus.

Our audit work was executed at levels of materiality applicable to each individual entity which were lower than group materiality.The range of materiality used was £0.8m to £1.5m (2014/15 £0.5m to £0.9m).

At the Group level we also tested the consolidation process.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- The part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- The information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;

- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

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.

Our duty to read other information in the Annual Report

Under International Standards on Auditing (UK and Ireland), 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;
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements.

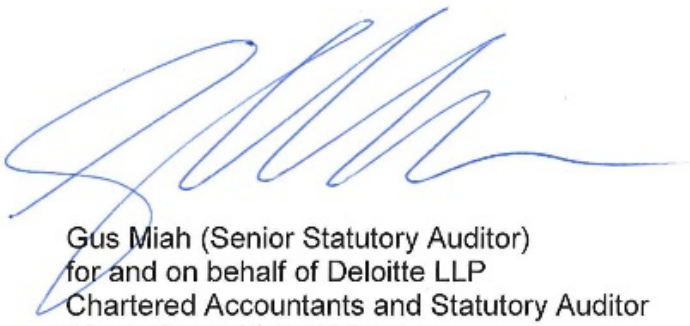
Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and International Standards on Auditing (UK and Ireland). We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team.

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of The Royal Orthopaedic Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Scope of the audit of the financial statements

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 the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. 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.



Gus Miah (Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Birmingham, United Kingdom
27 May 2016

Foreword to the accounts

The Royal Orthopaedic Hospital NHS Foundation Trust
Consolidated Accounts for the year ended 31 March 2016

These accounts, for the year ended 31 March 2016, have been prepared by The Royal Orthopaedic Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006 in the form which Monitor, the independent regulator of NHS Foundation Trusts has, with the approval of the Treasury directed.

Mrs. Jo Chambers

Chief Executive

Date: 27 May 2016

Consolidated Statement of Comprehensive Income for the year ended 31 March 2016

		Consolidated	
		Year ended	Year ended
		31-Mar-16	31-Mar-15
	Note	£000	£000
Operating income from patient care activities	3	74,020	72,867
Other operating income	4	7,556	7,510
Total operating income from continuing operations	2	**81,576**	**80,377**
Operating expenses	5, 7	(86,376)	(77,660)
Operating (deficit)/surplus from continuing operations		**(4,800)**	**2,717**
Finance income	9	63	74
Finance expenses	10	(127)	(31)
PDC dividends payable		(1,509)	(1,338)
Net finance costs		**(1,573)**	**(1,295)**
Movement in the fair value of investment property and other investments	13	(46)	27
(Deficit) / Surplus for the year from continuing operations		**(6,419)**	**1,449**
(Deficit) / Surplus for the year		**(6,419)**	**1,449**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(705)	325
Total comprehensive (expense)/income for the period		**(7,124)**	**1,774**
(Deficit) / Surplus for the period attributable to:			
the Foundation Trust		(6,419)	1,449
Total comprehensive (expense)/ income for the period attributable to:			
the Foundation Trust		(7,124)	1,774

All income and expenditure is derived from continuing operations. There is no surplus for the year attributable to minority interests.

The Trust has been subject to a valuation of its land and buildings during the current financial year. As a result, a loss has been identified, and recognised in the accounts. The element recognised in the Statement of Comprehensive Income is £3,238,000 (2014/15: £1,919,000 revaluation gain) as shown in note 6 Impairment. This is a technical or non-cash adjustment. For 2015/16 the Group had a deficit excluding this valuation loss of £3,181,000 (2014/15: £470,000 deficit).

Statements of Financial Position as at 31 March 2016

	Note	Consolidated 31 March 2016 £000	Consolidated 31 March 2015 £000	Trust 31 March 2016 £000	Trust 31 March 2015 £000
Non-current assets					
Intangible assets	11	484	595	484	595
Property, plant and equipment	12, 13	41,219	44,190	41,219	44,190
Other investments	13	690	735	-	-
Total non-current assets		**42,393**	**45,520**	**41,703**	**44,785**
Current assets					
Inventories	15	3,918	3,786	3,918	3,786
Trade and other receivables	16	5,008	6,290	4,838	6,287
Other financial assets	17	35	7	-	-
Cash and cash equivalents	18	11,873	13,895	10,598	13,748
Total current assets		**20,834**	**23,978**	**19,354**	**23,821**
Current liabilities					
Trade and other payables	19	(11,817)	(8,332)	(11,803)	(8,314)
Other liabilities	20	(257)	(397)	(257)	(397)
Borrowings	21	(163)	(157)	(163)	(157)
Provisions	22	(114)	(242)	(114)	(242)
Total current liabilities		**(12,351)**	**(9,128)**	**(12,337)**	**(9,110)**
Total assets less current liabilities		**50,876**	**60,370**	**48,720**	**59,496**
Non-current liabilities					
Borrowings	21	(221)	(384)	(221)	(384)
Provisions	22	(347)	(254)	(347)	(254)
Total non-current liabilities		**(568)**	**(638)**	**(568)**	**(638)**
Total assets employed		**50,308**	**59,732**	**48,152**	**58,858**
Financed by					
Public dividend capital		36,696	38,996	36,696	38,996
Revaluation reserve		2,036	2,741	2,036	2,741
Income and expenditure reserve		9,420	17,121	9,420	17,121
Charitable fund reserves	14	2,156	874	-	-
Total taxpayers' and others' equity		**50,308**	**59,732**	**48,152**	**58,858**

The notes on pages 14 of 55 form part of these accounts.

signed on its behalf by:

Mrs. Jo Chambers
Chief Executive
Date: 27 May 2016

Statement of Changes in Equity for the year ended 31 March 2016

Consolidated	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	NHS charitable funds reserves	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**38,996**	**2,741**	**-**	**-**	**-**	**17,121**	**874**	**59,732**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	-	-	-	(7,714)	1,295	**(6,419)**
Impairments	-	(705)	-	-	-	-	-	**(705)**
Other reserve movements	(2,300)	-	-	-	-	13	(13)	**(2,300)**
Taxpayers' and others' equity at 31 March 2016	**36,696**	**2,036**	**-**	**-**	**-**	**9,420**	**2,156**	**50,308**

Included within Other reserve movements is the amount of £2,300,000 agreed capital to revenue transfer from the Department of Health.

Statement of Changes in Equity for the year ended 31 March 2015

Consolidated	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	NHS charitable funds reserves	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2014 - brought forward	**38,996**	**2,416**	**-**	**-**	**-**	**15,634**	**912**	**57,958**
Surplus/(deficit) for the year	-	-	-	-	-	1,417	32	**1,449**
Impairments	-	325	-	-	-	-	-	**325**
Other reserve movements	-	-	-	-	-	70	(70)	**-**
Taxpayers' and others' equity at 31 March 2015	**38,996**	**2,741**	**-**	**-**	**-**	**17,121**	**874**	**59,732**

Statement of Changes in Equity for the year ended 31 March 2016

Trust Only	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**38,996**	**2,741**	**-**	**-**	**-**	**17,121**	**58,858**
Surplus/(deficit) for the year	-	-	-	-	-	(7,701)	**(7,701)**
Impairments	-	(705)	-	-	-	-	**(705)**
Other reserve movements	(2,300)	-	-	-	-	-	**(2,300)**
Taxpayers' and others' equity at 31 March 2016	**36,696**	**2,036**	**-**	**-**	**-**	**9,420**	**48,152**

Included within Other reserve movements is the amount of £2,300,000 agreed capital to revenue transfer from the Department of Health.

Statement of Changes in Equity for the year ended 31 March 2015

Trust Only	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2014 - brought forward	**38,996**	**2,416**	**-**	**-**	**-**	**15,634**	**57,046**
Surplus/(deficit) for the year	-	-	-	-	-	1,487	**1,487**
Impairments	-	325	-	-	-	-	**325**
Taxpayers' and others' equity at 31 March 2015	**38,996**	**2,741**	**-**	**-**	**-**	**17,121**	**58,858**

Consolidated Statement of Cash Flows for the year ended 31 March 2016

		Consolidated		Trust	
		2015/16	2014/15	2015/16	2014/15
Cash flows from operating activities	**Note**	**£000**	**£000**	**£000**	**£000**
Operating (deficit)/surplus		(4,800)	2,717	(6,098)	2,812
Non-cash income and expense:					
Depreciation and amortisation	5.1	2,347	2,343	2,347	2,334
Impairments and reversals of impairments/valuation gain	6	3,238	(1,919)	3,238	(1,919)
Loss on disposal of non-current assets	5.1	-	27	-	27
Income recognised in respect of capital donations	4	-	(80)	-	(80)
Decrease/(increase) in receivables and other assets		1,410	(1,778)	1,410	(1,780)
(Increase)/decrease in inventories		(132)	136	(132)	136
Increase/(decrease) in payables and other liabilities		3,776	(269)	3,776	(269)
(Decrease)/increase in provisions		(148)	83	(148)	83
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		(170)	12	-	-
Other movements in operating cash flows		(3)	-	(3)	-
Net cash generated from operating activities		**5,518**	**1,272**	**4,390**	**1,344**
Cash flows used in investing activities					
Interest received		36	46	36	45
Purchase of intangible assets		(54)	(299)	(54)	(299)
Purchase of property, plant, equipment and investment property		(3,596)	(5,367)	(3,596)	(5,356)
Receipt of cash donations to purchase capital assets		-	80	-	80
Investing cash flows of NHS charitable funds		-	102	-	-
Net cash used in investing activities		**(3,614)**	**(5,438)**	**(3,614)**	**(5,530)**
Cash flows used in financing activities					
Capital element of finance lease rental payments		(171)	(171)	(171)	(171)
Interest paid on finance lease liabilities		(14)	(19)	(14)	(19)
PDC dividend paid		(1,441)	(1,232)	(1,441)	(1,232)
Cash flows used in other financing activities		(2,300)	-	(2,300)	-
Net cash used in financing activities		**(3,926)**	**(1,422)**	**(3,926)**	**(1,422)**
Decrease in cash and cash equivalents		**(2,022)**	**(5,588)**	**(3,150)**	**(5,608)**
Cash and cash equivalents at 1 April		**13,896**	**19,484**	**13,748**	**19,356**
Cash and cash equivalents at 31 March	18.1	**11,874**	**13,896**	**10,598**	**13,748**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FREM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and certain financial assets and financial liabilities.

Going concern

After making enquiries due to the deficit this year, the directors have a reasonable expectation that The Royal Orthopaedic Hospital NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Significant accounting policies, judgments and sources of estimation uncertainty

Accounting policies that have been selected during the process of applying International Reporting Standards have been considered by management to ensure they assist users in understanding financial performance and financial position. Management is required to make various judgments and assumptions about the carrying amounts of assets and liabilities which require estimation of the effects of uncertain future events. Estimates and assumptions are based on historical experience and other factors that are considered to be relevant, all estimates and underlying assumptions are continually reviewed. Any revisions to accounting estimates are recognised in the period to which the revision relates.

Partially completed spells

Once a patient is admitted and treatment begins, income for a treatment or spell is accounted for within the financial statements. The income relating to those spells which are partially completed at the financial year end are apportioned across the financial year on a pro rata basis. This basis may be the expected or actual length of stay or may be based on the costs incurred over the length of the treatment.

Annual Leave provision

In accordance with the requirement of IAS 19, the Trust provides for unpaid annual leave carried forward by staff at year end. The total number of annual leave days that each of the Trust's employees has not taken at year end is accounted for within the financial statements. The number of unused days is multiplied by the employees' average salary per day, to give the total cost on individual cost centres.

Note 1.1 Consolidation

NHS Charitable Fund

The Royal Orthopaedic Hospital NHS Foundation Trust is the corporate trustee to The Royal Orthopaedic Hospital NHS Foundation Trust Charitable Fund ("the Charitable Fund"). The Royal Orthopaedic Hospital NHS 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 to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to eliminate intra-group transactions, balances, gains and losses. The Charity's accounts under UK FRS 102 were considered to identify whether any adjustments were required to bring them in line with The Royal Orthopaedic Hospital NHS Foundation Trust's accounting policies under IFRS. Adjustments were identified and amended.

The Charitable Fund's main accounting policies are as follows: Incoming resources

Income is recognised when the Charity has entitlement to the funds, any performance conditions attached to the item(s) of income have been met, it is probable that the income will be received and the amount can be measured reliably.

Donated professional services and donated facilities are recognised as income when the charity has control over the item, any conditions associated with the donated item have been met, the receipt of economic benefit from the use by the charity of the item is probable and that economic benefit can be measured reliably. In accordance with the Charities SORP (FRS 102), general volunteer time is not recognised - refer to the trustees' annual report for more information about their contribution.

On receipt, donated professional services and donated facilities are recognised on the basis of the value of the gift to the charity which is the amount the charity would have been willing to pay to obtain services or facilities of equivalent economic benefit on the open market; a corresponding amount is then recognised in expenditure in the period of receipt.

Resources expended

Expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party, it is probable that settlement will be required and the amount of the obligation can be measured reliably.

Fund accounting

Restricted funds are funds subject to specific restrictions imposed by the funding authorities and donors. These funds are not available for the Trustees to apply at their discretion. The purpose and use of the restricted funds is set out in the notes to the charities financial statements.

All incoming resources are included in full in the Statement of Financial Activities as soon as the following four factors can be met:

i) entitlement - arises when a particular resource is receivable or the charity's right becomes legally enforceable;

ii) certainty - when the trustees are virtually certain that the incoming resources will be received;

iii) measurement - when the monetary value of the incoming resources can be measured with sufficient reliability;

iv) apportionment - incoming resources that are not specifically attributable to a fund are apportioned quarterly pro rata to the value of each fund.

Investment management costs

Investment management costs are the fees charged by Schroder's for the management of the investment portfolio and are apportioned on the basis of fund values. The Trust is not currently incurring any investment management costs as part of its arrangement with Schroder's.

Grants payable

Grants payable are payments, made to third parties (including NHS bodies) in the furtherance of the Trust's charitable objectives to relieve those who are in poor health. They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant.

Non-current asset investments

Non-current asset investments are shown at market value.

i) There are no property assets.

ii) Quoted stocks and shares are included in the statement of financial position at mid-market price, ex div.

iii) Other non-current asset investments are included at Trustees' best estimate of market value.

iv) Non-current asset investments are program related investments.

Current asset investments

i) Comprise cash balances available for investment held in capital or income accounts.

ii) The investments generate dividends and interest, less administration costs.

iii) Investment current assets are program related investments.

Realised gains and losses

All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

Note 1.2 Income

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 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 subsequent following financial 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.

Note 1.3 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

NHS Pension Scheme

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:

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 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, 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 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 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 1 April 2016.

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 1 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.

Defined contribution scheme

The Trust offers a workplace pension and eligible employees are automatically enrolled, the Trust arranged a defined contribution scheme during 2013/14 to account for those individuals who are not eligible to join the NHS Pension scheme. The scheme is run by the National Employment Savings Trust. The contributions are as follows:-

	To Oct-17
Employer contribution	1%
Total contribution	2%

In the year to 31 March 2016 the Trust has made contributions of £2,560 to this fund, (2014/15 £2,396).

Note 1.4 Expenditure on other 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.

Note 1.5 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 Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably utilising the following criteria:
- individually have a cost of at least £5,000; or
- form a group of assets which individually have a cost of more than £200, 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 setting-up cost of a new building of a refurbishment of a ward or unit, irrespective of their individual or collective cost.
- Professional fees such as legal costs, design costs, planning fees and feasibility studies incurred in the construction/bringing the asset into use.

Measurement

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. All assets are subsequently measured at fair value.

Land and buildings are measured at fair value. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last independent asset valuations were undertaken on 31 March 2016 by Cushman and Wakefield. The revaluation undertaken at that date has been accounted for in these financial statements as follows:

- Land £4,518,585
- Buildings and Dwellings £29,711,642

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets (MEA) and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust has used this assumption with the revaluation.

Properties under construction for administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets depreciation commences when they are brought into use.

Operational equipment is valued at net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount. An item of land and buildings which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying value 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 Trust and the cost of the item can be determined reliably.

Where a component of 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 replaced is de-recognised.

Retentions that do not generate additional future economic benefits or service potential are charged to the Statement of Comprehensive income when final payment is made.

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 by straight line method. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon reclassification. Assets under construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

The economic useful lives of the main categories of assets, excluding land on which no depreciation is charged, are as follows:

Buildings – as per Professional Valuer's estimate - 26 to 83 years Plant and Machinery:
Engineering Plant and Equipment – short life 5 years Engineering Plant and Equipment – medium life 10 years Engineering Plant and Equipment – long life 15 years Medical Equipment – short life 5 years
Medical Equipment – medium life 10 years Medical Equipment – long life 15 years Decontamination Equipment – short life 2 years

Transport Equipment – 7 years
Information Technology – individually assessed based on type of asset - 3 to 10 years Furniture and Fittings:

- Furniture – short life 3 years
- Furniture – medium life 5 years
- Furniture – long life 10 years

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 recognised 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 service potential in the asset are charged to operating expenses regardless of existing revaluation reserves. 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.

An impairment that arises from a clear consumption of 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 is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated 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 imposes 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 to future financial years to the extent that the condition has not yet been met. Donated assets are accounted for in line with the principles set for government grants.
The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.6 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. 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. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Software

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. Expenditure on computer software which is deemed not to be integral to the computer hardware is capitalised as an intangible asset.

Intangible fixed assets are capitalised when:

- they are capable of being used in a trust's activities for more than one year;
- they can be reliably valued; and
- they have a cost of at least £5,000.

Purchased computer software licenses are capitalised as intangible fixed assets where expenditure of at least

£5,000 is incurred and amortised over the shorter of the term of the license and their useful economic lives.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Amortisation

Intangible assets are amortised by the straight line method, over their expected useful economic lives (3 to 10 years) in a manner consistent with the consumption of economic or service delivery benefits. The Trust deems the expected useful lives of intangible assets to be individually assessed based on type of asset.

Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to it technical feasibility and its resulting in a product or services that will eventually be brought into use;
- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Capitalised development costs are limited to the value of future benefits expected and are amortised through the Statement of Comprehensive Income on a systematic basis over the period expected to benefit from the project. Assets are re-valued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible, NHS foundation trusts disclose the total amount of research and development expenditure charged in the Statement of Comprehensive Income separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

Non-current assets acquired for use in research and development are depreciated/amortised over the life of the associated project.

Note 1.7 Revenue from government and other grants

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups or NHS trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

IAS 20 is applied to the accounting treatment of government and other grants with the following interpretations;

- The option to deduct the grant from the carrying value of the asset is not permitted.
- Grant income relating to assets is recognised within income when the foundation trust becomes entitled to it, unless the grantor imposes a condition that the future economic benefits embodied in the grant are to be consumed as specified by the grantor and if it is not, the grant must be returned to the grantor.
- Where such a condition exists, the grant is recognised as deferred within liabilities and carried forward to future financial years to the extent that the condition has not yet been met.

Note 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out method.

Note 1.9 Cash and cash equivalents

Cash and cash equivalents comprise of cash in hand and demand deposits, together with short-term highly liquid investments with maturities of 100 days or less and bank overdrafts. Account balances are only off set where a legal agreement has been made with the bank to do so. In all other cases bank overdrafts are shown within borrowings in ‘current liabilities’ on the Statement of Financial Position.

Note 1.10 Finance income and costs

Interest earned on bank accounts and interest charged on overdrafts is recorded as ‘interest receivable’ and ‘interest payable’ in the periods to which they relate, and shown on the Statement of Cash Flows. Bank charges are recorded as operating expenditure in the periods to which they relate.

Note 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 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.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance

leases are recognised and measured in accordance with the accounting policy for leases described in note 1.12.

Public Dividend Capital is not considered to be a financial instrument and is measured at historical cost.

All other financial assets and liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to the receive cash flows from the assets have expired or the 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'. Financial liabilities are classified as 'Other Financial liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income. The Trust does not hold any assets in this category.

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 Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently 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

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 Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised 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 recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

The Trust does not hold any assets in this category.

Other financial liabilities

All other financial liabilities 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 long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' 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.

Note 1.12 Leases Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other 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.

Note 1.13 Provisions

The NHS Foundation Trust recognises 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 rates published and mandated by HM Treasury.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS 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 NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 22.2 on page 49 but is not recognised in the NHS Foundation Trust's accounts.

Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority 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 when the liability arises.

The Trust has also taken out additional insurance to cover claims in excess of £1 million.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 24 on page 49 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 24 on page 49 unless the probability of a transfer of economic benefits are remote. Contingent liabilities are defined as:
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 entity's control; or

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.

Note 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. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS 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 NHS 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 (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, 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 annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the 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 fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Corporation tax

All surpluses are generated by activity authorised as an activity relating to the provision of core healthcare and therefore the Trust has determined that there is not a Corporation Tax liability.

Note 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 NHS foundation Trust has no beneficial interest in them.

Note 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 NHS Trusts not been bearing their 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.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

The following standards and interpretations listed below have had amendments which have been issued by the IASB, but are not required to be followed by the Foundation Trust until a future accounting period. None of them are expected to impact upon the Trust's financial statements.

Change published	Published by IASB	Financial year for which the change first applies
IFRS 11 (amendment) – acquisition of an interest in a joint operation	*May 2014*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IAS 16 (amendment) and IAS 38 (amendment) – depreciation and amortisation	*May 2014*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IAS 16 (amendment) and IAS 41 (amendment) – bearer plants	*June 2014*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IAS 27 (amendment) – equity method in separate financial statements	*August 2014*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IFRS 10 (amendment) and IAS 28 (amendment) – sale or contribution of assets	*September 2014*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IFRS 10 (amendment) and IAS 28 (amendment) – investment entities applying the consolidation exception	*December 2014*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IAS 1 (amendment) – disclosure initiative	*December 2014*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IFRS 15 Revenue from contracts with customers	*May 2014*	*Not yet EU adopted. Expected to be effective from 2017/18.*
Annual improvements to IFRS: 2012-15 cycle	*September 2014*	*Not yet EU adopted. Expected to be effective from 2017/18.*
IFRS 9 Financial Instruments	*July 2014*	*Not yet EU adopted. Expected to be effective from 2018/19.*

Note 2 Operating Segments

The Trust Board as 'Chief Operating Decision Maker' considers that all of its activities fall within one material segment, which is the provision of healthcare services. The segmental reporting format applied to these accounts reflects the Trust's management and internal reporting structure.

The Trust has identified five operating segments based on expenditure, being identified by the corporate performance report presented monthly to the board. All five operating segments have similar characteristics, the nature of services is similar, the production processes are similar, and also the type or class of customer and nature of the regulatory environment are the same. The five operating segments are all active in the same business being the provision of healthcare, thus reporting a single segment of Healthcare is consistent with IFRS 8.

The provision of healthcare is within one main geographical segment being the United Kingdom, and materially from Departments of HM Government in England. Income from within the whole of HM Government is disclosed below:

	Consolidated			
	2015/16		2014/15	
	£000	%	£000	%
Income from whole HM Government	77,990	95.60	72,867	90.66
Income from non HM Government	2,114	2.59	7,457	9.28
Charitable Funds	1,472	1.80	53	0.07
Total income from activities	**81,576**	**100**	**80,377**	**100**

All business activities of the Trust are continually reviewed for material segments.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	Consolidated	
	2015/16	2014/15
	£000	£000
Acute services		
Elective income	43,848	45,142
Non elective income	2,368	1,756
Outpatient income	7,688	6,833
A & E income	-	-
Other NHS clinical income	17,209	18,526
All services		
Additional income for delivery of healthcare services	2,300	-
Private patient income	607	610
Other clinical income		-
Total income from activities	**74,020**	**72,867**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2015/16 £000	2014/15 £000
CCGs and NHS England	69,468	70,992
Other NHS foundation trusts	64	47
NHS trusts	754	507
NHS other	47	237
Non-NHS: private patients	607	391
Non-NHS: overseas patients (chargeable to patient)	11	219
NHS injury scheme (was RTA)	43	31
Non NHS: other	726	443
Additional income for delivery of healthcare services	2,300	-
Total income from activities	**74,020**	**72,867**
Of which:		
Related to continuing operations	74,020	72,867

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	Consolidated	
	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Income recognised this year	11	219
Cash payments received in-year	-	172
Amounts added to provision for impairment of receivables	-	107

Note 4 Other operating income

	Consolidated	
	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Research and development	613	656
Education and training	2,217	2,441
Reversal of impairments	863	2,302
Income in respect of staff costs where accounted on gross basis	1,140	1,142
Incoming resources received by NHS charitable funds	1,472	53
Other income	1,251	916
Total other operating income	**7,556**	**7,510**
Of which:		
Related to continuing operations	7,556	7,510

All income for the Charity has been classified as other operating income.

Note 5.1 Operating expenses

	Consolidated	
	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Services from NHS foundation trusts	6	18
Services from NHS trusts	393	642
Services from CCGs and NHS England	10	15
Purchase of healthcare from non NHS bodies	2,326	1,962
Employee expenses - executive directors	785	703
Remuneration of non-executive directors	107	102
Employee expenses - staff	46,494	43,744
Supplies and services - clinical	11,067	10,399
Supplies and services - general	593	630
Establishment	1,043	957
Transport	13	12
Premises	2,920	3,018
Increase/(decrease) in provision for impairment of receivables	124	(309)
(Decrease)/Increase in other provisions	(92)	-
Inventories written down	-	26
Drug costs	410	478
Inventories consumed	9,772	9,290
Rentals under operating leases	87	85
Depreciation on property, plant and equipment	2,182	2,208
Amortisation on intangible assets	165	135
Impairments	4,101	383
Audit fees payable to the external auditor		
audit services- statutory audit	57	49
other auditor remuneration (external auditor only) (note5.2)	18	18
Clinical negligence	2,435	1,571
Loss on disposal of non-current assets	-	27
Legal fees	62	(4)
Consultancy costs	203	497
Internal audit costs	78	74
Training, courses and conferences	192	250
Patient travel	13	16
Hospitality	2	3
Insurance	85	83
Other services, eg external payroll	326	246
Losses, ex gratia and special payments	36	67
Other resources expended by NHS charitable funds	156	73
Other	207	192
Total expenditure	**86,376**	**77,660**

Note 5.2 Other auditor remuneration

	Consolidated	
	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Other auditor remuneration paid to the external auditor:		
Quality Accounts audit	18	18
External audit services	57	49
Total	**75**	**67**

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £1m (2014/15: £1m).

Note 6 Impairment of assets

	Consolidated	
	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price on land and buildings	3,238	(1,919)
Total net impairments charged to operating surplus / deficit	**3,238**	**(1,919)**
Impairments charge /(credit) to the revaluation reserve	705	(325)
Total net impairments	**3,943**	**(2,244)**

Note 7 Employee benefits

	Consolidated			
			2015/16	2014/15
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	35,328	809	**36,137**	34,538
Social security costs	2,894	-	**2,894**	2,897
Employer's contributions to NHS pensions	3,673	-	**3,673**	3,517
Agency/contract staff	-	5,715	**5,715**	4,637
Total gross staff costs	**41,895**	**6,524**	**48,419**	**45,589**
Recoveries in respect of seconded staff	(1,140)	-	**(1,140)**	(1,142)
Total staff costs	**40,755**	**6,524**	**47,279**	**44,447**
Of which				

Note 7.1 Retirements due to ill-health

During 2015/16 there were no early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2015). The estimated additional pension liabilities of these ill-health retirements is £0k (£19k in 2014/15).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors' remuneration

The aggregate amounts payable to directors were:

	Consolidated	
	2015/16	2014/15
	£000	£000
Salary	838	687
Taxable benefits	0	0
Performance related bonuses	105	82
Employer's pension contributions		
Total	**943**	**769**

Further details of directors' remuneration can be found in the remuneration report.

Note 7.3 Employee costs and numbers

Average number of employees (WTE basis)	Consolidated			
			2015/16	2014/15
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	93	-	**93**	99
Ambulance staff	-	-	**-**	-
Administration and estates	223	-	**223**	245
Healthcare assistants and other support staff	98	-	**98**	69
Nursing, midwifery and health visiting staff	254	-	**254**	274
Nursing, midwifery and health visiting learners	1	-	**1**	5
Scientific, therapeutic and technical staff	217	-	**217**	133
Agency and contract staff	-	64	**64**	104
Bank staff	-	87	**87**	89
Other	-	-	**-**	5
Total average numbers	**886**	**151**	**1,037**	**1,023**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	**-**	-

Reporting of compensation schemes - exit packages 2015/16

There were no exit packages during 2015/16

Reporting of compensation schemes - exit packages 2014/15

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	**-**
£10,001 - £25,000	-	-	**-**
£25,001 - £50,000	1	-	**1**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
Total number of exit packages by type	**1**	**-**	**1**
Total resource cost (£)	£40,000	£0	**£40,000**

For all off-payroll engagements as of 31 Mar 2016, for more than £220 per day and that last for longer than six months

	2015/16
Number of existing engagements as of 31 Mar 2016	1
Of which:	
Number that have existed for less than one year at the time of reporting	1
Number that have existed for between one and two years at the time of reporting	-
Number that have existed for between two and three years at the time of reporting	-
Number that have existed for between three and four years at the time of reporting	-
Number that have existed for four or more years at the time of reporting	-

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2015 and 31 Mar 2016

	2015/16
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year .	-
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	13

Note 8 Operating leases

Lessee

This note discloses costs and commitments incurred in operating lease arrangements where The Royal Orthopaedic Hospital NHS Foundation Trust FT is the lessee.

	Consolidated	
	Year Ended 31 March 2016 £000	**Year Ended 31 March 2015 £000**
Operating lease expense		
Minimum lease payments	87	85
Contingent rents	-	-
Less sublease payments received	-	-
Total	**87**	**85**

The Trust's operating leases for 2015/16 consists of £12,000 (2014/15: £12,000) for the use of an offsite car park, £50,000 (2014/15: £50,000) for Histopathology property lease and the remainder of £25,000 (2014/15: £25,000) relates to a small amount of plant and equipment.

	Consolidated	
	Year Ended 31 March 2016 £000	**Year Ended 31 March 2015 £000**
Future minimum lease payments due:		
- not later than one year;	112	123
- later than one year and not later than five years;	358	417
- later than five years.	126	178
Total	**596**	**718**

Note 9 Finance income

Finance income represents interest received on assets and investments in the period

	Consolidated	
	Year Ended	Year Ended
	31 March 2016	31 March 2015
	£000	£000
Interest on bank accounts	33	44
Investment income on NHS charitable funds financial assets	30	30
Other	-	-
Total	**63**	**74**

Note 10.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	Consolidated	
	Year Ended	Year Ended
	31 March 2016	31 March 2015
	£000	£000
Interest expense:		
Finance leases	127	31
Total interest expense	**127**	**31**
Other finance costs		
Total	**127**	**31**

Note 11.1 Intangible assets - 2015/16

Consolidated	Software licences	Intangible assets under construction	NHS charitable fund assets	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**949**	**-**	**-**	**949**
Additions	54	-	-	54
Gross cost at 31 March 2016	**1,003**	**-**	**-**	**1,003**
Amortisation at 1 April 2015 - brought forward	**354**	**-**	**-**	**354**
Provided during the year	165	-	-	165
Amortisation at 31 March 2016	**519**	**-**	**-**	**519**
Net book value at 31 March 2016	**484**	**-**	**-**	**484**
Net book value at 1 April 2015	**595**	**-**	**-**	**595**

Note 11.2 Intangible assets - 2014/15

Consolidated	Software licences	Intangible assets under construction	NHS charitable fund assets	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	**379**	**390**	**-**	**379**
Additions	239	60	-	239
Reclassifications	450	(450)	-	450
Disposals / derecognition	(119)	-	-	(119)
Valuation/gross cost at 31 March 2015	**949**	**-**	**-**	**949**
Amortisation at 1 April 2014 - as previously stated	**331**	**-**	**-**	**331**
Provided during the year	135	-	-	135
Reclassifications	(9)	-	-	(9)
Disposals / derecognition	(103)	-	-	(103)
Amortisation at 31 March 2015	**354**	**-**	**-**	**354**
Net book value at 31 March 2015	**595**	**-**	**-**	**595**

There is no active market for the Trust's intangible assets and there is no revaluation reserve in respect of these

This note relates to the Trust as the Charity does not hold intangible assets.

Note 12.1 Property, plant and equipment - 2015/16

Consolidated	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	NHS charitable fund assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**3,935**	**33,024**	**806**	**1,025**	**9,631**	**20**	**2,940**	**75**	**-**	**51,456**
Additions	-	1,186	-	902	800	-	247	19	-	**3,154**
Impairments	-	(6,558)	-	-	-	-	-	-	-	**(6,558)**
Reversals of impairments	-	2,615	-	-	-	-	-	-	-	**2,615**
Reclassifications	-	915	-	(1,110)	-	-	195	-	-	**-**
Revaluations	584	(1,932)	(30)	-	-	-	-	-	-	**(1,378)**
Disposals / derecognition	-	-	-	-	(217)	-	(146)	(3)	-	**(366)**
Valuation/gross cost at 31 March 2016	**4,519**	**29,250**	**776**	**817**	**10,214**	**20**	**3,236**	**91**	**-**	**48,923**
Accumulated depreciation at 1 April 2015 - brought forward	**-**	**153**	**-**	**-**	**5,284**	**7**	**1,770**	**52**	**-**	**7,266**
Provided during the year	-	1,195	30	-	754	3	191	9	-	**2,182**
Revaluations	-	(1,348)	(30)	-	-	-	-	-	-	**(1,378)**
Disposals/ derecognition	-	-	-	-	(217)	-	(146)	(3)	-	**(366)**
Accumulated depreciation at 31 March 2016	**-**	**-**	**-**	**-**	**5,821**	**10**	**1,815**	**58**	**-**	**7,704**
Net book value Total at 31 March 2016	**4,519**	**29,250**	**776**	**817**	**4,393**	**10**	**1,421**	**33**	**-**	**41,219**

Note 12.2 Property, plant and equipment - 2014/15

Consolidated	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	NHS charitable fund assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	**3,247**	**30,953**	**1,011**	**1,470**	**8,092**	**39**	**2,063**	**75**	**-**	**46,950**
Prior period adjustments	-	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 1 April 2014 - restated	**3,247**	**30,953**	**1,011**	**1,470**	**8,092**	**39**	**2,063**	**75**	**-**	**46,950**
Additions - purchased/ leased/ grants/ donations	-	1,227	-	1,057	1,625	-	143	-	-	**4,052**
Impairments	-	(218)	(165)	-	-	-	-	-	-	**(383)**
Reversals of impairments	688	1,939	-	-	-	-	-	-	-	**2,627**
Reclassifications	-	412	-	(1,502)	2	-	1,088	-	-	**-**
Revaluations	-	(1,289)	(40)	-	-	-	-	-	-	**(1,329)**
Disposals / derecognition	-	-	-	-	(88)	(19)	(354)	-	-	**(461)**
Valuation/gross cost at 31 March 2015	**3,935**	**33,024**	**806**	**1,025**	**9,631**	**20**	**2,940**	**75**	**-**	**51,456**
Accumulated depreciation at 1 April 2014 - as previously stated	**-**	**62**	**-**	**-**	**4,713**	**21**	**1,987**	**45**	**-**	**6,828**
Accumulated depreciation at 1 April 2014 - restated	**-**	**62**	**-**	**-**	**4,713**	**21**	**1,987**	**45**	**-**	**6,828**
Provided during the year	-	1,380	40	-	653	5	123	7	-	**2,208**
Reclassifications	-	-	-	-	-	-	9	-	-	**9**
Revaluations	-	(1,289)	(40)	-	-	-	-	-	-	**(1,329)**
Disposals / derecognition	-	-	-	-	(82)	(19)	(349)	-	-	**(450)**
Accumulated depreciation at 31 March 2015	**-**	**153**	**-**	**-**	**5,284**	**7**	**1,770**	**52**	**-**	**7,266**
Net book value at 31 March 2015	**3,935**	**32,871**	**806**	**1,025**	**4,347**	**13**	**1,170**	**23**	**-**	**44,190**
Net book value at 1 April 2014	**3,247**	**30,891**	**1,011**	**1,470**	**3,379**	**18**	**76**	**30**	**-**	**40,122**

This note relates to the Trust as the Charity does not hold any Property, Plant and Equipment

Note 12.3 Property, plant and equipment financing - 2015/16

Consolidated	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	NHS charitable fund assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016										
Owned	4,519	27,278	776	817	3,884	10	1,421	33	-	**38,738**
Finance leased	-	-	-	-	369	-	-	-	-	**369**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	-	**-**
PFI residual interests	-	-	-	-	-	-	-	-	-	**-**
Government granted	-	-	-	-	-	-	-	-	-	**-**
Donated	-	1,972	-	-	140	-	-	-	-	**2,112**
NBV total at 31 March 2016	**4,519**	**29,250**	**776**	**817**	**4,393**	**10**	**1,421**	**33**	**-**	**41,219**

Note 12.4 Property, plant and equipment financing - 2014/15

Consolidated	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	NHS charitable fund assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2015										
Owned	3,935	30,649	806	1,025	3,825	13	1,170	23	-	**41,446**
Finance leased	-	-	-	-	522	-	-	-	-	**522**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	-	**-**
PFI residual interests	-	-	-	-	-	-	-	-	-	**-**
Government granted	-	-	-	-	-	-	-	-	-	**-**
Donated	-	2,222	-	-	-	-	-	-	-	**2,222**
NBV total at 31 March 2015	**3,935**	**32,871**	**806**	**1,025**	**4,347**	**13**	**1,170**	**23**	**-**	**44,190**

This note relates to the Trust as the Charity does not hold any Property, Plant and Equipment

The Trust has undertaken an independent revaluation of its assets by Cushman & Wakefield on an alternative site valuation basis.

This has resulted in Land having a market value of £4,518,585, revalued from £3,935,000, whilst Buildings and Dwellings at the Hospital were impaired to £29,711,692 from £33,679,000

The Trust has undertaken an independent revaluation of its assets by Cushman & Wakefield on an alternative site valuation basis.

This has resulted in Land having a market value of £4,518,585, revalued from £3,935,000, whilst Buildings and Dwellings at the Hospital were impaired to £29,711,692 from £33,679,000

Note 13.1 Investments - 2015/16

Consolidated	Investment property	Investments in associates (and joint ventures)	Other investments
	£000	£000	£000
Carrying value at 1 April 2015	**-**	**-**	**735**
Acquisitions in year	-	-	1
Movement in fair value	-	-	(46)
Carrying value at 31 March 2016	**-**	**-**	**690**

Note 13.2 Investments - 2014/15

Consolidated	Investment property	Investments in associates (and joint ventures)	Other investments
	£000	£000	£000
Carrying value at 1 April 2014	**-**	**-**	**781**
Movement in fair value	-	-	27
Disposals	-	-	(73)
Carrying value at 31 March 2015	**-**	**-**	**735**

Note: all investments are held by the Trust's associated charity which has been consolidated into these accounts. Trust only statement of financial position has no investments.

The investments are held as Financial Assets at fair value through profit or loss and are valued annually by Cazenove who manage the multi-asset fund.

Note 14 Analysis of charitable fund reserves

	31 March 2016 £000	31 March 2015 £000
Unrestricted funds:		
Unrestricted income funds	284	377
Restricted income funds	1,849	474
Permanent endowment funds	23	23
	2,156	**874**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objectives. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 15 Inventories

	Consolidated		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Drugs	120	188	120	188
Consumables	3,798	3,598	3,798	3,598
Total inventories	**3,918**	**3,786**	**3,918**	**3,786**

Inventories recognised in expenses for the year were -£9,772k (2014/15: -£9,290k). Write-down of inventories recognised as expenses for the year were £0k (2014/15: -£26k).

Note 16.1 Trade receivables and other receivables

	Consolidated		Trust	
	Year ended 31 March 31 March 2016 £000	Year ended 31 March 31 March 2015 £000	Year ended 31 March 31 March 2016 £000	Year ended 31 March 31 March 2015 £000
Current				
Trade receivables due from NHS bodies	3,509	5,528	2,894	5,528
Other receivables due from related parties	-	91	-	91
Provision for impaired receivables	(444)	(323)	(444)	(323)
Deposits and advances	-	-	-	-
Prepayments (non-PFI)	572	285	572	285
Accrued income	153	31	768	31
Interest receivable	-	3	-	3
PDC dividend receivable	-	53	-	53
VAT receivable	151	115	151	115
Other receivables	897	503	897	503
Trade and other receivables held by NHS charitable funds	170	3	-	-
Total current trade and other receivables	**5,008**	**6,289**	**4,838**	**6,286**

Note 16.2 Provision for impairment of receivables

	Consolidated		Trust	
	Year ended 31 March 2016	Year ended 31 March 2015	Year ended 31 March 2016	Year ended 31 March 2015
	£000	£000	£000	£000
At 1 April as previously stated	**323**	**632**	**323**	**632**
Increase/(decrease) in provision	124	(60)	124	(60)
Amounts utilised	(3)	-	(3)	-
Unused amounts reversed	-	(249)	-	(249)
At 31 March	**444**	**323**	**444**	**323**

Note 16.3 Analysis of impaired receivables

Consolidated	**31 March 2016**		**31 March 2015**	
	Trade receivables	**Other receivables**	**Trade receivables**	**Other receivables**
Ageing of impaired receivables	**£000**	**£000**	**£000**	**£000**
0 - 30 days	-	-	2	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	-	-
Over 180 days	444	-	321	-
Total	**444**	**-**	**323**	-
Ageing of non-impaired receivables past their due date				
0 - 30 days	424	-	1,766	-
30-60 Days	57	-	283	-
60-90 days	176	-	93	-
90- 180 days	-	-	84	-
Over 180 days	-	-	15	-
Total	**657**	**-**	**2,241**	-

Trust	**31 March 2016**		**31 March 2015**	
	Trade receivables	**Other receivables**	**Trade receivables**	**Other receivables**
Ageing of impaired receivables	**£000**	**£000**	**£000**	**£000**
0 - 30 days	-	-	2	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	-	-
Over 180 days	444	-	321	-
Total	**444**	**-**	**323**	-
Ageing of non-impaired receivables past their due date				
0 - 30 days	424	-	1,766	-
30-60 Days	57	-	283	-
60-90 days	176	-	93	-
90- 180 days	-	-	84	-
Over 180 days	-	-	15	-
Total	**657**	**-**	**2,241**	-

Note 17 Other assets

	Consolidated		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Other assets	35	7	-	-
Total	**35**	**7**	**-**	**-**

The Trust did not hold any current asset investments or non-current asset investments in the period ending 31 March 2016, (31 March 2015, £nil). The Royal Orthopaedic Hospital NHS Foundation Trust Charitable Fund held short-term cash deposits within a multi-asset fund, of £35,000 (2015/16 £7,000).

Note 18.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Consolidated		Trust	
	Year ended	Year ended	Year ended	Year ended
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
At 1 April	**13,895**	**19,484**	**13,748**	**19,357**
Net change in year	(2,022)	(5,589)	(3,150)	(5,609)
At 31 March	**11,873**	**13,895**	**10,598**	**13,748**
Broken down into:				
Cash at commercial banks and in hand	-	147	-	-
Cash with the Government Banking Service	11,873	13,748	10,598	13,748
Total cash and cash equivalents	**11,873**	**13,895**	**10,598**	**13,748**

Note 18.2 Third party assets held by the NHS foundation trust

The Royal Orthopaedic Hospital NHS Foundation Trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Consolidated and Trust	
	Year ended	Year ended
	31 March 2016 £000	31 March 2015 £000
Bank balances	-	-
Monies on deposit	-	100
Total third party assets	**-**	**100**

Note 19.1 Trade and other payables

	Consolidated		Trust	
	Year ended	Year ended	Year ended	Year ended
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Current				
NHS trade payables	2,695	1,669	2,695	1,669
Capital payables	307	749	307	749
Social security costs	411	389	411	389
VAT payable	44	-	44	-
Other taxes payable	477	450	477	450
Other payables	5,551	4,798	5,551	4,798
Accruals	2,303	259	2,303	259
PDC dividend payable	15	-	15	-
Trade and other payables held by NHS charitable funds	14	18	-	-
Total current trade and other payables	**11,817**	**8,332**	**11,803**	**8,314**

Other Trade Payables include £52,210 outstanding pension contributions at 31 March 2016 (2014/15: £500,941)

Note 20 Other liabilities

	Consolidated		Trust	
	Year ended 31 March 2016 £000	Year ended 31 March 2015 £000	Year ended 31 March 2016 £000	Year ended 31 March 2015 £000
Current				
Other deferred income	257	397	257	397
Total other current liabilities	**257**	**397**	**257**	**397**

Note 21 Borrowings

	Consolidated		Trust	
	Year ended 31 March 2016 £000	Year ended 31 March 2015 £000	Year ended 31 March 2016 £000	Year ended 31 March 2015 £000
Current				
Obligations under finance leases	163	157	163	157
Total current borrowings	**163**	**157**	**163**	**157**
Non-current				
Obligations under finance leases	221	384	221	384
Total non-current borrowings	**221**	**384**	**221**	**384**

Note 21 Finance leases

Foundation Trust as a lessee

Obligations under finance leases where The Royal Orthopaedic Hospital NHS Foundation Trust is the lessee.

	Consolidated		Trust	
	Year ended 31 March 2016 £000	Year ended 31 March 2015 £000	Year ended 31 March 2016 £000	Year ended 31 March 2015 £000
Gross lease liabilities	**416**	**587**	**416**	**587**
of which liabilities are due:				
- not later than one year;	172	172	172	172
- later than one year and not later than five years;	244	415	244	415
- later than five years.	-	-	-	-
Finance charges allocated to future periods	(32)	(46)	(32)	(46)
Net lease liabilities	**384**	**541**	**384**	**541**
of which payable:				
- not later than one year;	163	157	163	157
- later than one year and not later than five years;	221	384	221	384
- later than five years.	-	-	-	-

Note 22.1 Provisions for liabilities and charges analysis

Consolidated	Other legal claims	Other	NHS charitable fund provisions	Total
	£000	£000	£000	£000
At 1 April 2015	**69**	**427**	**-**	**496**
Arising during the year	28	-	-	**28**
Utilised during the year	(36)	(20)	-	**(56)**
Reversed unused	(23)	(97)	-	**(120)**
Unwinding of discount	-	113	-	**113**
At 31 March 2016	**38**	**423**	**-**	**461**
Expected timing of cash flows:				
- not later than one year;	38	76	-	**114**
- later than one year and not later than five years;	-	54	-	**54**
- later than five years.	-	293	-	**293**
Total	**38**	**423**	**-**	**461**

The provisions included under legal claims are for employee and public liability, and are subject to changes in value and timing by either third party insurers or the NHS Litigation Authority depending on the incident date.

Other claims relate to injury benefit provisions which are discounted using the real discount rate set by HM Treasury. The rates below have been applied for 2015/16: -

Short-term (less than one year) -1.55%
Medium-term (one – five years) -1.00%
Long-term (later than 5 years) -0.80%

Other claims also contain a dilapidations provision for the leased histopathology laboratory at the University of Birmingham, £30,000 (2014/15 £30,000) and a provision for staff related employment claims of nil (2014/15 £97,000).

The note relates to the Trust as the Charity does not have any provisions for liabilities and charges.

Note 22.2 Clinical negligence liabilities

At 31 March 2016, £19,733k was included in provisions of the NHSLA in respect of clinical negligence liabilities of The Royal Orthopaedic Hospital NHS Foundation Trust (31 March 2015: £16,834k).

Note 23 Contingent assets and liabilities

There are no contingent liabilities or contingent assets for the period ending 31 March 2016 (2014/15 £nil).

Note 24 Contractual capital commitments

	Consolidated		Trust	
	31 March 2016	**31 March 2015**	**31 March 2016**	**31 March 2015**
	£000	**£000**	**£000**	**£000**
Property, plant and equipment	1,123	623	1,123	623
Intangible assets	-	-	-	-
Total	**1,123**	**623**	**1,123**	**623**

Capital commitments include £344,000 in relation to general site building works, £300,000 in relation to replacement medical equipment and £200,000 in relation to IT hardware replacement.

Note 25 Related parties

The Royal Orthopaedic Hospital NHS Foundation Trust is a public benefit corporation which was established under the granting of authority by the independent regulator for Foundation Trusts Monitor on February 1 2007.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with The Royal Orthopaedic Hospital NHS Foundation Trust.

The Department of Health is regarded as a related party. During the year The Royal Orthopaedic Hospital NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. These entries are listed below.

	Receivables 2015/16 £'000	Payables 2015/16 £'000	Revenue 2015/16 £'000	Expenditure 2015/16 £'000
Birmingham Children's Hospital NHS Foundation Trust	51	410	376	1,493
Birmingham Community Healthcare NHS Trust	-	221	1	378
Dept of Work and Pensions	113	-	44	-
Health Education England (NDPB from 1/04/15)	21	-	2,067	-
Heart of England NHS Foundation Trust	8	28	20	96
HM Revenue & Customs - Other taxes and duties and NI contributions (including o/s PAYE and NI creditors including both employee and employer contributions)	-	888	-	-
HM Revenue & Customs - VAT	151	44	-	-
NHS Birmingham Crosscity CCG	-	510	14,981	-
NHS Birmingham South and Central CCG	-	350	9,583	2
NHS Blood and Transplant	10	-	-	58
NHS Cambridgeshire and Peterborough CCG	16	-	62	-
NHS Cannock Chase CCG	67	-	460	-
NHS Coventry and Rugby CCG	-	61	386	-
NHS Dudley CCG	-	205	3,218	-
NHS East Staffordshire CCG	7	-	273	-
NHS England - West Midlands Commissioning Hub	236	428	18,557	-
NHS Gloucestershire CCG	27	-	204	-
NHS Herefordshire CCG	1	12	429	-
NHS Litigation Authority	-	-	-	2,435
NHS Nene CCG	39	-	116	-
NHS North, East, West Devon CCG	27	-	55	-
NHS Redditch and Bromsgrove CCG	136	-	3,520	-
NHS Sandwell and West Birmingham CCG	441	-	5,315	-
NHS Shropshire CCG	4	31	166	-
NHS Solihull CCG	51	-	1,915	-
NHS South East Staffs and Seisdon Peninsular CCG	-	155	1,342	-
NHS South Warwickshire CCG	-	81	506	-
NHS South Worcestershire CCG	9	-	1,916	-
NHS Southern Derbyshire CCG	49	-	169	-
NHS Stafford and Surrounds CCG	22	19	237	-
NHS Stoke on Trent CCG	35	-	63	-
NHS Telford and Wrekin CCG	10	-	76	-

	Receivables	Payables	Revenue	Expenditure
	2015/16	2015/16	2015/16	2015/16
	£'000	£'000	£'000	£'000
NHS West Leicestershire CCG	19	-	83	-
NHS Wolverhampton CCG	-	29	390	-
NHS Wyre Forest CCG	-	36	1,121	-
Sandwell and West Birmingham Hospitals NHS Trust	53	59	85	144
The Dudley Group NHS Foundation Trust	22	-	140	-
The Royal Wolverhampton NHS Trust	104	-	380	-
University Hospitals Birmingham NHS Foundation Trust	300	428	463	2,743
Walsall Healthcare NHS Trust	552	-	604	1

	Receivables 2014/15 £'000	Payables 2014/15 £'000	Revenue 2014/15 £'000	Expenditure 2014/15 £'000
Birmingham and the Black Country Area Team	100	299	19,323	-
Birmingham Children's Hospital NHS Foundation Trust	54	446	369	1,487
Birmingham City Council	-	-	-	159
Birmingham Community Healthcare NHS Trust	-	-	-	578
Department of Health	701	-	-	152
Dept of Work and Pensions	91	-	-	-
Dudley and Walsall Mental Health Partnership NHS Trust	-	-	121	-
Health Education England	223	101	2,241	-
Heart of England NHS Foundation Trust	-	-	-	109
HM Revenue & Customs - Other taxes and duties	-	839	-	2,897
HM Revenue & Customs - VAT	115	-	-	-
NHS Birmingham Crosscity CCG	497	94	16,948	-
NHS Birmingham South And Central CCG	459	-	8,785	-
NHS Cannock Chase CCG	-	-	425	-
NHS Coventry And Rugby CCG	166	-	528	-
NHS Dudley CCG	253	65	3,465	-
NHS East Staffordshire CCG	-	-	287	-
NHS England	346	346	19,973	-
NHS Gloucestershire CCG	-	-	176	-
NHS Herefordshire CCG	-	-	504	-
NHS Litigation Authority	-	-	-	1,571
NHS Pension Scheme	-	-	-	3,517
NHS Redditch And Bromsgrove CCG	482	-	3,469	-
NHS Sandwell And West Birmingham CCG	310	-	4,710	-
NHS Shropshire CCG	72	-	235	-
NHS Solihull CCG	144	-	2,083	-
NHS South East Staffs And Seisdon Peninsular CCG	89	-	1,506	-
NHS South Warwickshire CCG	-	-	551	-
NHS South Worcestershire CCG	101	-	1,754	-
NHS Southern Derbyshire CCG	-	-	158	-
NHS Stafford And Surrounds CCG	-	-	278	-
NHS Walsall CCG	58	-	1,714	-
NHS Warwickshire North CCG	-	78	491	-
NHS Wolverhampton CCG	80	-	452	-
NHS Wyre Forest CCG	116	-	1,237	-
Sandwell and West Birmingham Hospitals NHS Trust	132	65	137	241
The Royal Wolverhampton NHS Trust	-	-	328	-
University Hospitals Birmingham NHS Foundation Trust	243	222	427	2,700
Walsall Healthcare NHS Trust	335	-	336	-

The Trust has also received revenue payments from the associated charitable funds where the Trustees are also members of the NHS Foundation Trust Board. The Trust charged the charity for finance administration services totalling £13,000 during the year (£12,855 – 31 March 2015).

Note 26 Financial instruments

Note 26.1 Financial risk management

The Royal Orthopaedic Hospital NHS Foundation Trust seeks to minimise its financial risks and through its treasury management policy does not buy or sell financial instruments. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest Rate Risk

The Foundation Trust's financial assets and financial liabilities carry nil or fixed rates of interest. The Foundation Trust is not, therefore, exposed to significant interest-rate risk.

Credit risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the Trade and Other Receivables note. The majority of trade of the Foundation Trust and the Group is with Clinical Commissioning Groups and NHS bodies, as commissioners for NHS patient care services. As these are funded by Central and Devolved Governments to buy NHS patient care services, no credit scoring of them is considered necessary.

Liquidity Risk

The Trust's operating costs are incurred under contracts with NHS Clinical Commissioning Groups who are financed annually from resources voted from Parliament. Such contract income is received in accordance with the NHS funding mechanism Payments by Results with regular twelfth payments made monthly and a quarterly adjustment made to bring payments in line with actual activity. The Trust aims to fund capital schemes by internally generated funds. In addition the Trust can borrow from the Department of Health's financing facility or commercially. The Trust is therefore not exposed to significant liquidity risk.

Set out below is an analysis, by category, of the Trust's financial assets and liabilities as at 31 March 2016. Fair value approximates to the book value because of the short maturity of these instruments.

Classification

Financial assets are categorised as 'Loans and receivables'. Financial liabilities are classified as 'Other Financial liabilities'.

Note 27.1 Financial assets

Consolidated	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2016					
Trade and other receivables excluding non financial assets	4,436	-	-	-	**4,436**
Cash and cash equivalents at bank and in hand	10,598	-	-	-	**10,598**
Financial assets held in NHS charitable funds	(46)	-	-	-	**(46)**
Total at 31 March 2016	**14,988**	**-**	**-**	**-**	**14,988**

Consolidated	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2015					
Trade and other receivables excluding non financial assets	6,004	-	-	-	**6,004**
Cash and cash equivalents at bank and in hand	13,748	-	-	-	**13,748**
Financial assets held in NHS charitable funds	150	-	-	-	**150**
Total at 31 March 2015	**19,902**	**-**	**-**	**-**	**19,902**

Trust Only	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2016					
Trade and other receivables excluding non financial assets	4,266	-	-	-	**4,266**
Cash and cash equivalents at bank and in hand	10,598	-	-	-	**10,598**
Total at 31 March 2016	**14,864**	**-**	**-**	**-**	**14,864**

Trust Only	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2015					
Trade and other receivables excluding non financial assets	6,004	-	-	-	**6,004**
Cash and cash equivalents at bank and in hand	13,748	-	-	-	**13,748**
Total at 31 March 2015	**19,752**	**-**	**-**	**-**	**19,752**

Note 27.2 Financial liabilities

Consolidated	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2016			
Obligations under finance leases	384	-	**384**
Trade and other payables excluding non financial liabilities	11,817	-	**11,817**
Provisions under contract	461	-	**461**
Total at 31 March 2016	**12,662**	**-**	**12,662**

Consolidated	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2015			
Obligations under finance leases	541	-	**541**
Trade and other payables excluding non financial liabilities	8,313	-	**8,313**
Provisions under contract	496	-	**496**
Financial liabilities held in NHS charitable funds	18	-	**18**
Total at 31 March 2015	**9,368**	**-**	**9,368**

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2016			
Obligations under finance leases	384	-	**384**
Trade and other payables excluding non financial liabilities	11,406	-	**11,406**
Provisions under contract	461	-	**461**
Total at 31 March 2016	**12,251**	**-**	**12,251**

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2015			
Obligations under finance leases	541	-	**541**
Trade and other payables excluding non financial liabilities	8,313	-	**8,313**
Provisions under contract	496	-	**496**
Total at 31 March 2015	**9,350**	**-**	**9,350**

Note 27.3 Maturity of financial liabilities

	Consolidated		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
In one year or less	12,440	8,730	12,440	8,730
In more than one year but not more than two years	167	254	167	254
In more than two years but not more than five years	55	384	55	384
In more than five years	-	-	-	-
Total	**12,662**	**9,368**	**12,662**	**9,368**

Note 27.4 Fair values of financial liabilities at 31 March 2016

	Consolidated		Trust	
	Book value £000	Fair value £000	Book value £000	Fair value £000
Non-current trade and other payables excluding non financial liabilities	-	-	-	-
Provisions under contract	241	354	241	354
Total	**241**	**354**	**241**	**354**

Note 28 Losses and special payments

Consolidated and Trust	2015/16 Total number of cases Number	2015/16 Total value of cases £000	2014/15 Total number of cases Number	2014/15 Total value of cases £000
Losses				
Cash losses	-	-	2	-
Bad debts and claims abandoned	-	-	1	55
Total losses	**-**	**-**	**3**	**55**
Special payments				
Compensation payments	6	36	5	50
Ex-gratia payments	8	-	8	-
Total special payments	**14**	**36**	**13**	**50**
Total losses and special payments	**14**	**36**	**16**	**105**
Compensation payments received		-		-

For the period ending 31 March 2016 the Trust had 14 (31 March 2015: 16) separate losses and special payments, totaling £36,000 (31 March 2015: £105,105).

There were no clinical negligence, compensation under legal obligation or fruitless payment cases where the net payment for the individual case exceeded £300,000.

These amounts are reported on an accruals basis but excluding provisions for future losses.